Scaling-Up NCD Interventions in South-East Asia

Policy Brief

Strengthening primary health care:

The key to tackling non-communicable diseases and achieving universal health coverage and healthy ageing.

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Scaling-Up NCD Interventions in South-East Asia (SUNI-SEA):

The increasing prevalence of non-communicable diseases (NCDs) and their high impact on mortality, morbidity and public health, particularly in low- and middle-income countries, prompted the launch of an implementation research project, Scaling-Up NCD Interventions in South-East Asia (SUNI-SEA), implemented in Indonesia, Myanmar and Vietnam. This four-and-a-half year initiative began in 2019 and is a collaboration between 10 consortium members, namely University Medical Center Groningen (Netherlands); Faculty of Economics and Business, University of Groningen (Netherlands); University of Passau (Germany); Trnava University (Slovak Republic); HelpAge International; Age International; Sebelas Maret University (Indonesia); Thai Nguyen University of Medicine and Pharmacy (Vietnam); Health Strategy and Policy Institute (Vietnam); and Vietnam Association of the Elderly (VAE).

The SUNI-SEA project aims to identify the best and most affordable ways to expand programmes that prevent and control diabetes and hypertension in Southeast Asia. The project investigates which interventions work effectively and are worth the investment in other low- and middle-income countries.

Disclaimer

The contents of this document are the sole responsibility of the SUNI-SEA consortium and do not necessarily reflect the views of the European Union or the Global Alliance for Chronic Diseases.

Introduction

This brief includes:

- an introduction to the role of primary health care services, in achieving universal health coverage.
- an explanation of the burden of non-communicable diseases (NCDs), especially in low- and middle-income countries
- a summary of the learning from the Scaling-Up NCD Interventions in South-East Asia (SUNI-SEA) project
- key findings and policy takeaways from SUNI-SEA.

"Before joining the club, I didn't know very much about hypertension or diabetes. Sometimes I felt tired and lightheaded, but I thought it must be because of my age, so I ignored it. Then a club volunteer measured my blood pressure and weighed me every month, and I was told that I had high blood pressure. I didn't want to go to the health facility, but after receiving encouragement from my family and the club management board, I agreed. Now I better understand the severity of high blood pressure and diabetes, how to control them and the importance of compliance to my treatment."

Hoang Thi Lan, Member of Binh Hoa Intergenerational Self-Help Club, Vietnam

Fulfilling the right to health and the achievement of universal health coverage

Attainment of universal health coverage (UHC) has been recognised as key to securing and protecting the fundamental human right to health. The World Health Organization (WHO) defines UHC as access for all people to "the full range of quality health services they need, when and where they need them, without financial hardship".[1] The range of services covers the full continuum of basic health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.

[1] World Health Organization, *Universal health coverage*, 2022, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

Progress towards UHC is essential for promoting population health, healthy ageing and delivering social and economic development. It also builds resilient and equitable societies that respond effectively in times of crisis. The commitment of governments to achieve UHC as part of the Sustainable Development Goals aligns directly with their duty to respect, protect and fulfil all people's right to enjoy the highest attainable standard of physical and mental health, which is also indispensable for the exercising of other human rights.

Primary healthcare (PHC) is widely recognised as the foundation for UHC. It is the first point of access for people entering the healthcare system. In low- and middle-income countries (LMICs) PHC facilities are generally simple clinics with a limited package of (mostly outpatient) services. They may be staffed by paramedics rather than doctors, nurses and midwives. Traditionally, PHC facilities have focused on infectious diseases and maternal and child health services and often are unprepared for responding to NCDs and delivering prevention and care services. The WHO recommends that for delivering quality integrated PHC services key components should include: an adequate number of trained, multi-skilled health workers, with adequate infrastructure, supplies, equipment, supervision, and opportunities for continued professional development and career advancement[2].

Central to PHC is the meaningful and ongoing engagement of people and communities as the key to defining their health needs, identifying solutions and deciding on priorities in service delivery.[3] Preliminary findings of the SUNI-SEA project provide evidence of this. Research suggests that community engagement is also a key factor in enhancing the accessibility, acceptability and quality of PHC as the first point of contact with the health system.[4] People who are informed, engaged and empowered are better able to live healthy lives and access healthcare. In addition, meaningful engagement and inclusion of diverse people including groups who have the greatest need for health and care services, but who may be furthest behind in accessing them, will help health systems achieve health equity.

