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Building coalitions for better
health: Advancing place-based
change in communities

Foreword

Non-communicable diseases are among some of the defining health and economic challenges of our time. Their impact can be shaped not only by access and quality care, but also by the conditions in which people live, work, learn and age – in fact, up to 80% of individual health outcomes stem from the non-medical drivers of health.¹ That reality carries an important implication: improving outcomes will require more than strong institutions acting alone. It also requires practical coalitions that can

align capabilities across sectors, connect strategy to delivery, and organize action around the communities where risk is often experienced and where prevention, care and long-term resilience must take root. Critically, these conditions are not equally distributed. The burden of non-communicable diseases falls disproportionately on communities facing

“ Lasting progress on health outcomes will come from coalitions that help turn shared ambition into practical delivery, with trust, accountability, and dedication. ”

Joe Ucuzoglu

“ When science, policy, care and community action are aligned around people and place, prevention becomes more practical, more equitable in reach, and more likely to endure. ”

Nancy Brown

economic disadvantage, geographic isolation, and underinvestment in the environments and systems that determine health.

The case for better health outcomes may not be only moral and social; it can also be increasingly financial and strategic. Deloitte analysis indicates that shifting from reactive care toward prevention and early intervention could save the US health system up to **US\$2.2 trillion a year by 2040**,² Deloitte’s research in the UK similarly suggests that prevention

can generate approximately **£8 in value for every £1 invested**³ (~US\$11 in value for every US\$1.40 invested), underscoring that healthier populations are closely linked to stronger productivity, greater workforce resilience and more sustainable public finances. For leaders in business, public system and civil society, investing earlier in health could not only be better for communities, but also for economic performance and long-term institutional resilience.

“
The next frontier in population health is not simply knowing more about risk – it is integrating digital tools, real-world data, and community knowledge to organize prevention and care around the places and systems where risk is actually produced
”

Michelle A Williams

This is why place-based collaboration matters now. Around the world, leaders are navigating rising disease burden, constrained resources, fragmented delivery systems and growing expectations for measurable results. At the same time, the opportunity is significant. When public systems, health systems, businesses, community organizations, academics and civil society work together with clear roles, shared decision-making and shared accountability, they can have a greater impact. They can build stronger pathways for prevention, earlier detection, better care coordination and

more durable local capacity. In that sense, collaboration is not an adjunct to implementation; it is increasingly the mechanism through which implementation can become possible.

The case is both practical and urgent. Public health evidence continues to show that prevention should be treated as a central organizing principle. Scientific knowledge, policy, delivery capability and community trust each matter, but none is likely sufficient on its own. Lasting progress could depend on whether these assets can be connected in ways that reflect local context, lived experience and institutional reality. The most effective coalitions are therefore not defined by the number of organizations involved, but by whether they can translate shared intent into action that is coordinated, evidence-informed, and sustainable over time.

This report is written in that spirit. It is intended as an implementation companion: a practical guide for leaders seeking to move from commitment to execution in the places where health outcomes can be shaped. Its message is simple. Better health outcomes will not come from ambition alone. They will come from coalitions built with trust, clarity, and staying power – coalitions that are grounded in communities, informed by evidence, designed for delivery and capable of creating long-term value for people, systems and societies.

“
The opportunity now is to build coalitions that connect the private sector with health, finance and other ministries to create more holistic solutions – making health systems more preventive, more connected and more investable
”

Shyam Bishen

Joe Ucuzoglu

Global Chief Executive Officer, Deloitte

Nancy Brown

Chief Executive Officer, American Heart Association

Michelle A Williams

Professor of Epidemiology and Population Health, Stanford University School of Medicine

Shyam Bishen

Head, Centre for Health and Healthcare; Member of the Executive Committee, World Economic Forum

Executive summary

Non-communicable diseases (NCDs) are shaped as much by place as by medicine. Where people live, work, learn and move can influence exposure to risk factors, access to prevention, and the ability of systems to identify risk early and respond effectively. This matters because NCDs, including cardiovascular disease, cancer, chronic respiratory disease and diabetes, are one of the leading cause of death globally, accounting for at least 43 million deaths in 2021, including around 18 million premature deaths before the age of 70.⁴ Despite global commitments to reduce premature NCD mortality, progress remains off track⁵.

The previous World Economic Forum paper, “Closing Health Gaps: A Guide to Impactful Place-Based Change”,⁶ established the strategic case for place-based change. It argued that up to 80% of individual health outcomes are profoundly shaped by the non-medical social, economic and environmental conditions of communities⁷ and set out four principles for effective place-based change: community ownership and empowerment, a rigorous analytical approach, purposeful and lasting partnerships, and a sustainable, execution-oriented operating and governance model.

This report builds on that foundation. It asks how those principles can be operationalized through coalitions, with a particular focus on NCD-related health gaps. One of the central arguments is that place-based coalitions can act as the integration layer between strategy and delivery: aligning actors, capabilities and resources around a shared geography, population and set of outcomes to address the non-medical risk factors contributing to poor health.

Coalitions matter not only because they bring together complementary capabilities, but because they can create continuity of investment, support longer-term sustainability and connect prevention efforts more effectively into health systems over time. In complex NCD contexts for prevention, early detection, care coordination and community engagement, where outcomes depend on action across multiple sectors and

institutions, coalitions can provide the structure needed to align delivery, learning, financing and public-system ownership around a shared place, population and outcome.

However, coalitions may not automatically deliver impact. Many remain strong on ambition but may be ineffective on execution. They may have convening power but no operational backbone, strong collaborators but misaligned incentives, promising pilots but no route to public-system adoption, or community engagement that could be treated as consultation rather than ownership. The report therefore reframes coalition underperformance as a design problem: one that can be addressed through clearer ownership, better collaborator alignment, stronger delivery capability, public-system anchoring and early planning for sustainability.

The report is informed by three sources of evidence: a review of 150+ place-based health programmes using publicly available sources;⁸ collaborator discussions and implementation insights; and two deeper implementation archetypes in Brazil and Nigeria. The broader program review shows that place-based health action may no longer be niche, that NCDs are one of the major focuses of this landscape, and that many programs are strong on ambition but less transparent on operating model, financing pathway and long-term sustainability.

Two implementation archetypes illustrate different routes into coalition-building. Brazil represents an infrastructure-led route, where an existing cardiovascular platform, public-sector relationships and delivery assets created a foundation for a broader prevention proposition. Nigeria represents a problem-led route, where a defined maternal and newborn health commodity challenge required public system alignment, multistakeholder convening and phased diagnosis before proof-of-concept design. Together, the examples show that there is typically no single route into coalition formation, but that starting conditions should help shape coalition design.

The report concludes with an action guide for leaders on how to build effective place-based coalitions through five practical steps:

- Define the place, problem and rationale for action: select a geography and problem where coalition action is both needed and feasible, not based on challenges alone
- Build the coalition architecture: assemble the core functions required to act – convening, strategic collaborators, operational backbone, public-system ownership and community grounding
- Map capabilities and identify gaps: assess what assets, relationships, delivery capabilities, data systems and skills already exist, and what still needs to be built or recruited
- Co-design the intervention and operating model: translate coalition assets into a practical prevention or care pathway, with clear roles, coordination, proof-of-concept assumptions and success measures

- Design for sustainability and scale: plan early for public-system alignment, financing, ownership, evidence generation, adaptation and long-term coordination

The challenge now is implementation. If NCDs are shaped by place, then action should be organized in place too.

This report proposes that coalitions should not be treated as one-off convenings or pilot partnerships. They should be designed as practical operating models for place-based NCD prevention, care and long-term health improvement. At the same time, coalition models will vary by jurisdiction, institutional context and starting conditions. This report is therefore intended as a design framework, not a one-size-fits-all policy prescription. The accompanying global database of place-based health programs⁷ is intended to make this growing field more visible and connected, helping practitioners, funders and policymakers identify comparable initiatives, learn from existing models and contribute new examples to help strengthen the evidence base.



