

## Dialogue4Health Web Forum

Promising and Sustainable Global Methods for Non-communicable Disease Care  
Wednesday, December 5, 2018

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>> Welcome to Dialogue4Health and today's web forum, Promising and Sustainable Global Models for Non-communicable Disease Care. We thank Global Health Leaders and the Medtronic Foundation for sponsoring this event. My name is Laura Burr, and I will be running today's web forum with my colleague Kathy Piazza.

And now it is my great pleasure to introduce our moderator for today, Esther Tahrir. Esther is a principle investigator at the Public Health Institute, where, for the past 18 years, she has run and scaled up innovative and impactful leadership development and fellowship programs globally. She's the founder and director of Public Health Institute's Global Health Leaders Corporate Health Fellowship Program that supports local public health experts to act as technical and strategic global advisories to Medtronic Foundation. Welcome to Dialogue4Health.

Esther?

>> Thank you, and thank you, everyone, for joining us today. Global Health Leaders is the Public Health Institute's Corporate Health Fellowship Program that works in partnership with corporations and their foundations to amplify their philanthropic impact globally, and together we work to bridge the public and private divide. We have three Global Health Leaders fellows that will be joining us today to speak of their experience. As a global health leader fellow and in support of Medtronic Foundation's philanthropic work around the globe, and we look forward to this presentation.

>> Thank you, Esther. And we are going to go to another poll question now. I would like to ask everyone in the audience, do you practice mentorship of clinical staff in your organization or projects? Please select yes or no, and then be sure to click submit to let us know your response. So we can go ahead and take your responses now. I'm seeing so far that everyone has selected the yes option, who has participated in the poll so far. So, we'll give you just a few more moments. I see more responses coming in, and we can go ahead and close that poll. This is your last chance to click submit, please.

Thank you so much. So, now, we can see that about 36% say yes, you do practice mentorship of clinical staff, and about 58% say, no, you don't do that. Thank you so much for taking that poll, and now we'll move on and introduce you to Belinda.

>> Belinda Ngongo is the senior technical advisor for health integration and gender equity in Sub-Saharan Africa. She has more than a decade of experience working in global health through the private sector's lens, and as a Global Health Leaders Fellow with PHI. Ngongo provides technical assistance and program management support for all of Medtronic Foundation's global health

programs across Sub-Saharan Africa. Belinda works to ensure best practices and implementation among grantees in the region. Now we'll hear from Belinda. Welcome, Belinda.

>> Hi, everyone. Thank you very much, and really it's a pleasure being here this morning, and really today my presentation is going to focus on clinical mentorship to strengthen non-communicable disease capacity of health care workers, and I'll be talking of an example that is taking place in South Africa.

So, just to start with the big picture, as most of you probably know, we are currently overseeing global goals or sustainable development goals, and SDG number 3 ensures healthy lives and promotes well-being for role. And when you look at SDG footprint four, it's really more specific to non-communicable disease and training NCDs up to one third.

Something else that the World Health Organization has put together is the framework for monitoring, really to make sure that we track progress and we control measure NCD.

I'll speak about one project founded by Medtronic Foundation called HealthRise, and HealthRise is a five-year project in four countries aimed at improving hypertension and diabetes amongst the population, and the objective of the project is to increase screening and diagnosis of diabetes and hypertension and to increase the management and control of these two diseases. I really want to improve clinical outcomes. HealthRise, as I mentioned, is funded by Medtronic Foundation with partners that include -- monitoring and evaluation by IHME, and the project is currently being implemented in four countries. And our focus today is going to be South Africa. In South Africa, HealthRise works in two provinces. One province called KwaZulu-Natal, which is the most populous region in South Africa, as well as Pixley Ka-Seme, which is the Northern Cape province. And just to mention that the Northern Cape province, which is going to be our focus today, has -- is known to have a population of less than 25 years old, and it's a very rural area with a high crime rate and alcohol abuse, and in addition to that, this population has very high prevalence of disease, including hypertension around 49%, and diabetes at 2%. Just to mention, when this project was implemented, there was a needs assessment done looking at the literature that existed, but there was also some qualitative interviews that were done by our partners.

And the program approach in the Northern Cape has really been looking at strengthening our community-based services, and particularly primary care, by providing training to health care workers, as well as leveraging on existing platforms. As you probably know this, many places in South Africa are suffering from high rates of HIV, so we want to make sure that where we work in HealthRise are also where the country is implementing HIV services. So, looking at the gaps that were identified in this program are things that had to be taken care of, including making sure the people knew about the disease and contacting community campaigns, training of providers was something that was definitely needed, and also making sure that patients adhere to medication, by doing so making sure that they have access to the right medication. And we realize that diabetes and hypertension are diseases that require strong support, so there was a need to form community support groups so that patients would adhere and also change the lifestyles.

So, looking at intervention that has come out of this project, included screening, and this has been done by community events, activities, our partners worked with mobile and tents for screening communities, but the other interventions also really revolve around training. There was a need to training staff on diabetes medication -- there was a need to train the clinical staff and project staff on diabetes interventions, and this material came from the diabetes education foundation of South Africa. Training of community health care workers was also on top of the agenda. Most importantly for the discussion today for us, we are going to focus on clinical mentorship, and the clinical mentoring has been essential to ensure adherence to treatment guidelines.