Despite the increasing recognition of the essential role of primary health care and community engagement in tackling NCDs, there is a dearth of evidence on how to achieve the genuine participation of community stakeholders and local multi-sector decision-makers as part of PHC approaches.

[2] World Health Organisation (2018) Working Paper, Technical Series on Primary Health Care. Building the Primary Health Care Workforce of the 21st Century. https://www.who.int/docs/default-source/primary-health-care-conference/workforce.pdf

[3] World Health Organization and the United Nations Children's Fund (UNICEF), *Operational framework for primary healthcare: transforming vision into action*, Geneva, WHO and UNICEF, 2020.

[4] Dodd R et al., 'Organisation of primary health care systems in low- and middle-income countries: review of evidence on what works and why in the Asia-Pacific region,' *BMJ Global Health*, 2019;4: e001487.

The need for a paradigm shift

Although world leaders have repeatedly committed to tackling non-communicable diseases, and NCDs have become a major global health policy issue because of population ageing, progress on NCDs has stalled. NCDs continue to be the world's biggest killers, with more than 41 million people dying each year prematurely from mostly preventable NCDs, mainly cardiovascular disease, cancer, chronic respiratory diseases, and diabetes, making up 75% of all deaths. The burden of disability is also mainly driven by non-communicable diseases which caused 80% of global disability in 2017.[5,6]

NCD prevalence rises with age, so preventable disease, disability and death is highest among those aged 60 years and over. Yet this high-risk group is not being reached and face multiple barriers to accessing services, including ageism. This is particularly true in low- and middle- income countries (LMICs) where three-quarters of people living with NCDs live.

While health ministries recognise the importance of addressing NCDs, health systems and societies are not yet effectively preventing and managing them or mainstreaming NCD prevention and care into PHC to make progress towards UHC. This situation presents a serious threat to health and development, particularly in LMICs, where treatment for NCDs carries an immense financial burden.[7]

In addition, despite global and national policy guidelines recognizing that the integration of NCDs into primary healthcare services is essential and that community empowerment is key to the prevention and management of NCDs, national health budget allocations do not reflect this. A 2018 WHO analysis of health budget allocation in LMICs reported that governments allocated on average more than 70% of health spending to inpatient and outpatient curative care and medicines and medical supplies. Preventive care represented only 11% of public spending on health and 12% of total health spending.[8] This spending on prevention is mostly for vaccinations, not for NCD prevention.

Much of the NCD disease and disability burden is preventable if properly addressed, but 'best buys' (cost-effective, population-wide health interventions that address risk factors) and regulatory measures alone are not enough. The magnitude of the problem demands investment in workforce training and capacity, standards and protocols, medicines, integrated services, NCD rehabilitation, and care and support based on strong PHC systems. It also requires horizontal integration with services beyond health centres, such as the social welfare sector and community-based groups.

[5] The Lancet (2017) Global Burden of Disease Study. https://www.healthdata.org/sites/default/files/files/policy_report/2019/GBD_2017_Booklet_Issuu_2.pdf

[6] WHO (2023) Advancing the global agenda on prevention and control of noncommunicable diseases 2000 to 2020. https://www.who.int/southeastasia/publications/i/item/9789240072176

[7] World Health Organization, *saving lives, spending less: a strategic response to noncommunicable diseases*, World Health Organization, 2018.

[8] WHO, *Public spending on health: a closer look at global trends*, WHO, 2018. https://apps.who.int/iris/bitstream/handle/10665/276728/WHO-HIS-HGF-HF-WorkingPaper-18.3-eng.pdf

The NCD situation also provides a compelling case for why shifting population health needs require radical health system reform. A move away from the disproportional attention on curative services is needed, reorienting toward primary healthcare, with engagement of people and communities, to tackle the prevention of NCDs at an early stage by addressing the risk factors before diseases have developed. Community-based interventions and PHC services are best placed to offer this to the population.

"The SUNI-SEA project provided training for cadres [health volunteers] who previously could not measure waist circumference or check blood sugar. Now the cadres in our area understand how to conduct this health screening. They can independently carry out NCD screening. They no longer depend on health workers in the public health centre, which means that the health programme can run more smoothly."