From place-based principles to NCD implementation

Non-communicable diseases (NCDs) are often shaped by the non-medical social, economic and environmental conditions of communities.⁹ Where people live, work, learn and move can influence exposure to risk factors, access to prevention, and the ability of systems to identify risk early and respond effectively. This matters because NCDs remain one of the leading causes of death and disability globally. In 2021, NCDs – including cardiovascular disease, cancer, chronic respiratory disease, and diabetes – accounted for more than 43 million deaths, equivalent to around 75% of all non-COVID-19-related deaths worldwide. Around 18 million of these deaths occurred before the age of 70, and the majority of premature NCD deaths occur in low- and middle-income countries.¹⁰

Despite global commitments to reduce premature NCD mortality by one-third, progress remains off track in many settings.¹¹ Much of the NCD burden is shaped outside healthcare settings, through daily exposure to risk factors such as unhealthy diets, physical inactivity, harmful use of alcohol and tobacco use, as well as wider environmental, social and economic conditions. Food systems, transport, housing, education, employment, air quality, community infrastructure, and local service access each shape whether individuals can prevent disease, detect risk early, and manage long-term conditions.¹²

The case for prevention is strong. Informed interventions already exist, from fiscal and regulatory measures on tobacco, alcohol, salt, sugar and unhealthy fats, to hypertension and diabetes management, early detection, community-based prevention and continuity of care. Recent global

analysis suggests that relatively modest additional investment in proven NCD interventions could save many of lives and generate substantial economic returns by 2030.¹³ The harder challenge is implementation: how to organize delivery around the places where NCD risk is experienced and where prevention either succeeds or fails.

The previous World Economic Forum paper, “Closing Health Gaps: A Guide to Impactful Place-Based Change”,¹⁴ established the strategic case for place-based approaches. It indicated that health outcomes are profoundly shaped by the social, economic and environmental conditions of communities, and that up to 80% of individual health outcomes stem from non-medical drivers of health. It defined place-based change as collaborative, community-led and long-term action in a defined geography, bringing together community, public system, private sector, civil society and academia to help address root causes and multiple challenges at once.

That paper set out four principles for effective place-based change: community ownership and empowerment, a rigorous analytical approach, purposeful and lasting partnerships, and a sustainable, execution-oriented operating and governance model. These principles remain the foundation for this report. This paper takes the next step: it asks how those principles can be operationalized through cross-sector coalitions, with a particular focus on NCD-related health gaps.

Figure 1. From place-based principles to coalition implementation

Place-based principle	Coalition implication	Action guide step
Community ownership and empowerment	Build local legitimacy, trusted relationships and community-facing accountability	6.1 Define the Place, problem and rationale for action
Purposeful and lasting partnerships	Clarify partner roles, incentives, value propositions and decision rights	6.2 Build the coalition architecture
Rigorous analytical approach	Use evidence to define the place, population, problem, assets and capability gaps	6.3 Map capabilities and identify gaps
Sustainable and execution-oriented operating and governance model	Establish delivery backbone, public-system anchoring, financing and scale pathway	6.4 Co-design the intervention and operating model; 6.5 Design for sustainability and scale

Source: Deloitte analysis

The four principles are not separate from coalition design; they are a test of whether a coalition is likely to work. Community ownership becomes an operating requirement, not only a value statement. Rigorous analysis becomes the discipline of selecting an appropriate place, population and problem. Purposeful partnerships become explicit roles, incentives and value propositions. A sustainable operating model becomes the delivery backbone, financing pathway and governance required to move beyond pilot activity.

This shift from principle to implementation matters because many NCD strategies recognize the importance of prevention and wider drivers of health, but delivery still often remains fragmented across sectors, institutions and funding streams. Prevention may sit in one part of the system, primary care in another, community engagement somewhere else, and wider factors associated with health outcomes – such as food, transport, schools, housing, employment or climate – outside the health sector altogether. Communities may experience these factors together, but systems often respond through disconnected programs.

This does not mean that every coalition should intervene across all these areas, or that one-public system should finance them all through a single model. It means leaders need to understand how these factors shape outcomes

and implementation in a given place, then decide where coalition-based action is most practical and where coordination can add the greatest value

Place-based coalitions can help address this implementation gap. Their value is not simply that they bring organizations together, but that they create an integration layer between strategy and delivery: aligning actors, capabilities and resources around a shared geography, population and set of outcomes. For NCDs, this means enabling prevention, early detection, care coordination, community engagement, financing and public-system ownership to work together rather than in parallel.

This report is therefore an implementation companion to “Closing Health Gaps: A Guide to Impactful Place-Based Change”.¹⁵ It translates the four principles of place-based change into a practical coalition design lens for leaders working on NCD-related health gaps. Drawing on a broader review of place-based health programs, collaborator discussions and two implementation archetypes – Brazil and Nigeria – it shows where coalitions commonly break down, what effective coalitions do differently, and how leaders can move from shared ambition to coordinated local action.

What coalitions need to consider

Place-based coalitions matter because no single institution likely holds all the levers required to prevent, detect and manage NCDs in a community. Reducing cardiometabolic risk, improving early detection, supporting long-term condition management or shifting food and physical activity environments can require capabilities that sit across public institutions, community organizations, delivery collaborators, and strategic and technical collaborators. Public institutions typically provide legitimacy, policy alignment and a route to long-term system ownership. Community organizations can bring trust, local knowledge and reach. Delivery collaborators translate ambition into implementation. Strategic and technical collaborators may bring innovation, funding, skills, data or delivery assets.

A value of a coalition is that it can align these capabilities around a shared place, population and a set of outcomes. Many coalitions can remain strong on ambition but weak on execution. They can bring collaborators together but may not clarify ownership. They generate visibility but may lack a delivery backbone. They can launch pilots but may not build a route to public-system adoption, long-term financing or community ownership.

The question is therefore not whether collaboration is valuable, but what coalitions should consider as success factors in order to deliver.

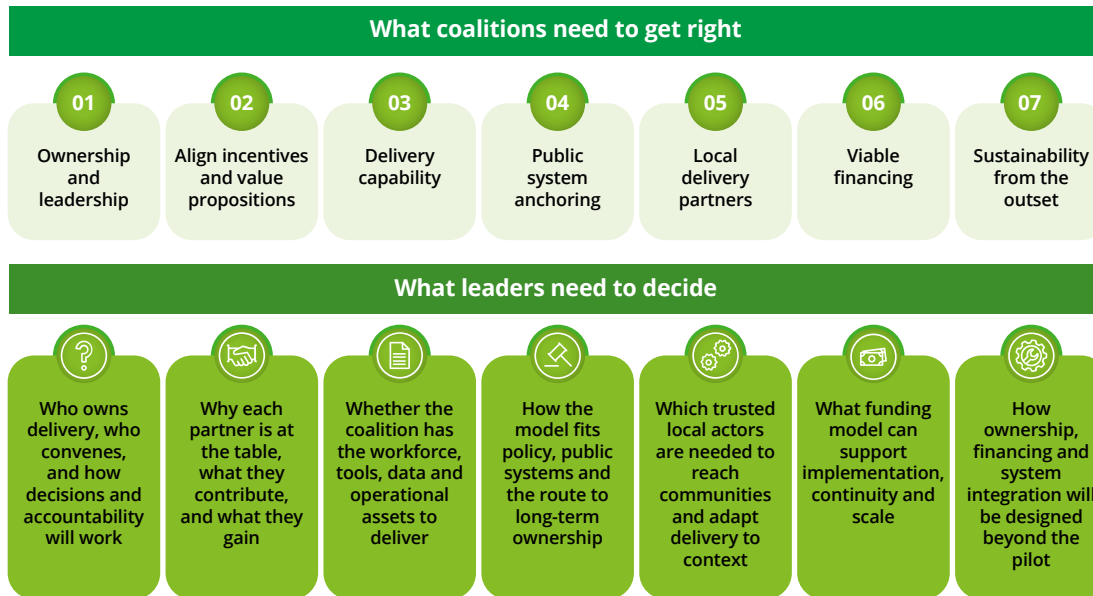
Common coalition design decisions

Coalition design decisions are often structural. In NCD-related work, this can be especially common because decisions are cross-sector, long-term and distributed across multiple systems. Prevention, early detection, chronic care, food environments, physical activity, local infrastructure and community engagement often sit with different institutions, funding streams and incentives. As a result, even when many organizations are active, their efforts can remain misaligned.

For example, a coalition may want to improve hypertension control, but the required action may span community screening, primary care follow-up, medicine access, patient education, employer engagement, food environments and data systems – each owned by different actors. Figure 2. highlights the most common design decisions leaders need to consider.

In practice, coalition-building can be slowed by legal agreements, data-sharing constraints, prolonged partner engagement, unclear decision rights and the time required to build trust across organizations. In some cases, these transaction costs can become so heavy that coalitions can spend disproportionate effort on participation mechanics rather than delivery. This is one reason coalition design matters: effective coalitions do not eliminate complexity, but they manage it early and proportionately so that governance and coordination enable implementation rather than potentially crowding it out.

Figure 2. What design decisions coalition leaders need to get right



Source: Deloitte analysis

Coalition system required for effective implementation

If the previous section identifies the common design decisions, the next question is what effective coalitions do differently. The answer is not simply to add more collaborators. Effective coalitions require a system of core roles that are clearly assigned, connected and accountable.