And finally, something else that has been instrumental in this project is the establishment of support groups for patients, and this has involved things like what they call the five-step self-care guide to help a patient know about the disease and make sure that they can manage it, as well as the VSL region, where patients were made financially independent.

So, for the clinical monitorings, just to mention, some of the progress made in South Africa, especially the Northern Cape, but it's something that I think could actually be representing the entire country, is a lack of skill, knowledge, and confidence to manage people with diabetes. So, for example, a diabetes patient will go to the clinic, but once they reach the clinic, the nurse will not be confident, for example, to put them on insulin. And although they were trained previously by the government, they still felt this they don't have the skill. Furthermore, some of the health care workers are just reluctant to support patients who require care or even who had to manage long term complications, such as food care or even with specialized nutritional needs. So one of the big solutions was to ensure that we empower the health care workers to actually take care of this patient, and then this required clinic mentorship. And the idea of the clinical mentorship program in place was to facilitate the health care provider and provide them knowledge, strengthen health care knowledge and decision making, and by doing so, it helped improve competency and increase confidence in delivering care. The model used started with didactic training, where the Diabetes Education Society of South Africa training material were used, and this was done through a pre-and post-assessment. And once the skills or the knowledge was acquired, it continued into clinical mentorship, and in there, there was a relation in trust building between the staff and the mentor. There was a case, a presentation. There were clinical discussions, and then finally I think it really gave the mentee the independence to make clinical decisions. And one of the tools that we use there is to make sure that there was a development of a competency framework to measure the gain in skill or knowledge of the clinical staff. And just to highlight some of the mentorship programs that have been delivered in South Africa, they include treatment guidelines for the APC or Primary Health Care 101 guidelines that have been developed by the government for care at the primary health care level, but there's also case presentations that happen in the mentorship program, and as well as class discussion to further strengthen clinical knowledge.

And what we saw over time is after a year of conducting quality interviews with many of the nurses that took the medical program, was there was definitely an increase in knowledge and skills. There was a greater number of referrals to other services, so, for example, patients that had foot problems or eye problems due to diabetes were referred to the right services. There was improved collaboration among hospital staff, but definitely something that was very significant is the ability to see the early detection of complication and also new patients on treatment.

Just to conclude, I think some of the big lessons that have been learned from the program is, you know, in order to succeed, three important things have to be put in place, and these include making sure there is a system in place, because traditionally what happens in South Africa, and particularly in the Northern Cape province, is patients came, but there was never a true follow-up or review of the case-by-case on a yearly or on a monthly basis. The mentorship was of value, but it wasn't formalized. In training, there is a need to identify the right training, as well as have champions in each facility, because these champions would be responsible for advocating for the right training and the right even equipment in place at each of those facilities.

Another important point in strengthening education in patients, by educating patients, it would enable them to ask the right questions to providers and adopt a lifestyle that is required to manage their disease.

And finally, sustainability planning. I think we realized that sustainability had to be set up at the

beginning of the project, and this could be achieved by making sure that the site or the partners are collaborating with all of the stakeholders, you know, to maintain some of the activities.

So I will end by sharing some of the photos from South Africa and just highlight the photo on the left bottom side, showing one clinical mentor demonstrating, you know, how to take care of a person who is suffering from diabetes on the foot, for example, and then the photos in the middle just showing the health care professional showing the other one how to maneuver equipment or tools when she is doing some diabetes or hypertension testing. So I will end here, and I look forward to questions.

>> Thank you so much, Belinda, for sharing the experience you have had working in partnership to implement HealthRise in South Africa, and we are going to go ahead and move to the next polling question.

>> Yes. So who should you engage from the beginning of a project, thinking of sustainability? Please select an answer on the right side of your screen in the polling panel. A, government authorities; B, private sector leaders in the same field; C, representatives from the community; D, national and local NGOs; E, academia; or F, all of the above. So please pick any response that applies to you. And after you choose your response, please go ahead and click submit. It will take a moment in WebEx. Don't forget to click submit after you select your response. And we can go ahead and close that poll now and look at the number of responses for each one. It looks like the overwhelming majority, 78%, selected all of the above, and next at about 20%, representatives from the community, and then about 11% was government authorities, 5% national and local NGOs, and then 4% with private sector leaders in the same field. So, thank you so much for participating in the poll.

>> Great, thank you. So our next panelist is Dr. Mark Barone, senior technical advisor of global sustainability in Brazil, and Dr. Barone has nearly two decades of experience working in education and research, as well as in health marketing and communication within Brazil, focusing mainly on Type 1 diabetes. As a Global Health Leaders Fellow, Dr. Barone serves as the technical advisor for Medtronic Foundation's global health programs in Brazil and globally, focusing on non-communicable diseases. He works with the implementing teams of HealthRise Brazil and HeartRescue Brazil and leads the global sustainability plans for Medtronic Foundation Global Health Programs. We are glad to have you, Mark, and please go ahead.

>> (Audio missing) -- integrating NCD's chronic and acute programs, strategies for scaling and sustaining. I would also like to welcome the participants from the NCD's forum in Brazil who are also attending the webinar today.

So, first of all, I will talk a little bit about the background of health in Brazil. So, in Brazil, we do have universal health coverage. 75% of the assistance depend exclusively on public health system. So they have no private insurance. It is a system that offers health care for all, and it also has an essential list of medicines available for free that includes medication for diabetes and cardiovascular diseases, among many others, but obviously we will talk about HealthRise in Brazil. That's why we are focusing mostly on diabetes and hypertension.

