Opportunities for civil society organizations to integrate non-communicable disease interventions into existing health programmes: a case of Amref Health Africa in Kenya

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Abstract

Introduction: non-communicable diseases (NCDs) are an increasing public health concern in Kenya. The Ministry of Health aims to reverse this trend however funding remains limited. Integration of NCDs into existing health programmes has been recommended as a cost effective approach. In Kenya, civil society organizations (CSOs) play a significant role in delivery of a range of health services. The objective of this study is to identify opportunities for CSOs to integrate NCDs in to existing health programmes.

Methods: this was a cross-sectional study targeting 31 health managers in one of the largest CSOs in Kenya, Amref Health Africa. Structured questionnaires using likert scales and key Informant Interviews (KIIs) were administered. Proportions of the most frequent responses were determined using Likert scale data. Qualitative data from the KIIs was analyzed thematically.

Results: a total of 23 project managers and 4 programmes managers were included in the study. Majority of project managers were implementing Reproductive Maternal Newborn and Child Health projects (43%) and HIV/TB and Malaria projects (39%). All the programme managers and 87% of the project managers agreed that there were opportunities for integrating NCD interventions within their programmes and projects. The interventions with greatest opportunities included awareness creation on NCDs through Community Health Volunteers (91%), through public forums (91%), through schools (74%) and at health facilities (74%).

Conclusion: there exist substantial opportunities to integrate NCD interventions within existing health programmes implemented by CSOs. There is need to test various integration models and influence their adoption in to the national health programmes.

Introduction

The world is currently experiencing an upsurge of non-communicable diseases (NCDs). Non-communicable diseases mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes represent a leading threat to human health and development [1]. These four diseases are the world's biggest killers, causing an estimated 35 million deaths each year - 60% of all deaths globally - with 80% in low - and middle-income countries. The World Health Organization (WHO) projects that, globally, NCD deaths will increase by 17% over the next ten years. The greatest increase will be seen in the African region (27%) and the Eastern Mediterranean region (25%) [1]. East Africa is currently experiencing a double burden of communicable and non-communicable diseases and the associated premature deaths and disabilities are exerting pressure on the already fragile health systems and the national economies. The result is a negative effect on the economic growth driving families deeper in to poverty [2]. In Kenya NCDs are an under-estimated cause of poverty and a barrier to economic development. Between 2005 and 2007, NCDs contributed over half of top twenty causes of mortality and morbidity in Kenya and half of the top ten leading causes of morbidity (MOH, 2007). This has led to a double burden of diseases where NCDs must be prioritized amidst the continuing burden of communicable diseases (CD). One of the strategic objectives of the Kenya National Health Strategic Plan 2013-2017 is to half and reverse the rising burden of NCDs. The Division of NCDs in the Ministry of Health is carrying out advocacy to prioritize NCD programmes and to integrate NCDs into the primary health care system.

Despite the call by various stakeholders to prioritize NCDs, the challenge of low funding streams and competing priorities threatens these efforts. Developing countries like Kenya rely heavily on external donor to meet health needs. It is estimated that only 3% of donor funding in health has been allocated to NCDs. A significant increase in national health expenditures is required to adequately address NCDs. There are two main programme implementation approaches that have been the topic of debate for several years. These are the vertical and integrated [3]. The vertical approach involves focusing attention on a specific health problem. In this approach additional resources are normally required to scale up specific interventions and the focus is on achieving specific objectives. The disadvantage of vertical approaches is that they can only be sustained by a continuous stream of funding [4]. In addition the vertical approach has been known to aggravate weak health systems by diverting attention from the comprehensive health system [5].

The other approach is the integrated approach where a range of interventions is provided through multifunctional health care delivery [4]. Integration of NCDs into existing health programmes such as HIV/AIDS has been recommended both globally and nationally as a cost effective approach with the potential to reduce the societal impact of NCDs [6]. In addition, the integrated approach provides holistic care focusing on health needs of individuals and communities [5]. The WHO has been providing technical support to countries in integrating cost-effective interventions against major NCDs into their health systems. This includes determining a set of core interventions that can be successfully integrated into primary health care (PHC) in low resource settings and adapting such a package to suit local contexts [7]. Before integration can take place, there is need to carry out a needs assessment to determine readiness of the primary health care level for NCD prevention and control. According to WHO, the minimum requirements for integrating NCDs in to primary care include stewardship, conducive policy environment, intersectoral links, engagement of community and family, empowerment for self-care, equitable financing, trained workforce, appropriate service delivery models that provided continuity of NCD care, access to essential medicines and supplies, medical information systems and appropriate referral links [7].