Five roles are especially important (Figure.3). The convenor aligns actors around a shared agenda and sustains momentum. Strategic collaborators bring funding, skills, innovation or influence. An operational backbone translates ambition into delivery. Public-system anchoring creates legitimacy, continuity and a route to scale. Community and local grounding can ensure that the coalition is shaped by local priorities, informed by lived experience, supported by trusted delivery collaborators and accountable for uptake and implementation quality.

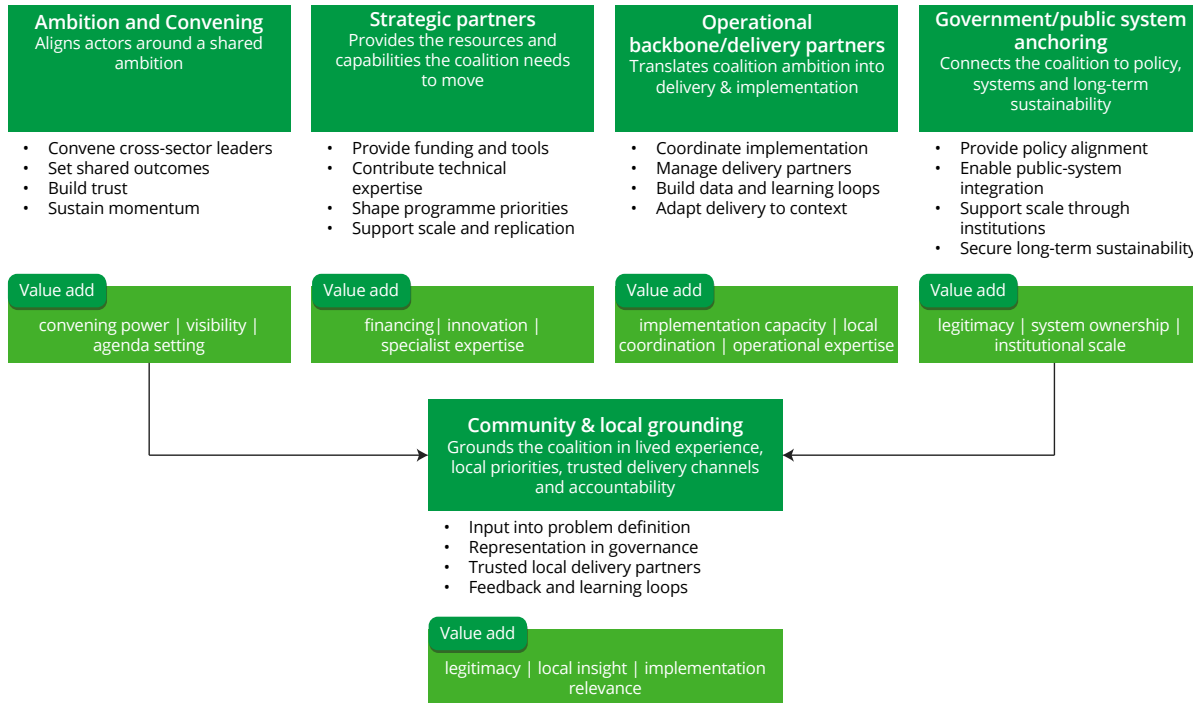
Across all five roles, coalitions should treat inclusive reach as a design requirement, not only a stated value. Within any defined geography, NCD risk, access to prevention, and quality of care are rarely distributed evenly. Disparities by income, gender, employment status, housing security, migration experience and neighborhood-level conditions

mean that coalitions operating at the level of "place" must still ask which populations within that place are being reached – and which are not. An effective coalition designs its screening, referral, follow-up and community engagement to actively close gaps in uptake and outcomes across sub-populations, rather than assuming that geographic targeting alone is sufficient.

In practice, community and local grounding can include community input into problem definition, representation in governance, use of local delivery collaborators, and community-facing feedback and learning loops. This is what turns community ownership from a principle into an operating requirement.

These roles are the practical expression of the four place-based principles. Community grounding helps operationalize community ownership and empowerment. Evidence generation, place selection and capability mapping can operationalize the rigorous analytical approach. Convening and collaborator alignment can operationalize purposeful and lasting partnerships. The operational backbone, governance and public-system anchoring can operationalize the sustainable, execution-oriented operating model.

Figure 3. Coalition system required for effective place-based implementation



Source: Deloitte analysis

Effective coalitions are not typically defined by the number of collaborators involved, but by whether the core functions required for delivery are present, connected and accountable. Community and local grounding should not sit outside the coalition model; it should shape how the whole system works.

What effective coalitions do differently

Effective coalitions may not just convene. They can make design choices that enable collaboration to become delivery. They can clarify who owns the agenda, align collaborator incentives, map what capabilities already exist, fill the gaps that may matter most, anchor the work in public systems and help build a credible route to sustainability.

For NCD-related place-based change, this can matter because impact can depend on coordination over time. Prevention, early detection, chronic care and

wider drivers of health cannot always be managed through short-term or disconnected activity alone. A screening campaign, for example, may have limited value if there is no pathway into diagnosis, treatment, follow-up and sustained support. Equally, prevention efforts are unlikely to endure if they are not connected to local institutions, financing and community ownership.

For companies, coalitions may also offer a more credible route to deploy capabilities, reach local populations, connect to public systems and mitigate fragmented standalone efforts.

Coalitions should create the conditions for different actors to work as one local system: organized around a shared problem, grounded in community need, supported by evidence, and connected to long-term ownership.

What the broader evidence base shows

The report is informed by three sources of evidence: a review of 150+ place-based health programs¹⁶ using publicly available sources; collaborator discussions and implementation insights; and deeper coalition examples in Brazil and Nigeria (Figure.4). Across the program review, the analysis assessed how initiatives reflected the four place-based principles, alongside their geographic distribution, NCD focus, intervention type, leading anchor organization and the sector leading the program.




Across the broader program landscape review, five patterns stand out:

- First, place-based health action is no longer niche. Programs are often being implemented across regions, income settings and health challenges, suggesting growing recognition that health outcomes should be addressed in the context of place.
- Second, NCDs are an important focus of place-based action. Many programs in the database target cardiometabolic health, obesity, behavioral and mental health, cancer, respiratory disease or wider prevention agendas. This helps reinforce the relevance of place-based approaches to the NCD implementation challenge.

- Third, while many place-based initiatives describe strong ambitions and partnership models, publicly available information is often less detailed on operating models, financing pathways and long-term sustainability. This can make it harder to compare what enables implementation and scale across contexts.
- Fourth, existing assets matter. Programs may appear more likely to gain traction when they build on established delivery platforms, trusted local relationships, institutional relationships or public system priorities, rather than starting from a blank slate.
- Finally, community ownership and public-system anchoring are frequently cited as important but are often less clearly operationalized.

Together, these findings help point to a practical conclusion: the next phase of place-based NCD action is not simply about creating more initiatives. It is about building coalitions that are better designed to deliver, learn, adapt and scale.

Figure 4. Evidence base informing this report

Evidence source	What it contributes	How it informs the report
 <p>Review of 150+ place-based programmes (Aligned to the four place-based principles, geographic region, NCD focus, intervention type, leading anchor organisation)</p>	<p>Shows recurring patterns across regions, NCD priorities, intervention types, anchor organisations and programme leadership models</p>	<p>Grounds the coalition framework in a wider programme landscape</p>
 <p>Partner discussions & implementation insights</p>	<p>Surfaces practical lessons on coalition formation, partner roles, delivery barriers and sustainability</p>	<p>Informs the design decisions and action guide</p>
 <p>Brazil and Nigeria implementation archetypes</p>	<p>Provide deeper examples of how coalitions form from different starting points</p>	<p>Bring the framework to life through practical lessons</p>

Framework distilled from programs review; archetypes used for validation and illustration

Source: Deloitte analysis



Implementation archetypes: two routes into coalition- building

There is typically no single route into coalition formation. Some coalitions may begin with an existing delivery platform and then look for ways to broaden, strengthen or adapt it. Others may begin with a clearly defined system bottleneck and then build a coalition around diagnosis, alignment and proof of concept (Figure.5).

The Brazil and Nigeria examples are included as implementation archetypes. They are not intended as exhaustive case studies. Their purpose is to help show how coalition design choices can play out in practice: what creates momentum, what slows progress, and what leaders should take from each route.

Brazil illustrates an infrastructure-led route: building from an existing platform, strong municipal relationships and operational capability, while working to help sharpen the prevention proposition and fill missing specialist capability.

Nigeria illustrates a problem-led route: building from a clearly defined system bottleneck, early public system alignment and multistakeholder convening, while using phased diagnosis to help understand bottlenecks before moving to proof of concept.