But as we would expect, the universal health coverage there has its challenges, so including efficiency in medicine delivery, which means that not always people find the medicine that the physician has prescribed, and also it's hard to go back to the facility every month for some people, especially the underserved, to go to get their medicine, since they need to get on a monthly basis, especially the ones with chronic conditions.

So, they also -- there are also common complaints of long waiting lines for consultations, exams, and treatment, not always the facilities are close to where people live, especially the ones in rural areas in Brazil. There is a shortage of health care professionals. Quality of care, especially when it's not in

the capitals, it tends to be poor in the system, and there is also a misuse of the health care system in general. So the system is organizing to primary, secondary, and tertiary here, but not always the person knows where to go for the different symptoms or conditions they have, so they may end up going to the wrong facility, to the hospital, and in cases that it would be -- the right thing would be to go to the primary health care facility.

So, my colleague, Belinda, has already started to talk about HealthRise, especially in South Africa. I'm going to focus, obviously, on Brazil, and in Brazil it is happening in two regions, one in the -- the region of Vitoria da Conquista and the region of Teofilo Otoni. In Vitoria da Conquista, it's one town. In Teofilo Otoni, it is the towns of the same region. And HeartRescue is also implemented in Vitoria da Conquista, and we will understand why we chose to implement both programs in one and the same region in this case.

So, here, several barriers we identify to be specifically addressed by both programs. So in the case of HealthRise, focusing on diabetes and hypertension. So there are a big number of individuals who are unaware of the disease. They don't have diagnosis of diabetes or hypertension, more than 25%. So we figured out also that the system seems to be more designed to women in a way that primary care, 80% of the individuals who go to primary health care facilities are women, not men, so there is a low -- behavior, and community health workers, which we have in Brazil the culture of community health workers. They are government employees. They cover most of the country, but they were underutilized, especially for non-communicable diseases. And also in those regions, we identified that civil society was not mobilizing, so people with their conditions, living with the conditions, they were not in associations, they were not participating in opportunities for the civil society to discuss with the government policies and other topics for health.

Regarding HeartRescue, so we identified that there was no local patient registry or other data collection for infarction. In addition, hospital-based fibrinolysis was the only primary strategy available in the public health system, and it was not always available in the hospitals and was never available in the ambulances, and besides that, there was a lack of treatment protocol, so different hospitals were treating differently the same condition, and as we see there on this graph, there was an increase in that due to infarction in Vitoria da Conquista.

So, here, just the general information on HealthRise and HeartRescue. So the general objective, as Belinda said, is associated with the SDG 3.4. There was a reduction by one third in primary mortality due to NCDs by 2030. And this strategy is public private partnership to strengthen the health system to improve rates of diabetes, hypertension, and infarction, especially STEMI. The approach is a multiyear demonstration project to empower health care professionals, community health workers, people living with NCDs and adopting their telehealth, point of care, and health education strategies and increase engagement of people living with, again, NCDs, and efficiency of the system. So for that, we engaged five academic partners. So three of them, federal universities, one is the hospital -- their institute of education and research, and the Brazilian Clinical Research Institute. The regions, as we said are two, and the health areas three, so hypertension, diabetes, and infarction. And besides the global health partners that include IHME, Abt, RTI, and PHI.

So specifically about HeartRescue in Vitoria da Conquista, so the objective is to improve access to time-critical care and survival rates for infarction with the implementation of standardized protocol and data registry, collaborate with HealthRise to implement community interventions. So this for us seems to be a great opportunity to partner to collaborate in between the programs in order to use their staff and the primary health care, and obviously especially the community health workers to educate the community on what to do, how to identify symptoms, and what number to call if they identify those symptoms. And obviously then when this person is treated, to receive it back to the

project, the program, HealthRise, to continue their treatment, and also develop agreements to guarantee availability of thrombolytics in different hospitals and ideally also in the ambulances. So here, so here, while HeartRescue is just starting, HealthRise is in its second year, so -- and now we have a clear picture of how health sustainability was generated in HealthRise Brazil. So beginning two years ago, an advisory committee was formed with individuals from the different sectors, from the public sector, so the federal level, the state level, and the municipal level. Also, the regions were selected in partnership with the government, so again from the federal minister of health, the secretary of health of the states. Then MOUs were developed with the secretary of health of the municipalities where the program was implemented, and during implementation, then, partnership with the municipal secretary of health to develop and scale the program for more than four years after the funding from Medtronic Foundation, and scale in a way that, as partners and also co-owners of the program, they understood that the program was important for the population, and then areas where the program was not being implemented, they scale it and implement it in other areas of the same cities.

Also, identifying opportunities to invest in showcases, and showcase presenting impartial results in conferences, and here I put the point of care, because it was a great experience for us to use point of care for A1c and TB. There are amazing results that will be presented soon in different international conferences and also in the publications that will come from health rise.

In addition to identifying and training community leaders, and their community leaders, I would identify two different groups. One, people living with the condition, so -- and those are the ones who started associations in both locations in Teofilo Otoni and also Vitoria da Conquista, and obviously now engaged more people and are participating in different opportunities with the local government in order to participate in discussions for policies for health in their towns. And also, obviously, community health workers and other frontline health workers that are leaders in the regions. So, I would also add that they received training in storytelling, among other workshops.

