NON-COMMUNICABLE DISEASES

Vision and Framework 2030

Vision and Framework 2030: Non-Communicable Diseases: NCD prevention, control, management, care and access to services for everyone everywhere at all times in all contexts

March 2024

ifrc.org

ACKNOWLEDGEMENT

CONTENTS

ABBREVIATIONS AND ACRONYMS

CBHW	Community-based health worker
HBV	Hepatitis B virus
HIC	High income country
HIS	Health information system
HIV	Human immunodeficiency virus
HPV	Human Papillomavirus
IFRC	International Federation of Red Cross and Red Crescent Societies
LMIC	Low- and middle-income countries
M&E	Monitoring and evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCD	Noncommunicable disease
PFA	Psychological first aid
RCRC	Red Cross Red Crescent
SDG	Sustainable Development Goal
TB	Tuberculosis
UHC	Universal health coverage
WHO	World Health Organisation

FOREWORD

Non-communicable diseases (NCDs), notably cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, often combined with or exacerbating mental health conditions, are the leading causes of death and disability globally, affecting more people each year than all other causes combined. NCDs are responsible for over 74 per cent of all deaths, with nearly 77 per cent of these deaths occurring in low- and middle-income countries. With the population ageing, rise in multimorbidity, longer life expectancies and increasing survival rates, more people are expected to live with the health burden of NCDs.

The rise of NCDs has been driven primarily by four major risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets. This suggests that adopting healthy behaviours is the first and most critical preventive measure to saving millions of lives every year. The epidemic of NCDs poses devastating health consequences for individuals, families and communities, and threatens to overwhelm health systems.

The International Federation of Red Cross and Red Crescent Societies (IFRC) and its member National Red Cross and Red Crescent Societies have a long history of implementing health programmes on NCDs and delivering services at community level. By using simple tools adapted to the local context and different settings (development-related, emergencies and protracted crises/fragile settings), the IFRC network of volunteers at community level can be mobilized to address community needs. Their role complements that of the public authorities, and they are thus in a unique position to pioneer the implementation of NCD integrated prevention, control, management and care programmes.

Looking to the future, National Societies aim to scale up a range of NCD health services, comprising promotion of healthy lifestyles, prevention, screening and early detection, communitybased care and support, follow-ups, palliative care, and mental health and psychosocial support services for people living with NCDs.

The IFRC NCD *Vision and Framework 2030* is intended to provide guidance and direction for National Red Cross and Red Crescent Societies and their staff and volunteers in implementing or scaling up NCD programmes. It does this by amalgamating evidence-based NCD interventions into core programming modalities with supporting operational guidance.

To this end, I believe that through this new vision and framework, IFRC together with National Red Cross and Red Crescent Societies will be guided and committed to combating NCDs on all fronts and alleviating the burden they place on each nation's healthcare.

Petra Khoury

Director Health and Care Department
International Federation of Red Cross and Red Crescent Societies (IFRC)
Geneva, Switzerland

VISION 2030:

NCD PREVENTION, CONTROL, MANAGEMENT, CARE AND ACCESS TO SERVICES FOR EVERYONE EVERYWHERE AT ALL TIMES IN ALL CONTEXTS

INTRODUCTION

Non-communicable diseases (NCDs) impose immense burdens around the world that the International Federation of Red Cross and Red Crescent Societies (IFRC) is committed to addressing.

NCDs account for approximately 74 per cent of all deaths globally according to the World Health Organization (WHO)[1], disproportionately impacting low- and middle-income countries. They strain limited health resources, hampering development and productivity, and they often lead to impoverishment of those who suffer from the diseases.

The economic toll of NCDs is estimated to reach over USD 30 trillion by 2030. Particularly in vulnerable communities, the annual economic burden already exceeds USD 500 billion[2]. The link between poverty and NCDs increases healthcare costs for low-income households and leads to higher mortality among disadvantaged groups.

Despite these challenges, the IFRC's strategic investment in proven interventions can yield substantial returns. National Red Cross Red Crescent Societies have been playing a significant role in addressing the burden of NCDs in communities all over the world and across the humanitarian development nexus.

---

1. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases
2. https://cdn.who.int/media/docs/default-source/ncds/saving-lives-spending-less-faq-final.pdf

Through an extensive workforce, including both qualified staff and skilled community-based volunteers, National Societies are working to reduce people's exposure to the major risk factors for NCDs, as well as providing essential community-based care and support for people living with NCDs[3].

The IFRC guides this work through advocacy and a policy framework, training models and tools and quality assurance. With an eye on the horizon, National Societies are gearing up to expand a diverse array of the NCD health services. This comprehensive approach focuses on preventive measures, early detection, community-based care, ongoing follow-up, palliative care, and mental health support for people living with NCDs.

OUR VISION

All communities have access to health coverage for NCDs, so that everyone everywhere at all times and in all contexts has an opportunity to thrive and lead a safe, healthy, productive and dignified life, free from the preventable sickness, disability and premature death caused by NCDs[4].

OUR GOALS

The pathway to our vision is guided by four strategic short goals to be attained by 2030. These goals are firmly rooted in our Fundamental Principles and are aligned with the strategic goals and priority areas of the 2030 Sustainable Development Goals, IFRC Strategy 2030[2], the IFRC Health and Care Framework 2030[5], IFRC Care in Communities guidelines[6] and the IFRC Community Health Strategy 2030[7].

Strategic goals:

1 Ensure **no one is left behind** on the path to Universal Health Coverage and Sustainable Development Goals, by improving equitable access to community-based healthy lifestyle, behaviours promotion, NCD preventive and curative services (including mental health and psychosocial support) for all, with a special focus for those who are outside or at the fringes of the formal health and social welfare sectors, including but not limited to older persons, those across the gender spectrum, migrants and other vulnerable or marginalized groups.