Figure 5. Two routes into coalition-building

	Infrastructure-led route	Problem-led route
Starting asset base	Existing programme platform, delivery assets, relationships and public-sector credibility	Clearly defined system bottleneck, early government alignment and a strong case for coordinated action
Core risk	Assuming existing infrastructure is enough, without sharpening the use case or identifying missing capability	Trying to design a solution too early, before the bottlenecks, feasible entry points and coalition roles are clear
Key leadership question	How can existing assets be converted into a more integrated, investable prevention model?	How can fragmented actors and evidence be organised into a credible proof of concept?
What unlocks progress	Capability mapping, proposition clarity, identification of missing specialist partners, and narrowing from broad alignment to a practical use case	Phased diagnosis, actor alignment, manageable geography or scope, and proof-of-concept design grounded in operational reality
Main lesson	Build from what exists, but do not assume existing infrastructure is sufficient	Start with the problem, then phase the coalition design around evidence and feasibility

Source: Deloitte analysis

Both routes can lead to effective coalition-building, but they create different design tasks for leaders. Infrastructure-led coalitions need to convert inherited assets into a specific and investable model. Problem-led coalitions need to turn a broad challenge into a feasible proof of concept.

Brazil archetype: building from existing infrastructure

Starting point

The Brazil example began from a comparatively strong base: an existing delivery platform, established public-sector relationships, operational capabilities and usable data (Figure.6). Rather than starting from a blank slate, the coalition could build on assets that were already in place and explore whether they could support a broader prevention proposition. In this case, the starting platform was cardiometabolic, with an opportunity to test whether it could be extended through an additional prevention entry point linked to oral health.

The opportunity was not to create another parallel program, but to build on an existing platform and determine whether it could support a more integrated use case. The rationale for broadening the proposition was clear: oral diseases affect an estimated 3.5 billion people globally and share major modifiable risk factors with NCDs such as cardiovascular disease and diabetes.¹⁷

Why a coalition was needed

The coalition was needed because existing assets alone may not automatically create a new intervention model. In infrastructure-led coalitions, the leadership task is not simply to recognize what already exists, but to determine what can be adapted, what is missing, and where a coalition can add value beyond parallel activity. In Brazil, that meant moving from a broad base of capability towards more integrated use case, target population, specialist capability plan and investable proposition.

Existing platforms can accelerate progress, but they can also create false confidence. Leaders should ask: what exactly are we adding, which population are

we serving, what gap are we closing, and what would make this investable or scalable?

What unlocked progress

Progress was enabled by four factors:

- Existing program infrastructure and delivery experience
- Established municipal relationships and public-sector credibility
- Capability mapping that clarified where the coalition could credibly add value
- Identification of a complementary prevention opportunity that could build on, rather than duplicate, the existing platform

What slowed progress

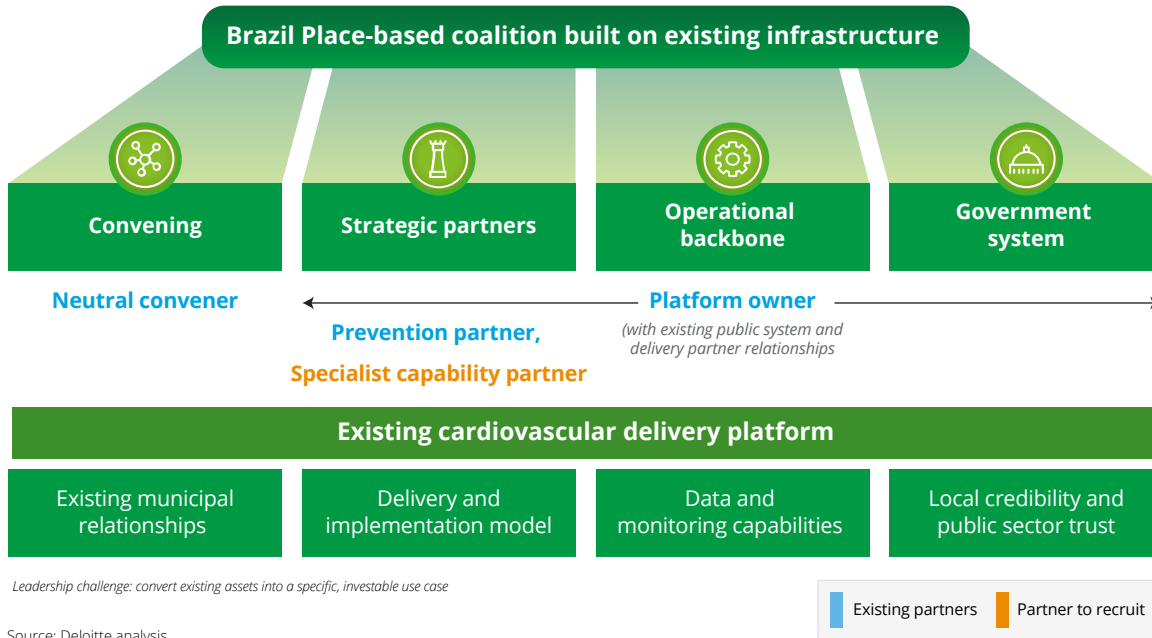
Progress was likely slowed by the fact that the initial starting point was broad. Brazil was already a priority country, cardiometabolic disease was already a priority area, and collaborators already had activity on the ground. That created momentum but did not automatically produce a clear intervention. The coalition still needed to narrow from broad country and disease alignment to a more specific use case, target population, missing capability and delivery model. The main remaining challenge was not basic infrastructure or access. It was proposition clarity: defining the final model, securing the missing specialist oral health capability, and aligning funding and implementation requirements.

What leaders should take from this case

Coalition leaders should build from credible platforms where they exist but mitigate the assumption that broad alignment is enough. Capability mapping is important to distinguish what already exists, what can be adapted and what still needs to be built.

Infrastructure-led coalitions start with a stronger delivery base, but their main design task is not simply to prove that assets exist. It is to convert those inherited assets into a narrower, investable prevention proposition with the right complementary capabilities.

Figure 6. Brazil archetype: building from existing infrastructure



Nigeria archetype: building from a defined delivery problem

Starting point

The Nigeria example began from a defined system challenge: persistent gaps in access to essential maternal and newborn health commodities. Stock-outs, ineffective last-mile delivery, fragmented activity, limited continuity from pilots to scale, and inconsistent payment or contracting mechanisms helped reduce reliability across the system.

Maternal and reproductive health services create opportunities for earlier screening, follow-up and risk management for conditions linked to later life NCD outcomes such as cardiometabolic disorders, including hypertension, gestational diabetes and obesity.¹⁸ This case therefore can offer transferable lessons for NCD coalitions facing similar challenges:

fragmented actors, data gaps, ineffective last-mile delivery and the need for phased diagnosis before intervention design.

Why a coalition was needed

The challenge was too broad and system-wide for any one institution to solve alone. Public system alignment was important, but public authorities could not close the gap by themselves. Development actors brought technical depth and field presence. Private-sector collaborators could contribute logistics, product experience and operational capability. The coalition was therefore formed around the idea that improving commodity access could require a more structured and coordinated model, not more isolated efforts.

What unlocked progress

Progress was enabled by four factors:

- A clearly defined system challenge
- Early public system alignment
- Large-scale convening that surfaced shared priorities
- A phased state-level approach that made the challenge more manageable

What slowed progress

Progress was slowed by the fragmented and inconsistent nature of the evidence base. Publicly available data was not sufficient on its own to identify the most important system bottlenecks. Data was often inconsistent, difficult to consolidate across sources or disconnected from the realities of delivery. As a result, the coalition needed to draw more heavily on field presence and local skills to gather qualitative insight on the ground.

