

Discussion Paper

Key Principles to Accelerate Progress in Noncommunicable Disease Care and Treatment

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BACKGROUND

In recent years, many people in the global health community have advocated for greater attention to the prevention and treatment of noncommunicable diseases (NCDs) such as cardiovascular disease and diabetes. Researchers, health care providers, and public health experts once thought these illnesses were prevalent only in high-income countries, but they now recognize that NCDs “rank as the leading cause of death across the globe” (Fuster et al., 2014, 3). In response, key actors have made policy changes at the global and country levels. For example, the United Nations hosted the High-level Meeting on Non-communicable Diseases in 2011, and last year India became the first country to adopt the World Health Organization’s Global Monitoring Framework on NCDs.

Evidence on how to advance NCD care and treatment programs that reach the underserved, especially in low- and middle-income countries, however, is lacking (Rabkin and El-Sadr, 2011). At the same time, implementers are increasingly putting NCD programs in place, yielding practice-based experiences and evidence that may not be systematically documented and shared. There is a limited body of peer-reviewed and gray literature, and few platforms for knowledge exchange, yet it is critical to learn from community-level implementers currently working to build and sustain positive outcomes for the underserved.

Medtronic Philanthropy recognized this gap in—and critical need for—knowledge grounded in experience as it embarked on a new global program on NCDs, and, with its implementation partners, it has employed several mechanisms to gather information that reflects the current state of knowledge on developing and implementing community-based services for health promotion and disease management. The efforts include reviews of literature, local needs assessments, technical dialogues at the national and local levels, and more structured global stakeholder engagement events such as a convening held in partnership with the Institute of Medicine’s Collaborative on Global Chronic Disease Prevention and Control that brought together implementers, foundations, and community-based organizations to reflect on lessons learned from their implementation experiences. From across these sources and information-gathering efforts, some key principles in NCD program design have emerged that, if applied consistently by funders and implementers, have the potential to accelerate progress in reaching low-resourced communities with NCD care and treatment services.

KEY PRINCIPLES

Support and empower people living with chronic disease to provide better self-care and advocate for improved services. Organizing people living with chronic disease can serve the dual goals of promoting self-care while pushing governments to fulfill commitments on NCD screening, treatment, and care and convincing donors to fund these efforts. For example, the Uganda NCD Alliance has built a membership of nearly 30,000 patients to form a strong support network that provides counseling, education, peer support, free treatment for members, and other critical services. This membership has also partnered with other groups to lobby for

sufficient NCD resources in the Uganda national budget. Furthermore, people living with chronic disease can play a key role on community advisory boards and quality improvement teams and can act as community liaisons.

Invest in integrating NCDs into existing development platforms but do not underestimate true costs and effort. Many countries have existing health and development platforms that could incorporate NCD prevention, care, and treatment. In particular, the similarities in managing HIV and other chronic diseases provide an opportunity to leverage the infrastructure built by global investments in HIV scale-up to integrate NCD services as well as key lessons, policies, and strategies (Lamprey and Dirks, 2012). NCD services may also be integrated into primary care and other programs requiring continuity care, such as services for tuberculosis, maternal and child health, and reproductive health. In high-prevalence settings, NCD screening and management could be integrated into multisectoral interventions, such as microfinance and education programs. Integration, however, will require additional resources, including funding, guidelines, staffing, training, laboratory and pharmacy services, and facility space. Experience with integration in other health areas, such as HIV and family planning services, reveals that programmatic success is not guaranteed and requires thoughtful advance planning, carefully defined goals and objectives, and ongoing monitoring of adjustments that are necessary within the health system, including service delivery, health workforce, and information systems (Church and Mayhew, 2009).

Engage a broad range of front-line health workers to champion care. Reaching underserved populations requires task shifting from one cadre to another, developing multidisciplinary teams of providers, and paying attention to both facility-level and community-level services. Effective teams include community health workers, pharmacists, nutritionists, peer educators and other cadres, as well as doctors and nurses. In India, local-level community health workers, ASHAs (Accredited Social Health Activists), are seen as potentially underutilized segments of the broader health workforce with enormous potential to expand outreach, screening, and referral and follow up. There is growing evidence that the use of integrated care teams and community health workers is effective in preventing and controlling NCDs (Kruk et al., 2015). In one promising study conducted in Nigeria, pharmaceutical care in coordination with a general practitioner was shown to improve adherence to blood pressure control medication and lifestyle behavior change (Aguwa et al., 2007).

Build coalitions to leverage the strengths of the public sector's and private sector's capacity and leadership. The importance of working with government leadership from the outset arises as a critical principle. For example, engagement of high levels of government early in the process has been a key factor in the success of cervical cancer programs carried out by Population Services International (PSI); this approach has allowed this organization to work across different government departments effectively. The Open Society Foundations' experience abroad confirms this. Although the private sector may be able to innovate more rapidly, government participation is essential for ownership and, ultimately, to reach sustainability and scale.

APPLYING PRINCIPLES IN PRACTICE: THE EXAMPLE OF HEALTHRISE

Funded by Medtronic Philanthropy, HealthRise is a 5-year, \$17 million program implemented by Abt Associates that will support community-based demonstration projects to expand access to care for diabetes and cardiovascular disease among the underserved. HealthRise has applied the above principles in designing solicitations for grant applications in both the United States and India and will do the same for South Africa and Brazil in the near future. These solicitations,

or Requests for Applications (RFAs), underscore the necessity of empowering patients, strengthening front-line health workers, and advancing policy and advocacy. Applicants are encouraged to design projects that directly address one or more of these key principles. Similarly, RFAs have requested applicants to build on existing health platforms, leverage existing programs, and ensure complementarity with government priorities to ensure success, sustainability, and scale up. Preference for explicit partnership with the government, the private sector, and the broader community of stakeholders is also stipulated in the RFAs.

The grantee projects themselves will be evaluated by a third party—the Institute for Health Metrics and Evaluation—in order to contribute to the evidence base in expanding access to NCD care. This work depends not only on strategic, multisectoral, NCD planning and policy engagement at local, national, and global levels but also on a continued, proactive approach to harvesting lessons learned from the young and dynamic world of NCD programming. HealthRise is committed to this harvesting and to sharing what is learned with the world. If implementers commit to proactively, transparently, and collaboratively sharing experience-based learning, the NCD movement will be well equipped and able to speed up the pace and benefit from programmatic, financial, and political synergies at global, national, and local levels.

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