At the funder exit, also the opportunities there for sustainability that we saw was -- so the organization of the diabetes and hypertension associations that stay there in both regions and also the federal government that committed with two more years of funding the program in both regions, dissemination of best practices, and adoption of the model by neighboring towns in both regions also. So, I brought this figure because it's what we are using to see with hypertension and diabetes poor management leading to infarction and stroke and eventually even death, and the idea to have both programs in one single region is to link them in a way that, first of all, with HealthRise, there is investing in improving treatment for diabetes and hypertension, so most people do not have an infarction or stroke, so we have a good management of the chronic condition, but the ones who eventually develop an infarction or stroke, you have a good care in hospitals following protocols, and then eventually they will go back home, and they will continue their chronic care treatment in the other program, HealthRise.

So that's what I had to share today. Thank you very much.

>> Thank you so much, Dr. Barone, for sharing your experience integrating NCDs, chronic and acute programs, with so many partners in Brazil.

And we are going to move on to the next polling question.

>> Yes. Please respond in the polling panel on the right side of your screen to this question. In a community-based health intervention, you realize that community engagement has transformed into community ownership when, A, community leads its own action plan; or, B, community identifies its own problems; or, C, the health outcomes start improvement. So, please select A, B, or C on the right side of your screen, and don't forget to hit submit after you make your selection. And we can

see that about 80% of you selected A, community leads its own action, and about 20% selected B, community identifies its own problems. So, thank you so much for participating in our poll.

Thank you. Next, we are going to move on to our next presenter, Dr. Nayanjeet Chaudhury, and calling in from India today, so thank you for joining us, Dr. Chaudhury. Dr. Chaudhury has over 18 years of experience in diverse clinical public health and research settings. And as a Global Health Leaders with PHI, Dr. Chaudhury provides strategic support to Medtronic Foundation global health programs, particularly HealthRise and HeartRescue. He provides advisory on best practices for Medtronic Foundation programs internationally. Welcome, Dr. Chaudhury. We look forward to your presentation.

>> Thank you, Esther, and good morning, good afternoon, good evening to the participants from whichever geography in the world you are in. I can see that the participation is really high and there are people from all over the world, including from India, so thank you for joining. And after two very interesting and informative presentations, I thought it is important to talk about what happens in the community setting when you do a large-scale program. So I'll also be talking about the HealthRise project as it was experienced in India, and I will not spend much time talking about what HealthRise is, because Belinda and Mark have very elaborately shared the objectives and the structure of the program. I chose this topic of community ownership because I saw one of the HealthRise program managers stating in her blog this particular statement that we can see on the slide, where she says roles have started changing. Community is now organizing the health camps. When she had seen actually community health workers in Shimla, one of the HealthRise sites, were taking action to conduct health care for patients, you know, taking care of them, this reflects the natural adoption of ownership by the local community of their own health actions, and this was possible through a very unique experiment that the HealthRise partners in India did in a small site, and this is what I'm going to share today in a couple of minutes from now. So I'm not going to spend much time with what HealthRise is. Of course, its primary objectives were to increase, you know, screening and diagnosis of diabetes and hypertension and also provide demonstration of improved management and control of these conditions. So, we employed, you know, three different strategies, empowering patients, strengthening frontline health workers, which Belinda has described, and focusing on policy in the health care systems. More importantly, I want to talk about the settings, basically in Shimla, which is in the Rajasthan state, and Shimla is in Himachal Pradesh up in the north, so both had rural settings where we worked. There is so shortage of human resources, an awareness among the populations about disease. Particularly, NCD is very low. They are definitely not in their best state, and also we had done a baseline study before we started intervention where we picked up very high rates of hypertension, and also diabetes and diabetes in both states, for the places where it was rising. We worked with Catholic Health Association of India. We are implementing partners in Shimla with the Institute of Mother and Child Health, and of course overall global management was provided by Abt Associates. Now, I just want to very quickly go through the model here, which already I think Belinda and Mark have very, very appropriately described, but I'm just going to scan through. So, essentially, this particular model of chronic care at a community level comprises of six components, to just make things easy for the audience. So they are patient-centric care, definitely the foremost, empowerment of health care coworkers, quality assurance by standardized procedures both in the community as well as in the facilities for both screening and diagnosis, organize support for patients in support groups, which is one of the main ways of community engagement that we have experienced, and obviously active surveillance for patients by a monitoring system that we have employed in India. In Shimla, we intervened in 180 villages in two blocks, and therefore we picked up 62 villages in two blocks. However, in case of the model that I'm going to share with you now, which