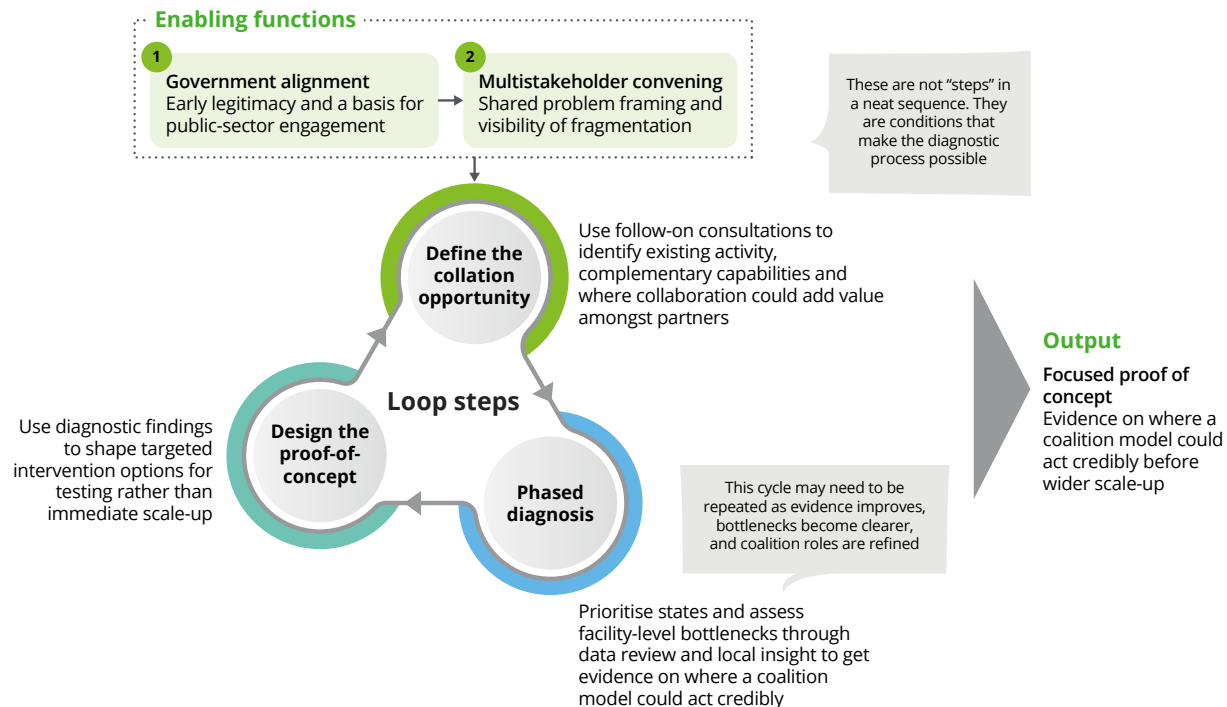
This took more time, but it created a more realistic understanding of delivery constraints. The lesson is important for NCD coalitions: where data is weak, the answer is not to skip diagnosis, but to combine available data with local insight, operational experience and phased testing.

What leaders should take from this case

Political momentum and launch ambition are not always the same as operational readiness. Where a challenge is broad, fragmented or misunderstood, the stronger route may be to define the problem first, test through a manageable geography and then move toward proof of concept (Figure.7).

The leadership task in problem-led coalitions is to resist premature solutioning and earn the right to scale through diagnosis, narrowing and proof of concept.

Figure 7. Nigeria archetype: building from a defined delivery problem



Location selection, evidence gathering and coalition-role clarification may be revisited as diagnosis progresses

Source: Deloitte analysis

Comparative lessons for leaders

The two archetypes show that coalition formation can start from different places. In Brazil, the coalition began from existing infrastructure and then worked to sharpen the proposition. In Nigeria, the coalition began from a defined delivery problem and then worked to build the evidence base and operating model (Figure.8).

Infrastructure-led coalitions can move faster because relationships, delivery assets and credibility already

exist. One of the main risks is assuming that existing activity is enough. Leaders should define what the coalition adds, which gap it is solving and what additional capabilities could be required.

Problem-led coalitions can be more focused because the system challenge is clear from the outset. Their main risk is moving too quickly from problem recognition to solution design. Leaders need to invest in diagnosis, evidence and phased testing before scaling.

Figure 8. Comparative lessons from the two archetypes

Lesson	Infrastructure-led route	Problem-led route
Starting advantage	Existing platform, relationships and delivery assets	Clear problem, government relevance and urgency
Main risk	Broad alignment without a specific use case	Launch ambition before operational readiness
Critical design question	What does the coalition add beyond existing activity?	What diagnosis is needed before intervention design?
What leaders should do	Use capability mapping to sharpen the proposition	Use phased diagnosis to build proof of concept

Source: Deloitte analysis

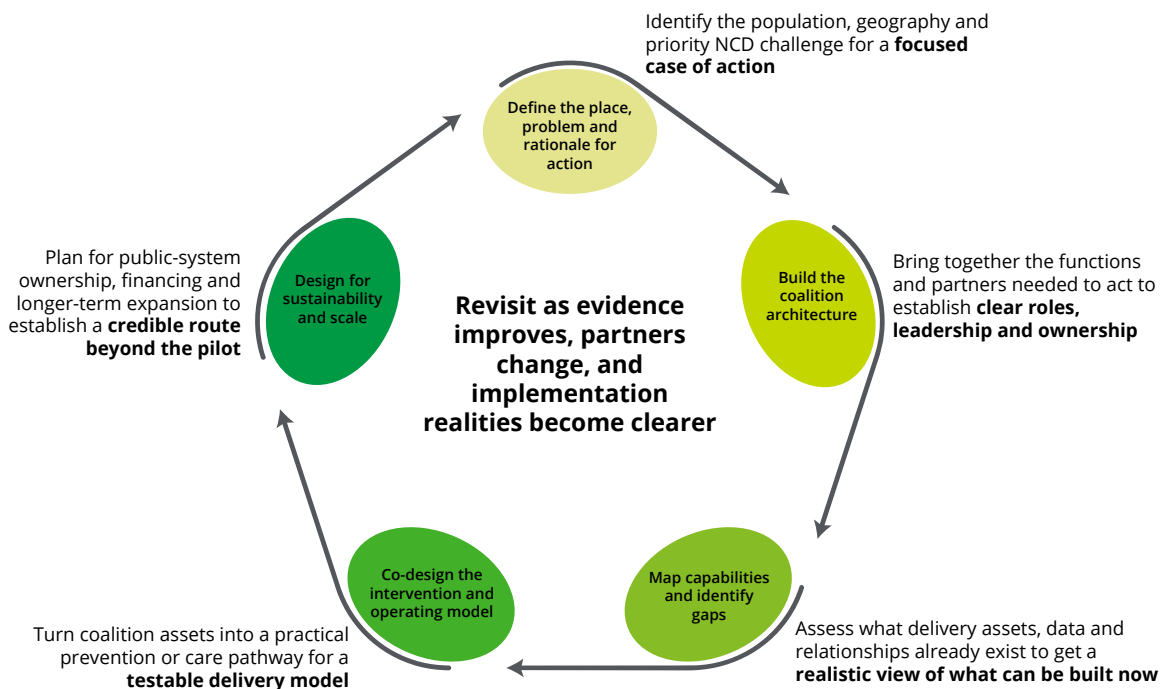
Action guide for leaders: building effective place-based coalitions

Effective coalitions are typically built through a series of practical decisions: where to act, what problem to solve, which functions are needed, what capabilities exist, what intervention can credibly be delivered, and how the model should be owned, financed and sustained over time.

This section translates the four principles of place-based change into an action guide for coalition

leaders (Figure.9). It is designed for organizations seeking to move from shared ambition to coordinated local delivery, particularly in NCD prevention, early detection and long-term condition management. Each step sets out the purpose of the step, the key decisions leaders should answer, common pitfalls, and a framework to help support leaders to complete the step.

Figure 9. Action guide for leaders: five steps to help build effective place-based coalitions



Source: Deloitte analysis

Coalition-building is rarely linear. Leaders may need to revisit earlier decisions as evidence improves, relationships change, or implementation realities become clearer. What matters is not completing each step once but ensuring that the coalition has answered the core design questions before moving from ambition to implementation.

Define the place, problem and rationale for action

What leaders need to decide

- Are we choosing this place because burden is high, or because coalition action is both needed and feasible?
- Has the problem been defined with community and local delivery input, not only through data?
- Is there a realistic pathway from this starting point to institutional, public or local ownership?

Coalitions are often formed around a broad ambition – such as prevention, access, women’s health or urban health – but broad ambition alone is rarely enough to support coordinated delivery. Leaders need to identify a geography where need is clear, the problem is specific enough to organize around, and the conditions exist for collective action to gain traction (Figure.10).

For NCD-related health gaps, this can mean looking beyond disease burden alone. A place may have high rates of cardiovascular disease, diabetes, obesity or chronic respiratory disease, but that may not automatically make it the right starting point for a coalition. A strong candidate geography should combine health need with feasibility: existing delivery assets, community relationships, data availability, public system openness, collaborator relevance and a realistic pathway to institutional, public or local ownership.

The problem should not be defined through epidemiology and system data alone. It should also be shaped with community stakeholders and local delivery actors so that the coalition is grounded in lived experience, delivery reality and local priorities.

The rationale for action should also explain why a coalition is needed, not only why the issue matters. In many settings, the challenge is not simply that outcomes are poor, but that multiple actors are already active without sufficient coordination around a shared population, pathway or outcome. Place selection can therefore be stronger when it identifies where a coalition has genuine additionality: where it can reduce fragmentation, align resources, fill capability gaps or create a more coordinated route to prevention, early detection and long-term care.