Globally and nationally, Civil Society Organizations (CSOs) have been influential in determining the health agenda and creating a global spotlight on diseases such as malaria, HIV/AIDS and maternal health. In Kenya, CSOs contribute significantly and greatly influence the health sector due to its conducive environment [8]. These CSOs offer a suitable platform to accelerate the response to the rising burden of NCDs through integration with the existing health programmes. In addition, this provides an opportunity

to test various integration models and influence their adoption in to the national health programmes. The purpose of this study was to explore the opportunities and assess readiness of CSOs to integrate NCDs within existing health programmes. Amref Health Africa, one of the leading health CSOs in the continent, headquartered in and with operations originating from Kenya provides a good case study due to the scale and diversity of operations and its sixty year track record. The organization has offices established in 10 countries in Africa and implements more than 150 health projects across the continent. This study provides the much needed information to support of integration of NCDs within the existing health programmes implemented by many health and non-health CSOs. In addition, the study outlines the minimum requirements for integrating NCDs into primary health care level among CSOs.

Methods

Study design and setting: a cross-sectional study was carried out targeting 27 Project Managers and 4 Programme Managers at Amref Health Africa in Kenya. The organization implements projects in all the 47 counties in Kenya categorized under 4 programmes: Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNACH); HIV, AIDS, TB and Malaria; Water, Sanitation and Hygiene (WASH) and Clinical and Diagnostics. The programmes are headed by a Programme Manager and the individual projects are managed by Project Managers. The Project Managers are based across different counties in Kenya. These respondents were selected due to their understanding of the organization's strategic, programme and project level priorities as well as the donor requirements.

Data collection and analysis: a structured questionnaire was sent to all the 27 Project Managers through an online survey. The questionnaire captured the basic characteristics of the projects (health programme area, implementation sites, project scope and characteristics of beneficiaries), opportunities for integration of specific NCD interventions and capacity to support implementation of minimum requirements for integrating NCDs into primary health care. Likert scale was used to score responses from the structured questionnaire. A Key Informant Interview guide (KII) was used to collect data from the 4 Programme Managers on feasibility of introducing NCD interventions within the specific programmes. Proportions of the most frequent responses were determined from the Likert scale data obtained from the structured questionnaire. Qualitative data from the KIIs was analyzed thematically.

Results

Characteristics of projects implemented: twenty three 23(75%) of the project managers responded to the structured questionnaire, indicating a 15% non-response rate. Majority of the projects implemented were in reproductive, maternal, neonatal and child health (RMNCH) programme 10(43%) followed by HIV/TB and Malaria programme 9(39%) and WASH programme 4(17%). None of the projects represented was in the Clinical and Diagnostics Programme. Overall, the projects interventions covered all the 47 counties in Kenya with an approximate number of beneficiaries reached per project ranging from 30,000 to 12,000,000. The projects implemented had been in operation between 10 and 168 months with a mean of 47.55 (sd 47.403) months. With regard to project beneficiaries, majority of the projects implemented 21(91%) reached pregnant women and/or children under 5 years, 20(87%) reached adults, 19(83%) reached adolescents and youth and 17(74%) reached children aged between 6 and 14 years. Another 17(74%) of the projects included community level activities delivered by community health volunteers (CHVs) as stipulated in the MOH community health strategy.

Opportunities for integration of NCD interventions within existing health projects: majority of the project managers 20(87%), indicated that there were opportunities for integrating NCD interventions within their project activities. The NCD activities with the greatest opportunity for integration included awareness creation through CHVs 21(91%), awareness creation through public forums 21(91%), awareness creation through school health programmes 17(74%), awareness creation at health facility level 17(74%), capacity building of Health workers on NCDs 15(65%) and capacity building of CHVs on NCDs 14(61%). This is summarized in the **Figure 1**. These findings were corroborated by KII findings

where the Programme Managers indicated that there were opportunities to integrate NCD interventions within the various health programmes in particular those related to community awareness. Specific examples cited by the WASH Programme Manager include use of existing water and sanitation committees and school health clubs to disseminate awareness on NCDs at the community level.
Minimum requirements for integrating NCDs into primary health care: responses from project managers indicated that the projects were able to support implementation of the minimum requirements for integrating NCDs into primary health care. Specifically, majority 21(91%) of the projects have the capacity to support engagement of the family and community on NCD awareness and management, formation of intersectoral (education, health, agriculture) links to address NCDs 18(78%), empowerment of patients with NCDs on self-care and peer support 12(52%), advocacy and policy implementation to scale up NCDs management 12(52%) and training of health workforce on NCDs 12(52%). These findings are summarized in **Figure 2**. The programme managers supported these findings that the organization had the capacity to support the integration with one of them stating that:

"Yes, just like the organization focuses on TB, HIV and Malaria it can expand the programme to include NCDs since the capacity and infrastructure are already available" - PM1.