Dr Munawaroh, Head of the Batang 2 Community Health Centre

Stronger primary healthcare and community engagement

The overall aim of the SUNI-SEA project was to improve the prevention and control of hypertension and diabetes in Vietnam, Indonesia and Myanmar by strengthening primary healthcare, engaging people and communities and creating linkages and synergies between them. The project provided evidence from implementation research to inform the scaling up of effective, cost-effective and sustainable strategies in the project countries and globally.

The SUNI-SEA project had three focus areas: (i) strengthening the quality of community activities and reaching more people with health education as well as lifestyle promotion and provision of community NCD screening via community groups and volunteers; (ii) strengthening primary healthcare services for early diagnosis and treatment of NCDs; and (iii) increasing collaboration and communication between community groups and PHC staff to improve the quality of NCD control programmes. SUNI-SEA has built on the experiences of primary healthcare and community-based approaches to capitalise on the existing health system's structures to improve health outcomes for prevention and control of diabetes and hypertension in Indonesia and Vietnam (see box). Linkages and synergies between the PHC facility and the community are essential for achieving sustainable improvements in health outcomes. SUNI-SEA also worked to strengthen linkages between community groups, primary health facilities and stakeholders in local government.

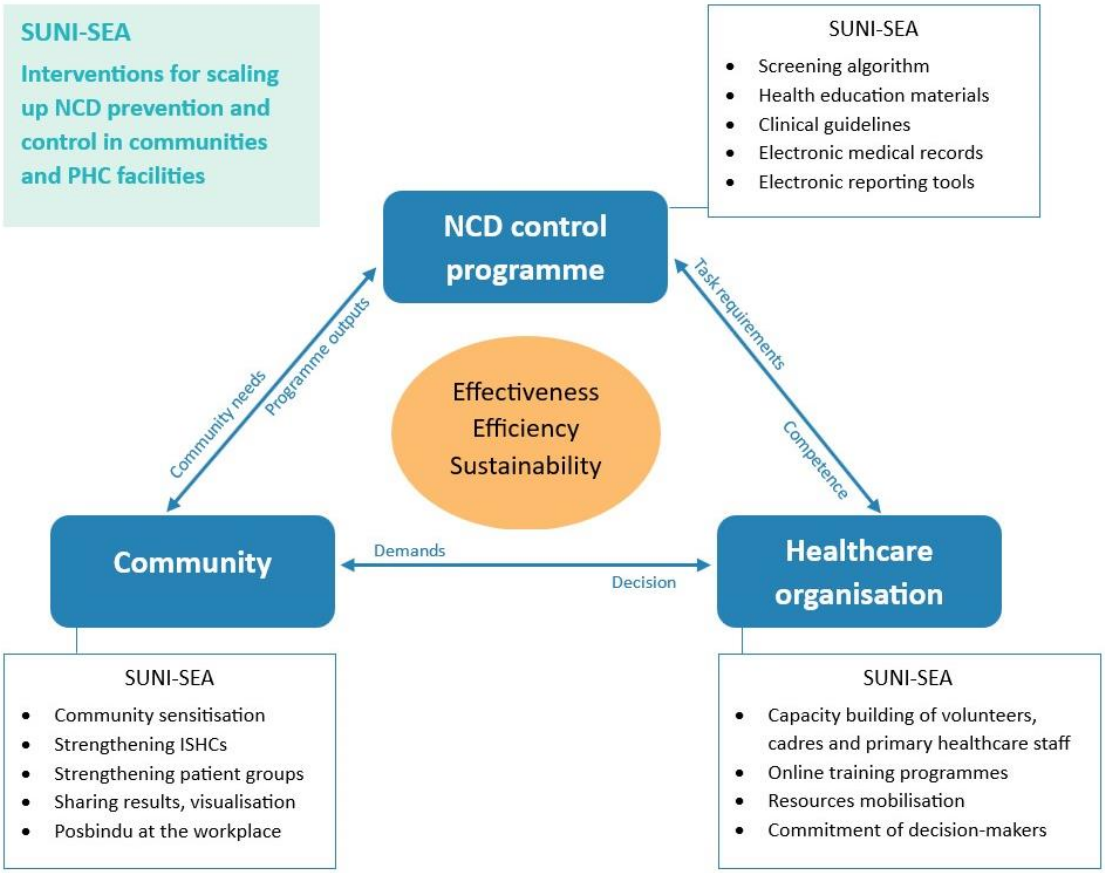
Non-communicable diseases in Indonesia and Vietnam