Figure 10. Place selection framework for coalition-led action

Selection criteria	What to look for	Illustrative data sources/ways to access
Leadership and government commitment	Evidence that local or national leaders recognise the issue and are open to coordinated action	Policy documents, government strategies, stakeholder interviews, letters of intent, existing partner relationships
Government and funding alignment	Fit with public priorities, financing opportunities or institutional mandates	Health plans, donor strategies, budget documents, development-bank priorities
Geography, scale and manageability	A defined geography that is large enough to matter but specific enough to act within	Administrative boundaries, city/region data, service catchments; partner landscape analysis; feasibility assessments
Health challenge relevance and data availability	A significant NCD-related burden with enough data to define the problem and track progress	WHO and national health observatories; epidemiological data, service utilisation, screening data, local surveys
Shared population and outcome definition	A clear target population and measurable outcome that partners can align around	Population data, segmentation, service-use data, community insight
Ecosystem diversity and partner relevance	Presence of actors across public, private, civil society and donor communities whose capabilities are relevant to the problem	Partner mapping, stakeholder interviews, existing programme landscape
Existing assets and delivery readiness	Existing platforms, relationships, infrastructure or services that can be built on	Programme reviews, capability mapping, community channels
Coalition additionality	Evidence that a coalition can add value beyond what actors are doing alone	Gap analysis, duplication review, interviews with implementers
Pathway to public ownership and scale	A realistic route to government support, financing or institutionalisation	Policy documents; public financing strategies; ministry interviews; development-bank engagement; existing public-private partnership arrangements
Potential for measurable impact and learning	Ability to generate credible evidence on outcomes, feasibility and implementation learning	Baseline indicators, monitoring systems, evaluation feasibility

Source: Deloitte analysis

What this step should achieve

By the end of this step, coalition leaders should be able to answer:

- Why this place?
- Which sub-populations face the greatest barriers to prevention and care, and is the coalition designed to reach them?
- What specific NCD-related problem is being addressed?
- Why is coalition-based action needed here?
- What existing assets, relationships or institutional pathways can be built on?
- Is there a realistic route to public system engagement and longer-term ownership?
- Can this setting generate measurable outcomes and learning?

Common pitfalls to mitigate

- Selecting a geography based on challenges alone
- Starting from a broad theme rather than a specific problem
- Treating public system buy-in as a later-stage concern
- Defining the problem too broadly to support coordination
- Ignoring fragmented activity already happening in the same place
- Choosing a setting where impact can be difficult to demonstrate or validate
- Assuming that place-level targeting will automatically reach the most underserved populations within that place

A strong coalition does not begin by asking who wants to participate. It should begin by defining where coordinated action is both needed and feasible, and by choosing a problem specific enough for collaborators to organize around.

Build the coalition architecture

What leaders need to decide

- What are the minimum functions the coalition needs in the first phase?
- Which collaborators are essential now, and which can come later?
- What is the value proposition for each collaborator: what they contribute, what they gain, and what role they play?

Once the place, problem and rationale for action are clear, leaders should build the coalition architecture. This step moves the discussion from “who is interested?” to “what functions are needed to act?”. The aim is not to assemble the largest possible partnership, but to put in place the minimum viable coalition that may be required to help translate shared intent into coordinated delivery.

For NCD-related health gaps, this is important because the relevant levers often sit across multiple systems. Prevention, early detection, long-term condition management, community engagement, data, financing and local delivery are rarely owned by a single institution. A coalition therefore needs to be designed around the functions required to act, rather than around organizational visibility or broad expressions of interest.

Effective coalition architecture should clarify five things: who convenes, who brings strategic capability, who provides the operational backbone, how the model is anchored in public systems or long-term institutions, and how local communities are meaningfully represented (Figure.11).

This step can also require clarity on collaborator incentives. Public institutions, private-sector collaborators, foundations, delivery organizations and community actors may all support the same ambition, but they often have different mandates, timelines and definitions of success. Leaders should make these differences visible early and define a clear value proposition for each collaborator: what they contribute, what they gain, and what role they play in the coalition.

Finally, coalitions should not try to recruit every possible collaborator at once. In many cases, it is better to begin with a smaller group that covers the critical functions for the first phase, then add collaborators as capability gaps become clearer.

Figure 11. Building the coalition architecture in practice

Required function	What the function is for	Typical participation options	What leaders need to decide	What participation looks like
 Convening	Brings actors together, aligns them around a shared agenda, and maintains momentum and trust	Neutral convener, multilateral platform, foundation, respected intermediary	<ul style="list-style-type: none"> Who should convene and sustain momentum? Does this actor have enough trust, neutrality and visibility? 	Convene meetings; set agenda; broker trust; maintain senior engagement; keep the coalition moving between touchpoints
 Strategic partners	Contribute funding, technical expertise, innovation, influence or specialist knowledge relevant to the challenge	Corporate partners, foundations, multilaterals, academic or technical institutions	<ul style="list-style-type: none"> Which partners are essential for funding, expertise, innovation or influence? Are incentives aligned enough to sustain action? 	Provide co-funding; contribute technical expertise; open policy or market access; support evidence generation; strengthen proposition credibility
 Operational backbone/ delivery partners	Translates ambition into a practical programme, coordinates delivery and manages implementation	Delivery organisation, implementing partner, programme team, local intermediary	<ul style="list-style-type: none"> Who will coordinate day-to-day delivery? Who turns strategy into implementation? 	Coordinate workplans; manage milestones; run implementation; connect partners across the pathway; oversee learning and reporting
 Government/ public system anchors	Provides policy alignment, legitimacy, institutionalisation and a route to scale within existing systems	Ministry, state or city government, public agency, health authority	<ul style="list-style-type: none"> What is the realistic route to institutional or public ownership? Can the model be integrated into existing systems? 	Align with policy priorities; support adoption into existing services; provide legitimacy; embed model in public structures; enable scale through institutions
 Community & local stakeholders	Ensures the coalition reflects local priorities, lived experience, trust and delivery realities	Community organisations, patient groups, local civil society, frontline actors	<ul style="list-style-type: none"> How will local perspectives shape design and adaptation? How will accountability to communities work in practice? 	Co-define the problem; shape local adaptation; support community trust and uptake; provide delivery insight; strengthen accountability and feedback loops

Source: Deloitte analysis

What this step should achieve

By the end of this step, coalition leaders should be able to answer:

- What are the minimum functions the coalition needs in order to deliver?
- Which collaborators are important for the first phase, and which can come later?
- What is the specific role of each collaborator in the coalition?
- What does each collaborator gain from participating?
- Who will coordinate the coalition between senior touchpoints?
- Is there a clear route to institutional ownership and local legitimacy?
- Is the coalition small enough to move, but broad enough to matter?

Common pitfalls to mitigate

- Building a coalition around interest rather than function
- Bringing in collaborators without a clear role or value proposition
- Over-indexing on senior participation without enough delivery capacity
- Leaving governance and decision-making vague
- Assuming one influential actor can substitute for a balanced architecture
- Trying to recruit every possible collaborator too early
- Failing to assign a coordinating function between convenings

An effective coalition is not simply a group of willing organizations. It is a deliberately designed architecture of functions, incentives and accountability, structured to make collaboration work in practice.

Map capabilities and identify gaps

What leaders need to decide

- Which capabilities are essential for the first phase of delivery?
- Which capabilities already exist, which can be adapted, and which are missing?
- Do missing capabilities require new collaborators, investment, or a narrower initial scope?

Once the coalition architecture is in place, leaders need to test whether the coalition has the capabilities required to act. Coalition design identifies who needs to be involved; capability mapping tests whether those collaborators can credibly move from alignment to delivery.

This step should be treated as a practical assessment of coalition readiness. Its purpose is not simply to catalogue collaborator strengths, but to determine whether the coalition has the strategic and operational assets required for its chosen use case.

Capability mapping should be specific to the place, population and problem selected in Step 1. The relevant question is not “what are our collaborators good at?” but “what capabilities are needed to deliver this intervention in this place, for this population?”

The assessment should draw on evidence rather than reputation alone. In practice, this may include structured collaborator interviews, review of program playbooks and operating models, prior evaluations, delivery data, local presence, public-sector relationships, digital and data assets, and validation with operational teams rather than senior leadership alone. This helps distinguish between capabilities that already exist, those that can be adapted, those that need strengthening, and those that are missing altogether.

Capability mapping also helps leaders make better sequencing decisions. Not every gap needs to be filled immediately. Some capabilities are essential for the first phase of action; others may only become critical when the coalition moves towards scale. A structured map, using a framework like Figure.12, helps leaders identify which gaps must be closed now, which can be built over time, and which require new collaborators or investment.