Discussion

The integrated approach has been highlighted by the WHO as the most appropriate for delivery of NCD programmes in low resource settings due to its cost-effectiveness and client oriented nature [**6**]. The East Africa NCD Alliance has recommended the integration of NCDs into existing health systems such as HIV/AIDS, reproductive health and maternal and child health [**2**]. This study confirms that there are opportunities for integration of NCD interventions within existing health programmes (TB, HIV, maternal and child health, water and sanitation) implemented by CSOs. Lessons from other integration efforts suggest that there is need to determine which set of interventions can be effectively integrated for each particular situation [**3**]. The findings from this study indicate that NCD interventions focused on awareness creation and capacity building can provide a suitable entry point for integration within existing health programmes. This is particularly relevant for CSOs which have strong focus on health service delivery at community level in line with the ministry of health Community Health Strategy in Kenya [**9**]. NCD awareness creation can be integrated with existing health awareness interventions delivered by CHVs or through public forums and school health programmes. Capacity building sessions of both health care workers and CHVs on NCDs can be done during available training sessions covering other health areas. It may not be possible to deliver the entire curriculum for management of the various NCDs, and it may be necessary to develop a minimum package of information on NCDs for delivery within the existing training opportunities. While the integration approach has been highly recommended, it is important to note that integrating new activities into an existing system will need the entire system to be better resources and the desired outcome may not be achieved where the resources are inadequate [**6**]. WHO has set out the minimum requirements for integrating NCDs in to primary care [**7**]. These requirements must be put in place to ensure the integration efforts are successful. The Kenya's MOH, Division of Non-communicable diseases has been carrying out advocacy to prioritize NCD programmes and to integrate NCDs into the National Health plans and into the primary health care system. However, with limited funding towards the health sector, availability of these requirements remains a challenge. This study found that majority of projects had the capacity to support some the minimum requirements for NCD integration. This could be partly explained by the fact that some health projects engage additional sectors of the government besides the health sector. For example, the school health projects implemented within the WASH programme works closely with the education sector and can provide a suitable opportunity to discuss incorporation of NCD awareness in to the school curriculum and activities. There is need to carry out similar studies in other CSOs to corroborate these findings and also as a way to mobilize other CSOs to embrace this integration approach. In addition, further evaluation with regard to staff capacity both at project and senior management level is required to ensure there is adequate staff capacity to support the integration process.

Conclusion

There are substantial opportunities for CSOs to integrate NCD interventions within existing health programmes. There is need to develop a policy document for CSOs and other partners implementing health programs on the need to integrated NCD services and the recommended interventions for integration. At the organizational level, employment of this approach should be supported by a clear implementation strategy to ensure NCDs are prioritized and to facilitate coordination across existing programmes. The opportunities for integration of NCD interventions will vary across various health programmes and projects and it is important for organizations to prioritize the interventions which can be successfully integrated. CSOs should take advantage of the available technical assistance from WHO and work closely with the MOH to come up with integration models that can be scaled up within the country. Integration of NCDs within existing health programmes provides a good starting point to begin addressing the growing NCD burden. However, there is need for continued advocacy to ensure governments, MOH, CSOs and other development partners prioritize NCDs and allocate adequate resources towards a more comprehensive approach.

What is known about this topic

- It is already widely accepted that the integrated approach is a cost-effective approach which also provides client-oriented services in a holistic manner;
- This approach has been recommended for delivery of NCD services in light of the shortage of funding and the availability of already established and funded health platforms such as the HIV program.

What this study adds

- This study confirms existence of opportunities to integrate NCD interventions within existing programmes implemented by CSOs and recommends the set of interventions that are more likely to be successfully integrated.

Competing interests

Authors declare no competing interests.

Authors´ contributions

Lilian Kagure Mbau is the lead author and contributed in the conception and design, acquisition of data, analysis and interpretation of data and writing of this paper. Fred Newa is a co-author and contributed in the writing of the paper and revision of the manuscript for the crucial intellectual content.

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Figures

Figure 1: proportion of projects with opportunities to integrate specific NCD interventions

Figure 2: proportion of projects with capacity to support implementation of minimum requirements for integrating NCDs in to primary health care

References

1. World Health Organization. **2008-2013 action plan for the global strategy for the prevention and control of noncommunicable diseases: prevent and control cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.** 2009. Accessed on 19th December 2017.
2. East Africa NCD Alliance. **A civil society benchmark report responses to NCDs in East Africa the East Africa NCD Alliance Initiative** . 2014. Accessed on 19th December 2017.
3. Narain JP. Integrating services for noncommunicable diseases prevention and control: use of primary health care approach. Indian J Community Med.2011; 36(Suppl 1):S67-71. **PubMed** | **Google Scholar**
4. NCD alliance. **Tackling non- communicable disease: what can health systems do?** 2011. Accessed on 28th October 2017
5. Nigatu T. Integration of HIV and noncommunicable diseases in health care delivery in low- and middle-income countries. Prev Chronic Dis. 2012;9:E93. **PubMed** | **Google Scholar**
6. World Health Organization. **Integrated health services -what and why? Making health systems work**. 2008. Accessed on 28th October 2017.
7. World Health Organization. **Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings**. 2010. Accessed on 28th October 2017
8. U.S. President?s Emergency Plan for AIDS Relief. **A Firm Foundation The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS**. 2012. Accessed on 28th October 2017
9. AMREF. Transforming communities from within by improving the health of women and children. Nairobi: Amref Headquarters. 2011.