In Vietnam, 3% of the population has diabetes, while 18.5% of men and 10.2% of women have hypertension. In Indonesia the prevalence of the two diseases is even higher: 6.5% of the population has diabetes, while 29.1% of men and 26.6% of women have hypertension. In both Indonesia and Vietnam many people with NCDs are still not reached through screening and early intervention, at a stage when small investments could yield significant economic benefits. Diabetes and hypertension are significant causes of morbidity and mortality in both countries.

Both countries have national or large-scale evidence-based programmes to prevent diabetes and hypertension, to detect people at risk, and to treat patients. They have adopted different healthcare strategies in regard to financing, standards, community involvement and the use of information and digital technology, but they share the same aim to achieve universal health coverage and scale up NCD prevention and control.

To achieve this, more people need to be aware of risk factors for NCDs, such as being overweight, hypertension and smoking; more will need early-stage diagnosis at a health facility; and more of those will then require quality treatment, disease management and follow-up care.

Figure 1: Priority intervention plan developed within SUNI-SEA project



Country-level community interventions

In Vietnam, there are over 5,000 intergenerational self-help clubs (ISHCs).[9] These are community-based organizations that are membership based, self-managed and generate their own funds. The goal of these clubs is to contribute to the improved quality of life of older people. Health is one of the ISHCs' eight activity areas, while the other areas address the social determinants of health, including social connection, income security, rights-based awareness and advocacy. Fifty-nine ISHCs based in Ninh Binh and Hai Phong provinces participated in the SUNI-SEA project. The intervention included capacity building of ISHC volunteers for NCD prevention and control. Volunteers provided health education sessions, individual counselling and community activities to promote a healthy lifestyle, and community NCD screening events, using an android phone application for monitoring and reporting. People who were screened and found to have risk factors were advised to attend the primary healthcare facility for diagnosis and management. ISHCs collaborated closely with and were supervised by the Vietnam Association of the Elderly and HelpAge International Vietnam.

"I found the health screening offered by the [Intergenerational Self-Help] Club very helpful. The Club referred me to the Community Health Service for a proper check-up because I was at high risk of hypertension. The Club and the health service advised me to exercise, take medicine regularly, eat healthy food and fruit, and drink lots of water.

After the treatment, my blood pressure fell. I was diagnosed at an early stage through health screening at the Club and received treatment on time, so my condition improved."

Ninh Thi Hoa, Member of Lien Huy Intergenerational Self-Help Club, Ninh Binh, Vietnam

In Indonesia, to help tackle NCDs, the Ministry of Health (MoH) gives responsibility to the primary health care centres, called *puskesmas*, to organise *posbindu*, health outreach clinics for NCDs, staffed by community volunteers (Cadres). *Posbindu* aim to increase community participation in the process of NCD prevention and strengthen early detection.[10] The SUNI-SEA project team worked with *posbindu* volunteers and *puskesmas* staff in Batang and Kediri districts in Central Java and East Java provinces to drive increased reach and engagement of community members, to strengthen the approach beyond what the *posbindu* were currently doing. The NCD screening intervention targeted members of the general population aged 15 years and over at the project sites. The project also aimed to strengthen the capacity of *posbindu* volunteers for NCD screening, provision of health

[9] New Urban Agenda, *Hanoi's intergenerational self-help clubs,* UN-Habitat, 2020, https://www.urbanagendaplatform.org/best-practice/hanois-intergenerational-self-help-clubs.

[10] Widyaningsih V et al., 'Missed opportunities in hypertension risk factors screening in Indonesia: a mixed-methods evaluation of integrated health post (*posbindu*) implementation,' *BMJ Open* 2022;12: e051315. doi: 10.1136/bmjopen-2021-051315.

education and counselling of people with risk factors and improve the collaboration and communication between the *posbindu* volunteers and the *puskesmas* staff. The project also introduced a *posbindu* android phone screening application to strengthen the quality of the screening activities and improve data collection and management; and a digital package of health education materials about NCDs for the general population.