Figure 12. Capability mapping framework for place-based coalitions

Cluster	Capability	Example capability					
Place, Population & Trust	Geographic Reach & Local Presence	Ability to operate in specific cities, regions, or underserved urban areas					
	Brand & Community Trust	Influence and credibility with local populations and stakeholders					
	Target Population Expertise	Experience working with priority groups (e.g., children, elderly, low-income, marginalized communities)					
	Disease & Health Focus Areas	Specialization in relevant health challenges (e.g., infectious diseases, chronic conditions, maternal health, mental health)					
Design, Funding & Ownership	Programme Design & Management	Capacity to co-create, implement, and monitor health interventions at the city level					
	Funding & Resource Mobilisation	Ability to provide financial support, in-kind resources, or facilitate access to additional funding					
	Transition to Local Ownership	Experience establishing a sustainable structure with local (in-country) ownership, governance, and funding					
Delivery Infrastructure & Systems	Physical Infrastructure & Facilities	Clinics, mobile units, laboratories, warehouses, or other assets available for program delivery					
	Digital Health Infrastructure	Telemedicine platforms, electronic health records, and other foundational tools that support the delivery and management of interventions to individuals					
	Data & Analytics	Capacity for data collection, management, analysis, and sharing to inform decision-making and measure impact					
Delivery Channels and Implementation	Individual Interventions	People-facing tools and technologies designed to support, engage, or treat individuals					
	Human Resources & Training	Availability of healthcare professionals, community health workers, and training programs					
	Community & Channel Partnerships	Non-medical Relationships with local organizations, NGOs, pharmacies, and other distribution channels to reach a target population					
	Service Delivery & Implementation Partners	Medical experience to deliver last-mile interventions, logistics, and operational execution in urban settings					

Already exists
 NCD use case applicability
 Adaptable
 Needs strengthening
 Missing / new investment

Source: Deloitte analysis

How to use the framework

For each capability area, coalition leaders should assess whether:

- The capability already exists within the coalition
- It is strong enough for the intended NCD use case
- It can be adapted from an existing platform or program
- It is partially present and needs strengthening
- It is missing and requires a new collaborator or investment

In practice, this assessment can be carried out through:

- Structured interviews with collaborator organizations using a common question set
- Review of program playbooks, implementation manuals and operating models
- Analysis of prior delivery experience, evaluation results and monitoring data
- Assessment of local presence, public system relationships and access to target populations
- Review of staffing, infrastructure, digital tools and service-delivery channels
- Validation with operational teams, not only senior leadership

What this step should achieve

By the end of this step, coalition leaders should be able to answer:

- What capabilities are required for this specific NCD use case?

- Which of these capabilities already exist within the coalition?
- Which existing assets can be adapted rather than rebuilt?
- Which capabilities are only partially present?
- Which gaps are critical for the first phase of delivery?
- Do missing capabilities require new collaborators, investment or a change in scope?
- Is the coalition building from scratch, or working from an existing base?

Common pitfalls to mitigate

- Treating collaborator reputation as evidence of capability
- Assessing capabilities in the abstract rather than against the use case
- Assuming that because a collaborator works in an area, it can deliver in this specific context
- Relying only on senior interviews without testing claims with operational teams
- Trying to fill every possible gap at once
- Overlooking capabilities needed for transition, learning or scale
- Confusing coalition enthusiasm with coalition readiness

Capability mapping is the point at which coalition-building becomes operational. It turns a list of interested collaborators into a realistic assessment of whether the coalition can act, what it can build on, and what still needs to be put in place.

Co-design the intervention and operating model

What leaders need to decide

- What is the first intervention the coalition will test, and why this one first?
- How will delivery, data, feedback and accountability work in practice?
- What is the proof of concept intended to show before the coalition moves to scale?

Once the coalition has defined the place and problem, assembled appropriate functions and mapped capabilities, leaders should co-design the intervention and operating model. This is the step where coalition-building moves from alignment to delivery. The coalition must agree what will be delivered, for whom, through which pathway, by which collaborators, and with what evidence of success. For NCD-related health gaps, this may mean moving beyond broad ambition – such as “improve prevention” or “reduce cardiometabolic risk” – towards a practical first intervention. This could be, a hypertension or diabetes management model, a digital monitoring pathway, a workplace prevention model, or a broader care coordination approach. What matters is that the intervention is specific enough to implement and focused enough to test.

Leaders should identify where there are already delivery structures, programs, agreements, care pathways or community channels that can be strengthened, connected or adapted. They should also focus on areas of real overlap across collaborator capabilities – for example, a point in the care pathway, a shared prevention model or a common delivery bottleneck – rather than trying to satisfy every collaborator equally.

The operating model should show how collaborator contributions connect into one coherent delivery pathway rather than remaining as parallel activities. It should define where delivery happens, how

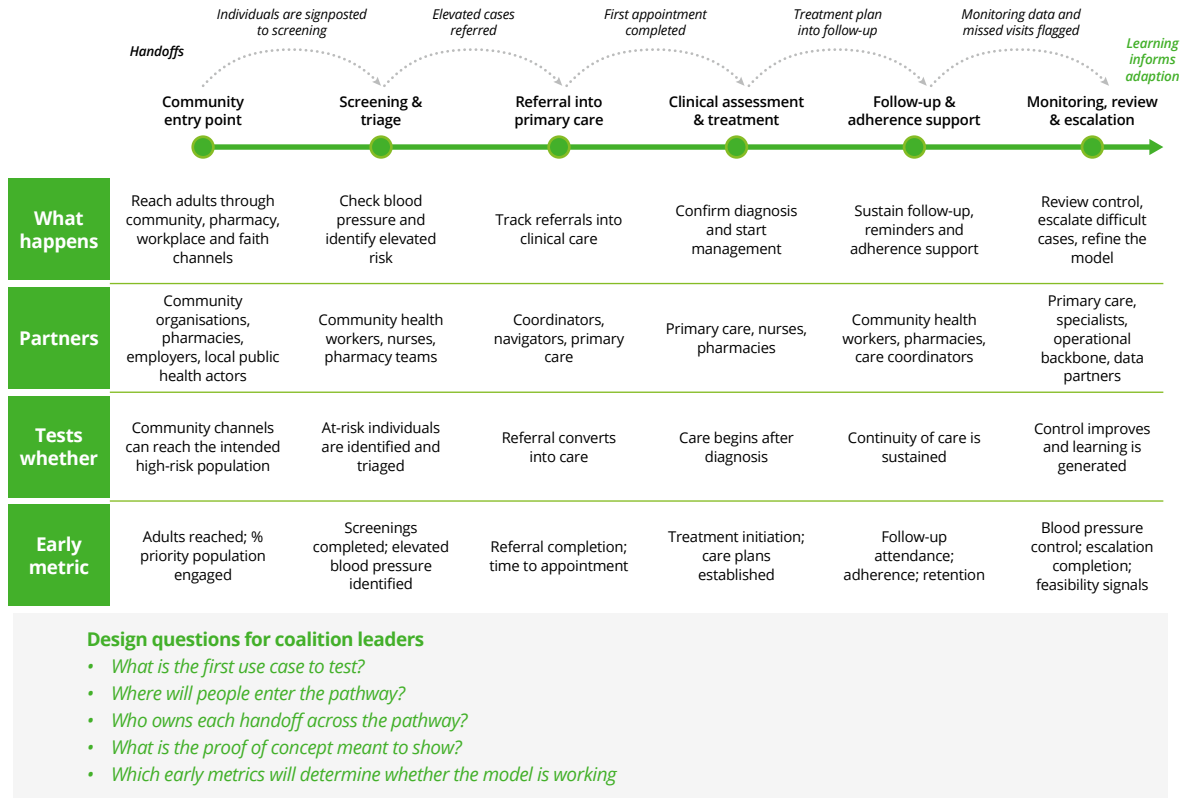
people enter the model, what services or support they receive, where data is captured, who acts on that data, how referrals or escalation work, and who is accountable for follow-up. The operating model should also specify how communities will shape adaptation, how feedback and accountability mechanisms will work, and how local experience will inform ongoing refinement of the model - This is where community ownership as a design requirement becomes more concrete. In NCD coalitions, this can be especially important because prevention, diagnosis, treatment and long-term support often sit across different organizations.

This step can also require clarity on coordination. A backbone or coordinator is typically needed to establish the roadmap, timeframe, milestones and collaboration model required to move from design into delivery. Without this, even well-designed interventions can fragment into disconnected workstreams.

Finally, co-design should define what the coalition is trying to solve for first. Most coalitions should not move directly to scale. The first phase should function as a proof of concept, testing a small number of critical assumptions: whether the model reaches the intended population, whether the pathway works in practice, whether collaborators can coordinate effectively, whether priority outcomes can improve, and whether there are early signs of feasibility or cost-effectiveness. For NCDs, this can often mean connecting prevention, early detection, treatment, follow-up and community support into a practical model that can be tested before scale.

