I declare no competing interests.

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Reframing NCDs and injuries for the poorest billion: a *Lancet* Commission

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In the post-2015 era, the Sustainable Development Goals have come to include non-communicable diseases (NCDs). And yet the world's poorest people are still unlikely to benefit from this expanded focus. Despite efforts by WHO and many others, the development community has mainly understood NCDs as a problem linked to ageing, urbanisation, affluence, and lifestyle choices.[1] This perspective is also reflected in some of the agreed global targets for NCD control.[2]

Despite progress in global welfare, the poorest billion people in the world still live in extreme poverty (<US$1·25 per day) without adequate food, education, housing, sanitation, and health care.[3] More than 700 million people, mostly in rural south Asia and sub-Saharan Africa, are deprived of more than a third of their most basic human needs.[4]

The recognition of the link between illness and poverty shaped the focus of the Millennium Development Goals on control of HIV, tuberculosis, and malaria, and on reducing maternal and child mortality.[5] Health-care providers working in the most deprived settings have long known that NCDs and injuries (NCDIs) are also responsible for a substantial portion of the suffering and death endured by the poorest populations.[6] However, until recently the nature of NCDIs among the most destitute has largely been misunderstood by the broader policy community.

In 2011, the Program on Global NCDs and Social Change in the Harvard Medical School Department of Global Health and Social Medicine, Boston, MA, USA, hosted a meeting on the NCDs of the poorest billion.[7] This meeting put forward the idea that the NCDIs afflicting these populations are more likely to be the result of infections and harmful environments than behavioural risk factors. NCDIs in these populations include many entities, for example, type 1 and malnutrition-associated diabetes, rheumatic heart disease, Burkitt's lymphoma, cervical cancer, haemoglobinopathies, kidney diseases, epilepsy, depression, appendicitis, and trauma in its various manifestations. None of these NCDIs alone represents a major cause of death or disability. Collectively, however, they could account for more than a third of the disease burden among those living in extreme poverty, with more than two-thirds of this burden concentrated among individuals younger than 40 years.[8,9] The distinctive epidemiology of NCDIs among the poorest people highlights the limitations of the common behavioural risk factor model, and underlines the need for emphasis both on the role of material poverty and on integrated health-service interventions to address a range of diseases.

Since 2011, this message has matured and found traction with influential actors in global health. Regional offices of WHO have embraced a broader set of NCD risk factors and conditions.[10,11] In July, 2013, the non-governmental

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organisation Partners In Health and the Rwandan Ministry of Health convened NCD focal points from a group of countries in the African region to develop a network, NCD Synergies, focused on understanding and addressing NCDIs among their largely poor and rural populations.[9] In April, 2015, WHO held a dialogue on NCDs, poverty, and development cooperation, in which there was a special session devoted to the NCDs of the poorest billion.[12]

Additionally, in 2013, the *Lancet* Commission on Investing in Health projected the feasibility of a global convergence of health outcomes between low-income and upper-middle-income countries by 2035.[13] The Disease Control Priorities Network is also now well on the way toward defining the health and economic effects of multiple essential packages that comprise universal health coverage.[14]

We are launching a *Lancet* Commission on Reframing NCDs and Injuries for the Poorest Billion. Our aspiration is to build on these developments and provide the analytical basis for country-level investments that prioritise the needs of the most indigent. A group of 22 Commissioners will work over 18 months with ten partner countries and a group of high-level advisers. This work will begin with an initial meeting in London in January, 2016, with anticipated publication of the Commission report in 2017.

The Commission will have six working groups. The first working group will focus on poverty, defining the NCDI burden in relation to poverty both as a cause and as a consequence. The second group will evaluate the cost, effect, and priority of integrated health-service delivery platforms and packages in specific countries. The third group will look at the opportunity to shape the market for commodities associated with these integrated interventions. The fourth group will explore the effect of multisectoral action. The fifth group will study the opportunity for expanded and innovative financing for NCDIs targeted toward the poor in low-income countries.[15] Finally, the sixth group will review the history of advocacy for NCDIs in relation to other global health initiatives, in search of lessons for movement-building. The activities of the Commission will be transparent and accessible, reported regularly on the Commission website and discussed through Twitter.

The ambition of this Commission is to catalyse a quantum leap in progress toward global health equity and poverty eradication in advance of the next UN high-level meeting on NCDs in 2018.

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