is called the Community Life Competence Process, we only chose a small site within the HealthRise geography. So, therefore we picked up five villages, and in Shimla, we chose 14 villages out of the larger site, and used this particular community engagement process. So what is Community Life Competence Process, or, in short, CLCP? So this is a very well-known community appraisal method, widely used by the Constellation Group, based out of Belgium, but they work worldwide across more than 70 countries. We adopted it from them and employed it in a few villages in the HealthRise project to particularly see the effect of health outcomes on diabetes patients. Typically, CLCP involves several steps of community engagement which gradually build ownership within the community to recognize its specific problems, identify the community's own goals for achievement, and set an action plan to achieve them with regular assessment of progress and revised planning. This is the first time this method has been piloted in this space, and we see very encouraging results. I personally got very impressed in the community knowledge phase in Shimla, where patients, as well as the community together demonstrated significant ownership of the health actions that they were taking, not prompted by stakeholders from the public health system or from the external agencies, so this is where we thought this is important to not only document but also to foster the capacity of the community to sustain their action forward. So, these are some of the results that we picked up from a prospective evaluation of this model of patients. So, as you can see, at the top of the slide, patient support groups, as I had mentioned earlier, were also employed here. In this particular slide, patient support groups demonstrated that the health outcomes, that particularly the clinical data for intervention were significantly improved in both the sites. Shimla was nearly 59%. Udaipur, it was 64%, compared to before the intervention was introduced, and these are all record sheets from patient self-assessments that our team collected before and after the intervention.

I can also see that treatment adherence rates improved in both sites. There were other very visible changes that we documented, including people's choice of lifestyle, including food regulation, physical activity, regular testing of their blood sugar and blood pressure and other related, you know, issues. While we did not really work on alcohol, we did try to pick up their behavior, because we are considering to work with all of the patients on an extended period, so but we didn't really see much results there. But patients, the smoking rates have come down. The sample sizes are good enough. I mean, for Shimla we had 6 patients, and Udaipur we had 15 patients. There was a significant reduction in people who were part of the self-assessment, declared that they were not smoking, which was verifiable at the end of the program. So this sort of helps us here to document the lessons in further analysis, and while these are still preliminary results, but nevertheless it is important to discuss so that we actually have clues for community intervention through unique models of community engagement.

So it was interesting to note that spouses in the family, and even neighbors of patients suffering from hypertension showed active interest in the care process. Children were seen leading adults, including patients, to adopt healthier lifestyle, including outdoor physical activities, et cetera. The patient support groups turned out to be a very successful peer-led strategy, especially with the CLCP exposed sites, where they not only attempted to address their barriers to diabetes and hypertension and related issues, but also identified wider health issues, including hygiene and sanitation, stigma around TB, active management of nutritional disorders, et cetera.

The local governments have taken governance of the visible changes within the community, thus feeling empowered and are actively supporting HealthRise India partners now. So it is interesting that, you know, there is an actual visible demand within the community to continue their activities, and they are seeking support from us, so which we are considering at this moment. Here are some examples of different activities that were conducted. So if you see this, the first photograph is about a



community knowledge fair that I was offering in the beginning, where not only patients but their family members, caretakers and other opinion leaders are gathering to discuss their progress and update themselves on their progress as well as strategies. Other photos talk about organized screening camp held by the community members themselves. You know, people have started actually going out in the morning in groups, you know, in the pursuit of a healthier lifestyle.

They are regularly organizing health talks today, not necessarily led by a health worker.

It is also interesting to note that health workers realize that they are part of the community, and therefore they have an ownership in terms of helping the community lead its own health action, rather than doing their statutory duties. So, similarly, you see in the photographs women exercising in groups, especially sessions being conducted for women and children, and, you know, other than these, we were amazed to see actually people taking action for cleanliness and hygiene and building toilets and using them, or even, you know, planting garden vegetables. So with this experience, although this was a very small intervention site, we are very encouraged to consider this kind of community engagement process that eventually transforms communities' intent of leading their own health actions to community ownership, and the partners are currently working towards applying for new funding opportunities so that they can support not only in the existing sites but also in an expanded geography, and hopefully it will succeed. So I would like to end here and would look forward to questions, if any. Thanks.

>> Thank you so much, Dr. Nayanjeet Chaudhury, for sharing your experience in community engagement in chronic care, particularly around the implementation of the HealthRise program in India.

We are going to move on now to the question and answer feature, and you'll see on your screen the instructions on how to go about -- on the bottom of your screen, clicking to open the question and answer panel. Type in your question for any of our three panelists into the question and answer box, and selecting ask all panelists, and then clicking send. And when you do that, we'll be able to review your questions, and you can ask a question directed to one of the specific panelists or a general question. So while you're going about doing that, we did have some people send in questions in advance, so go ahead and ask the first question of Dr. Nayanjeet Chaudhury, specifically about the competence approach. So the question is the competence approach is that communities use their own resources to achieve their own dreams. Those communities avoid as much as possible external resources. Will their sustainability be ensured beyond the first competence cycle?

>> So, I can go ahead and -- yeah, go ahead, Dr. Chaudhury.

>> Yeah, so it's a very gradual process, and initially people need to understand the -- not only the, you know, the entire cycle, but also a very important technique that the CLCP cycle uses called the SALT. SALT stands for stimulating, appreciating, and learning and transfer. So the beginning of the cycle, they actually learn how to express their collective dreams for that particular domain, and then gradually they are facilitated to work on progressing with an action plan, monitoring its execution, and then also reassessing where they are in terms of the dream that they initially targeted.

So, what we have experienced and also have heard from the Constellation Group from their experience across so many countries is that it takes about at least a year or two for the community to understand the process, but once they are at it, they are able to exercise their own action plans without assistance, but with assistance, better for sure. With NCDs, this is the first time we have tried. It is very difficult at this moment to tell very, very confidently as to what is in store for the community to describe after one year. But having seen the encouraging results, I think it's worth considering for larger experiments.