Figure.13 demonstrates an integrated coalition delivery pathway using an illustrative NCD use case: hypertension detection and control through a community-to-primary-care pathway. This illustrates how leaders can translate coalition assets into a testable NCD intervention by defining the use case, pathway, collaborator contributions, proof of concept and early success measures.

Figure 13. Co-designing an integrated coalition delivery pathway



Source: Deloitte analysis

Footnote:
 Figure 13 Cross-pathway coalition roles:
 Operational backbone: coordinates delivery, handoffs and milestones across the pathway
 Public system / public-system actors: support system integration, legitimacy and sustainability
 Data and digital collaborators: support tracking, monitoring and implementation learning
 Community-facing collaborators: strengthen trust, uptake and continuity across the pathway

What this step should achieve

By the end of this step, coalition leaders should be able to answer:

- What is the first intervention the coalition will deliver?
- Why is this the best starting point, given the place, problem and available capabilities?
- How will the intervention work in practice across the pathway?
- Which collaborator does what?
- Who coordinates delivery and tracks milestones?
- What assumptions will the proof-of-concept test?
- What metrics will show whether the model is working?

Common pitfalls to mitigate

- Designing from a blank slate when existing structures could be leveraged
- Trying to solve too many problems in the first phase
- Defining the intervention too broadly to be testable
- Allowing collaborator activities to remain parallel rather than integrated
- Leaving coordination and milestone ownership unclear
- Moving to scale before proving operational feasibility
- Waiting until implementation begins to agree metrics and outcomes

Co-design is the step that helps turn coalition potential into a practical model for action. It works best when coalitions build on existing structures, focus on areas of real delivery synergy, define one integrated pathway and use a proof of concept to test what matters most.

Design for sustainability and scale

What leaders need to decide

- Who will own, support or steward this model if it succeeds?
- What financing and institutional pathway could sustain it beyond the first phase?
- What evidence is needed for continuation, adaptation or scale?

The final step is to design for sustainability and scale from the outset. If a coalition wants its work to endure, the route to ownership, financing and institutionalization should shape the model from the beginning.

For NCD-related health gaps, this can be especially important because impact can depend on continuity over time. Prevention, early detection and long-term condition management cannot always be sustained through short-term activity alone. A coalition may successfully launch a screening campaign or community prevention pilot, but without a route into public systems, ongoing financing, local ownership and follow-up pathways, the model may struggle to continue or scale.

Where long-term sustainability depends on public-system support, early alignment matters. If public systems or public institutions ultimately need to adopt, finance or support the model, this should shape the intervention from the beginning. Leaders should consider how the work aligns with public system priorities, whether it can be embedded into existing delivery systems, and what evidence would

be needed for public-sector collaborators to back it over time.

Sustainability is also stronger when coalitions build on existing structures rather than creating parallel systems. Programs are more likely to endure when they connect to delivery platforms, care pathways, financing arrangements, data systems or institutional relationships that already have traction. A model that sits entirely outside the system may be harder to sustain and harder to scale.

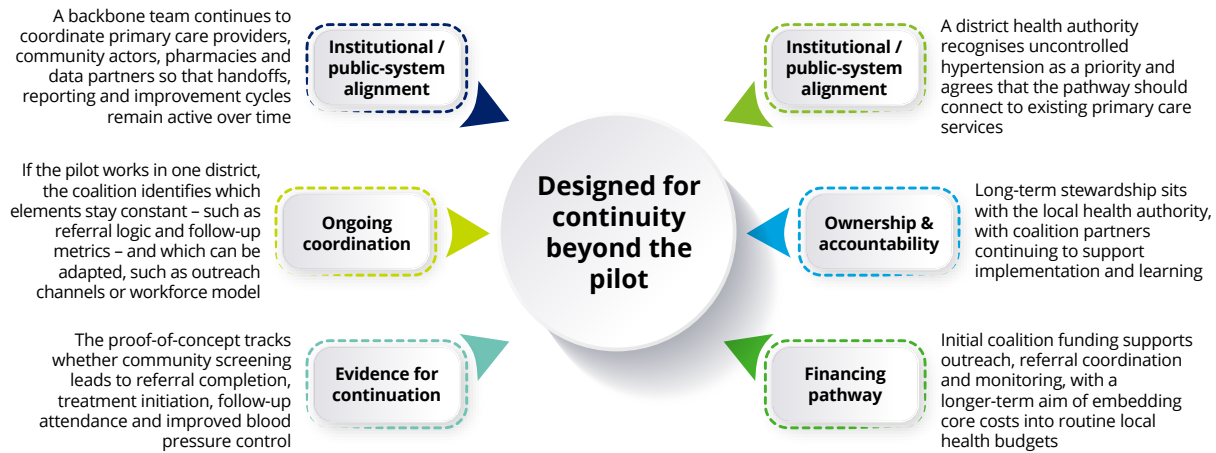
Coalitions should also think early about financing and institutional support collaborators, including donors, co-funders, development banks or private-sector collaborators where relevant. In some settings, these actors can help strengthen public system engagement, provide a bridge to longer-term financing and improve the credibility of the pathway to scale.

Scale can depend not only on proving that an intervention works, but on generating the right kind of evidence. Early phases should build evidence on outcomes, feasibility, implementation learning and, where possible, cost-effectiveness. Scale is rarely simple replication; it is usually adaptation supported by credible evidence.

Finally, coalitions should plan for how coordination, learning and accountability will be sustained over time. Sustainability therefore depends not only on the program itself, but on who will steward the roadmap, maintain alignment and support adaptation as the coalition matures.

Figure.14 uses an illustrative NCD use case (Hypertension control) to support leaders with what can be designed early if a coalition is to move beyond pilot activity and become a durable model for NCD prevention, care and system strengthening.

Figure 14. Reinforcing system for sustainability and scale



Sustainability and scale system definitions

- *Institutional / public-system alignment*: The model fits policy priorities, delivery systems and institutional realities
- *Ownership and accountability*: There is a clear route to who will own, steward or support the model over time
- *Financing pathway*: There is a credible route to funding beyond the first phase
- *Evidence for continuation*: The coalition generates proof on outcomes, feasibility, uptake and value
- *Adaptation and scale*: The model distinguishes what is core from what can be adapted across settings
- *Ongoing coordination*: The coalition maintains alignment, learning and accountability as the model evolves

Source: Deloitte analysis

What this step should achieve

By the end of this step, coalition leaders should be able to answer:

- Who will own or support this model if it succeeds?
- How will the model align with public system priorities and public systems?
- What financing pathway could sustain the model beyond the first phase?
- What evidence will decision-makers likely need before backing continuation or scale?
- Which elements of the model are important, and which can be adapted locally?
- Who will maintain coordination, learning and accountability over time?

Common pitfalls to mitigate

- Treating sustainability as something to solve after the pilot

- Assuming public system backing will emerge automatically if outcomes are positive
- Building a model that sits outside existing systems and structures
- Focusing only on delivery metrics rather than evidence for scale
- Treating replication as copying rather than adaptation
- Neglecting the need for ongoing coordination and stewardship
- Failing to maintain a value proposition for collaborators over time

Sustainability and scale are not the final stage of coalition-building; they are typically design choices that should be built in from the beginning if place-based NCD action is to endure beyond an initial proof of concept.

Conclusion: from commitment to coalition-led delivery

The challenge now is implementation: translating global commitment into coordinated action in the places where risk accumulates, prevention happens, and long-term care can be sustained.

The four principles of place-based change – community ownership, rigorous analysis, purposeful partnerships and sustainable operating models – remain the foundation⁶. This report has shown how those principles can be translated into coalition design: selecting the right place and problem, building the right functions, mapping capabilities, co-designing a practical intervention and planning for sustainability from the outset.

For leaders, the task is no longer simply to convene. It is to help build coalitions that can act: coalitions with clear ownership, trusted local relationships, evidence-based priorities, operational capability, public-system anchoring and a credible route to scale. If NCDs are shaped by place, then implementation must be organized in place too.

Alongside this report, the accompanying global database of place-based health programs⁷ is intended to help make the field more visible and connected. It can help practitioners, funders and policymakers identify comparable initiatives, learn from existing delivery models, mitigate reinventing the wheel and understand how programs align with the four principles of effective place-based change. Organizations running relevant place-based health programs are invited to contribute to the database so the field can continue to learn from emerging examples across regions, sectors and health challenges.

Considerations

Public systems, funders, businesses, civil society and delivery collaborators should use place-based coalitions not as one-off pilots, but as practical operating models for NCD prevention and long-term health improvement.

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