In Myanmar, due to the political situation, activities were shifted to safe areas, and were implemented mostly online. The project offered electronic self-management tools for NCDs including mental health. The people using it were also able to access e-learning health education materials for improving their physical and mental health. The project was able to demonstrate that in emergency situations in unstable countries progress towards UHC can be supported with innovative 'Information Communication Technologies' (ICT) approaches.

What we learned

SUNI-SEA's research findings provide important lessons to inform the design of community-based and primary health care approaches for NCD prevention and control to achieve UHC:

1. Results from the endline surveys showed that community-based groups were able to engage more people than previously in NCD prevention and control activities. There was an increased awareness of NCDs in the intervention communities through community sensitisation and the number of people participating in health education and screening sessions increased. The attitudes of people towards improving their diets and physical activity and reducing the use of alcohol and tobacco, changed positively. It is too early to measure the impact on health indicators such as overweight and hypertension.
2. The community-based screening by community volunteers for early detection of risk factors and the detection of early stages of NCDs was successful. In all project countries there was active participation at screening events with increased detection of people with risk factors. Approximately 25 to 30% of people participating in the screening were identified as having high blood pressure, and approximately 5 to 10% people screened had a high-risk score for diabetes. Those identified with risk factors were advised to attend a PHC facility for further diagnosis and treatment.
3. Training of primary healthcare facility staff in Vietnam resulted in improved quality of counselling of patients on lifestyle and treatment options, and better understanding and adherence to treatment.
4. The implemented interventions are cost-effective. The strengthening of PHC and community activities requires an investment from governments and commitments from communities. These investments are paid back by savings on treatment of chronic diseases and complications. On top of this increased productivity and participation in society of older people is achieved. It is necessary to maintain high quality of the primary health care activities to safeguard the impact and achieve a high rate of return on these investments.

5. In Indonesia and Vietnam, the decentralised government system allocates budget for community development, including health. Community groups advocate directly to their local authorities for funding for community health activities. In the SUNI-SEA project, the multi-sector stakeholder meetings at the local level provided a forum for community groups, healthcare providers, health managers and local government to exchange ideas. The local authorities demonstrated their commitment to provide support for community-based health activities. In Vietnam the local government signed official collaboration agreements and approved the ISHCs to fundraise from their membership fees to promote the sustainability of the club activities.

Policy recommendations

- To address the major disease burden from NCDs all countries must focus on NCD prevention and care as a top priority in the coming decades. To achieve progress on UHC requires that governments address the global epidemiological transition including population ageing and increased rates of NCDs and disabilities. Governments must drive investment towards primary healthcare and ensure that facilities are better staffed and equipped to prevent, diagnose and treat the early stages of NCDs.
- As NCDs take a long time to develop and only cause disease after several years, it is important to start as early as possible to create awareness in the population, provide health information, and promote healthy lifestyle approaches. Prevention of NCDs is an urgent priority, so UHC should focus on both curative services and prioritising preventive services. SUNI-SEA has provided evidence that communities are the right places in which to implement prevention activities to drive better outcomes.
- NCD prevention and care must be prioritised within progress towards UHC in all countries through including NCD prevention and care in the essential service benefit packages available at PHC facilities and in communities; scaling up NCD services to unreached geographical areas and populations; and improving the quality of NCD service delivery so that effective interventions are provided.
- SUNI-SEA has provided evidence that a combination of empowering communities to provide community-based health education and screening, and strengthening PHC, leads to increased awareness, changes in behaviours, early detection of NCDs, and better adherence to treatment. It is therefore a valuable and tested approach to increase UHC for NCDs.

Why do we think these approaches are replicable in other countries?

1. The results of the multi-country study show that experiences were very similar in Indonesia and Vietnam. The findings are likely to be valid in other LMICs.
2. The selected approaches worked: *Posbindu* as outreach from primary healthcare services, and ISHCs as community development groups. Approaches should be adapted to context, and countries should select the approach that best fits the national NCD policy and build on and expand existing community engagement mechanisms.

3. The interventions in primary health care are cost-effective and investments pay themselves back overtime if quality is sustained.
4. Evidence-based toolboxes and digital instruments from SUNI-SEA are available for anyone who wants to use them.