>> Thank you, Dr. Chaudhury.

A question is coming in from the participants, and I think any of the three of you could offer some of your tips around this, and the question is how did you build trust that you would follow through and actually be there for the community. So all of you spoke about working with the community, so go ahead, Ms. Ngongo.

>> Yes. I think very importantly to establish sustainability and ownership, it's very important to engage with the community. So I think the work that we have done, we have made sure to engage the community from the beginning. It's not a decision that is taken by the international partners. Rather, we work very closely with the provincial government, with the community leaders, because they are the ones who know the community and are able to decide for the community. And I believe that I think by using that approach in any programming, we will then be able to ensure community ownership.

>> Thank you, Ms. Ngongo. Go ahead, Dr. Barone.

>> Yeah, just so usually I say that the individuals with the chronic condition in the communities are the ones who will, after the program -- if there is -- if the funder doesn't continue funding the program but it is implemented there, it was implemented there, they are the ones who fight for continuing the program, for continuing the benefits, and to make sure that the government and other partners make sure that the benefits don't just finish when the funder exits.

(Sirens in background.)

>> Great, thank you. There is another question that was sent in advance, and I think this person was saying that they want to know how to plan for a non-communicable disease prevention control and treatment program. So you've spoken a lot about partnership. You've spoken a lot about community engagement. But are there some other key tips that you would say that you could offer to this person, asking how to plan for an NCD prevention control and treatment program?

>> Okay. I can go. This is Nayanjeet. So I think that is the most important question today across the world, whether it's a developed country or a low or middle income country. So, particularly in the low and middle-income countries, the systems are not ready enough to sudden surge of non-communicable diseases, so therefore, first of all, the awareness within the public health system to combat NCD burden is paramount, because what you usually see is that sporadic experiments do show successful results. However, without political will and, you know, systems in place, it's extremely difficult. So political will for sure.

And then I think our experience is that, however small, I think an integration of both public and private sector, as well as not for profit sector, especially as regards to NCDs is very pertinent, because nobody knows an exactly perfect way of preventing and controlling NCDs on a large scale. So everybody comes with a distinct experience and expertise, and therefore it is very, very important for all of these partners to get together and identify and assess risks and accordingly set priorities. I mean, just to cut short, we must not also forget that appropriate resource allocation, plus building technical capacity of the health workforce, both in the public and the private sector, is nonnegotiable here, because NCD is complex, and there are so many of them. NCD is not just one disease, right? So each of them behaves so differently, and then there are cultural issues with the community. There are practices, so there's a lot to take care of. So a comprehensive care, as we have practiced in HealthRise, showed us encouraging results, which includes patient-centric care, community empowerment, health providers, capacity building at all levels, and most importantly policy and advocacy for system strengthening, would be a good answer, I guess.

>> Thank you so much, Dr. Chaudhury.

Another question that was sent in, and I think it's pertinent in terms of what you were discussing about the importance of political will, and this question is how do we convince world leaders that spending

money on prevention today pays off in the form of lower costs in the future. It's a big question.

>> Hi. Yes, I'll take --

>> Did you want to? Go ahead.

>> Yeah, yeah. So I think right now in the world, definitely the political movement that is coming out is government recognizes that, you know, prevention is a cheaper way to combat NCDs, and I think in many international forums, you know, that's what countries are advocating for. I think most importantly, especially when you look at low and middle-income countries, is allocation of funds for health care is problematic. So I don't think it's a problem of whether it is for problematic for intervention. It is tough in general. The budgets for health care in many countries, especially dependency on funding like PEPFAR and ID, but also there was a strong focus on communicable diseases, so firstly there is a need to change the mind set of governments, telling them that, you know, NCDs should become a priority, and there needs to be more allocation of funds towards NCDs, and I have no doubt that once more funds are allocated, many governments will first start with prevention, because I think that is something that has been spoken about and that has been recommended by many international organizations.

>> Thank you. Any other thoughts, either Dr. Barone or Dr. Chaudhury?

>> I would add something. So I would say that also prevention, strategies for prevention that are successful are also very complex. I would say that it is hard to change the environment in a way that works and that is sustainable, so we know that in several places, for example, there is this increase in taxation of ultra-processed foods or sugary drinks and labeling, the front labeling of different food products, and different strategies for increasing the exercise people do. So it's not easy, and obviously there are many, many challenges to achieve this, and also to measure the effectiveness of those strategies. But I am sure that we will see more and more this taking place in the next years, because, obviously, the governments I think are aware that nobody will be able to pay for the consequences of this huge increase of NCDs everywhere.

>> Thank you. Another question is do you expect a global economic downturn in the next five years, and how might that impact public health strategies, either around the world or in your countries?

>> Yeah. This is Nayanjeet. That's a very, very critical question, and having seen the ups and downs in the global economy over the last, I think, more than one decade, it is very possible, and, you know, just if we look at the HIV episode, where we were very busy sort of, you know, combatting the increase in the incidence, and then eventually we were fairly successful globally. However, we ended up with a huge number of, you know, people infected with the virus, and therefore eventually, you know, the load on the economy for providing antiviral treatment eventually we have to bear. Similarly, the NCD space is still in kind of an infancy stage. Of course, China and India I think are the largest owner of NCD, but around the world right now, I think, however, the bomb has not exploded as yet. So obviously it is the most important time when the government and all stakeholders must wake up to this call to allocate resources appropriately so that the current burden of existing, you know, non-communicable and reproductive health-related burdens, and special the LMICs are abated, but at the same time be prepared to combat NCDs in this entire spectrum from, you know, womb to tomb, because with increasing longevity, also as the countries are improving their economy, I think the burden on the countries for NCDs is increasing, not only because of the surge in lifestyle-related disorders but also because of increasing longevity, but at the same time we have to also realize that unless we treat pregnancy, unless we treat maternal anemia, unless we treat low birth weight, well, I think combatting NCDs in the long run is going to be a very, very huge expensive affair. Most LMICs will not be able to afford. Not only is it a question, but I think it is a warning. All public health conscious citizens must wake up to this call. Thanks.

>> Thank you, Dr. Chaudhury.

Based on the experience of the three of you supporting the HealthRise programs and the HeartRescue programs in your countries, and given the need for both political will and funding, and at times the lack of both of those, what advice do you have for funders, maybe private foundations or others in the NCD space?

>> I think that to be successful, it's very important for funders to align with the local government's strategic plan, because I think in some cases, people come with great ideas or crazy ideas, want to implement them in the field, but they did not work or they did not last because there is no local buy-in. So, definitely, I would encourage international funders to start conversation with government, and really cocreate programs and ensure that there is sustainability discussion, because these funders are not going to fund forever, so really starting to talk about the sustainability discussion at the beginning, but also making sure that, you know, they build local capacity when they are implementing those projects, so that, you know, when they leave, there is true local ownership. But again, I think for me, it's really making sure that the partners fold into the national plan, not coming with ideas for the plan but support the plans that is established.

>> Thank you, Ms. Ngongo.

A follow-up question, working with community and gaining the trust takes time. However, many programs work within a time frame, as outlined by funders, which is often inflexible. How do you suggest working within time restrictions, but at the same time working with the communities' rhythm?

>> I guess aimed at, you know, me, so let me take that first. So I think we realize that as well in HealthRise, because we have a time frame as well, and so our partners came to us and said can we experiment with a small site within the larger geography of HealthRise, where we want to really do deeper engagement with the community and see what difference it makes, because in the thick of things, you know, in a community, although we talk about community needs, it becomes community engagement, and eventually it becomes more of a cursory activity, because as the person who put this question very aptly stated, community ownership takes a very long time, so community engagement does not necessarily translate into community ownership within the project cycle, so therefore a very deep level of community engagement is necessary which the funders will probably have to trade with in terms of other deliverables. So that's where the partners came to us and requested us to allow them to experiment with a smaller site, and then convince us as funders that, you know, this is possible. And we actually saw visible change within the smaller geography, both in Shimla and the Udaipur sites, that was happening within the community. But, yes, funders need to also open their eyes towards such important and unique models of unit engagement and properly support for future experiment.

>> Thank you, Dr. Chaudhury.

You mentioned the engagement of community and that it takes sustained engagement to create local ownership. There's a question that has come in that asks what is the best incentive or structure or reward for community or patients to be engaged with this programming?

>> Our experience is that reward is the best, I think, motivator. So in terms of health outcomes, so when patients themselves saw that their results were really moving towards a positive, they were improving, they were feeling better. In fact, in some of the, you know, meetings, I personally saw a number of patients who participated in these groups came forward and told us how they did it. So I think seeing is believing. So demonstrating better health outcomes through sustained engagement is the most important, I think, reward for not only the patient but also the immediate caregiver, as well as the community, and also the second one that has worked in our experiment is the peer support of the patient support group. So we have over 200 patient support groups in each of the sites. They are

very small groups, but they are very active. So we organized these patient support groups not only across the CLCP site but the entire health care geography, and then also we saw a lot of cascade in ownership happening from one small group to a larger group.

>> Great, thank you. I think this question --

>> And also --

>> Oh, I'm sorry, go ahead. Go ahead, Mark, yes, please.

>> Thank you. So, from my experience, I would say that we want to encourage people to engage, is to listen to them. So value their ideas, and make sure that it is part of, you know, the plan. They have influence on the plan, and that their perspectives are taken into consideration. I think that's the best way to engage. It sounds simple. It sounds like, oh, that should be something else. That should be something, you know, to give them in order to encourage them to participate. But actually, they usually don't know that they can participate. They have the space. When they realize, when they gain this space from us, from whoever is developing the project, then they usually get engaged, and they bring brilliant ideas that are truly consistent with the reality where their live.

>> Very well said, Mark. Thanks.

>> Thank you both, obvious strong patient advocates.

>> I think the next question is directed to Belinda Ngongo, and the question is what type of self-care was taught to community health workers or providers, and including the participants who were given the intervention. So what type of self-care was taught in these programs?

>> Yeah. I think the idea, just to mention, I think what happens in South Africa is, you know, the government has put together protocols that partners have to follow. I think I mentioned, for example, the primary care 101, which really looks at symptom-based integrating clinical care management tools, you know, and it contains like a series of checklists to guide patients on the management of common symptoms and chronic conditions, and this particular one, for example, is an adult. So what happened, one of the gets that we have noticed in the programs in South Africa is despite all of these wonderful tools available from the government, a lot of the health care workers were not aware of it or were not following them. So as a result, for self-care, for example, would be the government has a dispensing mechanism for chronic disease medication, and the idea was really, for example, to train the community health care workers about that, so they would in turn inform the patient on how they could acquire their chronic medication, as well as make sure that they are following the right regimen to ensure adherence to medication. So these are a couple of examples, but I think one of the most prominent ones, definitely, the fact that they can access the medication from -- for example, from a pharmacy. And recently, in South Africa, they have actually launched like an ATM, like when you go in for money at the bank, but now some patients can actually withdraw their medication in the townships, so I think this will reduce the amount of time to travel to the clinics to get the medication. They can just go to an ATM at a supermarket and get the medication from there. So these are very innovative tools that have been implemented, and just to mention, there's a strong drive towards technology that is there, and a great learning from HIV programs. You know, in HIV, those who have worked in infectious disease before, you know, you have, for example, SMS technology that is being used to remind patients of taking medication. You know, also there are programs that are mushrooming very similarly for chronic diseases.

>> Thank you. There's another question specifically around working with the community. And I think any of the three of you could answer this. How did you deal with cultural stigma addressing these NCDs, diabetes, hypertension, mentioning in some places that there are deeply rooted cultural nuances that many communities have around these diseases?

>> Yeah, I think here that's the beauty about working with a community health care worker. I think we

have mentioned community health workers a couple of times, and, you know, community health care workers are members of the community. They are trusted by the community. They know the problem of the community, and they help us get closer to the community, and they can also help alleviate some of the stigmas when it comes to the diseases. But I think there's also other pitfalls, because, for example, if a patient happens to have HIV, they might be scared of telling the community health care worker that they know they have HIV. But I think in general the model that we have been using has been working very closely with community health care workers, and because they trust in the community, they are able to convey the message of why dealing with diabetes or hypertension is important and why it shouldn't be stigmatized.

>> This is Nayanjeet. I would like to add to what Belinda said. I think she has stated very, very appropriately about the ownership being given to the community itself to decide on its own social norms. So in our experiment in India, what we saw is that being nonjudgmental by actively listening and appreciating the community's, you know, feelings, perceptions, perspectives, and not as experts, helped us. I mean, of course, there are, you know, several ways of sort of dealing with stigma, but here it is the principles are very simple, because if you see in the CLCP cycle, the whole plan of action begins with a dream, so if the community owns its own dream of ridding itself of the debilitating diseases, whether it's a communicable or non-communicable, or even for that matter, you know, age old diseases like TB, they will do everything that they need to do, and that's what we saw, by only listening to them on how they would like to handle their own problems. That's why in one of my slides I did mention that we actually saw a community taking care of their TB patients, although we were there only to intervene on diabetes and hypertension. So we also saw chronically malnourished children being taken better care of after the intervention. So I think the crux of the answer that I'm trying to offer here is as an external stakeholder, it is important for the project team or the partners to remain totally nonjudgmental about what belief systems they have, what perceptions they have, and gradually asking them how they would like to handle certain health outcomes and identify barriers to those health outcomes. They would probably figure it out.

>> Thank you both. I wanted -- a few questions came in that are sort of going back to sort of more of a macro level, and one is whether environmental stewardship, social change, particularly sort of the green space management, and food sustainability and access, are these a part of the discussion in your countries and the programming that you have been doing in the HealthRise programming. How do these come into play in this NCD work?

>> Hi. I think a social determinant was a very important component in determining some of the work in our sites, and I think most importantly in the region that I presented today, in the Northern Cape, where it's one of the poorest areas in South Africa, there is no employment. There is high alcohol intake. The population is less than 25, the average population, and it's really in the arid region of South Africa, so it's dry. It's very difficult to grow food. I mean, you can grow food, but you need to partner with someone, and some of the examples in our programs that we did not really present today is that we also looked at supporting patients by providing them, for example, with tools to start gardening, and how this was done is there was a partnership between our partners that were working the province and the Department of Agricultural, who provided tools, soil, seed, for a patient to use to grow their vegetables, but also they also partnered with the -- what's it called -- like the Social Security in the US, the social department. So really having that multistakeholder partnership to drive social security. So I'm really proud to say that the patient started growing their own food. There was kind of this seed funding that was provided by the Department of Health, but at least some of them, the parents who were part of the program, have gained skill on how to produce their own vegetables.

>> Thank you so much. I'm going to move on, and thank you for that final answer, Belinda. We

wanted to go ahead and begin to close out this very lively discussion, I'll say I think three excellent examples of the HealthRise program being implemented with clinical mentorship, with community engagement, and with public-private partnerships. So we wanted to go ahead and thank Ms. Belinda Ngongo from South Africa, Dr. Nayanjeet Chaudhury from India, and Dr. Mark Barone from Brazil, and I'm going to turn it over to Laura to close us out.

>> Yes, thank you so much, Esther, Belinda, Mark, and Nayanjeet, for the really valuable information and experiences you shared with us today.

Many thanks also to Global Health Leaders and the Medtronic Foundation for sponsoring today's event. And thank you to you, our audience. Our recording of today's presentation, the slides, and a transcript will be available to you by next week at [Dialogue4Health.org](http://Dialogue4Health.org). You will also receive an email from us with a link to a brief survey that we hope you'll take. We'd really like to hear from you. The survey includes instructions for getting a certificate of completion for this event as well. Thanks so much for being with us, and that concludes today's web forum. Have a great day.