3. IFRC (2020) *Community health strategy. Healthier and more resilient communities and individuals 2020–2030.* https://www.ifrc.org/sites/default/files/2021-07/IFRC%20CommunityHealthStrategy.pdf

4. IFRC (2021). *Strategy 2030. Platform for change: Global reach, local action..* https://www.ifrc.org/strategy-2030
5. IFRC Health and Care Framework 2030. https://www.ifrc.org/sites/default/files/IFRC_Brochure_HealthCareFramework_EN_Web.pdf
6. IFRC (2020) *Care in Communities Guidelines.* https://www.ifrc.org/sites/default/files/IFRC_CIC_Guidelines_EN_20200212_Web.pdf .
7. IFRC *Community Health Strategy.* https://www.ifrc.org/sites/default/files/2021-07/IFRC%20CommunityHealthStrategy.pdf

2 Ensure **communities and individuals affected by humanitarian crises**, including natural and man-made emergencies, protracted crises and fragile settings, have access both to quality health services and for the early screenings, early detection, treatment, care and prevention of NCDs, by delivering sustainable community-based programmes that target critical service gaps, as well as engaging in high-level humanitarian diplomacy for the purposes of increasing political focus, seamless funding and continued support for NCDs in humanitarian settings.

3 Ensure individuals and communities in all settings can live and work in health promoting environments, by advocating for increased multi-stakeholder and multisectoral action in order to successfully address the **social, environmental and economic determinants of NCDs**, and by delivering health promotion activities to reduce people's exposure to the most common risk factors for NCDs, namely, tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity[8].

4 To mitigate the detrimental impact of NCDs on the **long-term and sustainable development of communities, efforts are needed to mobilize resources** in support of NCDs as part of the wider development agenda and ensuring NCD-related interventions are well integrated into community-based health and social services, promoting research and innovation, advocating for NCD policies and regulations, and strengthening partnerships and collaboration among stakeholders.

OUR GUIDING PRINCIPLES

We are guided by the seven Fundamental Principles of the Red Cross and Red Crescent Movement: *humanity, impartiality, neutrality, independence, voluntary service, unity* and *universality*. Our work to address the preventable burden of NCDs in individuals and communities is people-centred and community-led as they are the experts in their own contexts. The IFRC approach to NCD prevention and care in communities is about supporting people to empower themselves through having sufficient information and appropriate resources to make lifestyle choices, and to increase their access to quality, equitable and sustainable health services. We are committed to evidenced-based programming and remain accountable to the people and communities we serve[6, 9].

8. IFRC, *Health and Care Framework 2030.* https://www.ifrc.org/sites/default/files/IFRC_Brochure_HealthCareFramework_EN_Web.pdf
9. IFRC, *Community health strategy 2020 – 2030. Healthier and more resilient communities and individuals 2020–2030.* https://www.ifrc.org/sites/default/files/2021-07/IFRC%20CommunityHealthStrategy.pdf

FRAMEWORK FOR THE PREVENTION AND CARE OF NON-COMMUNICABLE DISEASES

KEY CONCEPTS

Non-communicable diseases

Non-communicable diseases are chronic conditions that are not passed from one person to another (i.e. not communicable), have a prolonged course, do not spontaneously resolve and rarely have a complete cure. This framework refers to the main types of NCDs which are cardiovascular diseases (e.g. hypertension, coronary heart disease, cerebrovascular disease, peripheral vascular disease), diabetes, chronic respiratory diseases (i.e. asthma and chronic obstructive pulmonary disease [COPD]) and cancers.

Care in communities

In this document, "care in communities" refers to any "health-related actions carried out by community-based health workers (CBHWs) (including trained Red Cross Red Crescent volunteers) related to primary, secondary and tertiary prevention in varied settings"[10]. This definition is consistent with other key reference documents, including the IFRC's *Care in the Communities: Guidelines for National Red Cross Red Crescent Societies*.

---

10. IFRC (2020), *Care in Communities: Guidelines for National Red Cross and Red Crescent Societies* https://www.ifrc.org/sites/default/files/IFRC_CIC_Guidelines_EN_20200212_Web.pdf .

Community-based health workers

This framework adopts the WHO definition of community-based health workers (CBHWs), which is: "...health workers based in communities (i.e. conducting outreach beyond primary health care facilities or based in peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours"[11]. Although Red Cross Red Crescent volunteers work in a variety of roles (whenever there is a need and whenever there is a paucity of doctors, nurses, paramedics or other CBHWs in the available sectors), this framework is intended to be a guide for volunteers working at the community-level, undertaking tasks that are most applicable to a CBHW.

Humanitarian crises

In this framework, "humanitarian crises" is a collective term encompassing emergency situations, protracted crises, as well as fragile and complex settings. Such situations may result from conflict, war, natural disasters or a combination of factors[12].

PURPOSE AND AUDIENCE

The purpose of this IFRC *Vision and Framework 2030* for NCD prevention, control, management, care and access to services for everyone everywhere at all times in all contexts, hereafter "the IFRC NCDs Framework", is to outline the priorities and key operational components of NCD programming for the IFRC network. It is intended to be relevant for all settings in which National Red Cross and Red Crescent Societies operate, namely in high-income countries (HICs), in development contexts in low- and middle-income countries (LMICs), and in humanitarian crises (e.g. emergencies and protracted crises/fragile settings).

The IFRC NCDs Framework aims to align and support the operationalization of the Health and Care Framework 2030, Community Health Strategy, and Care in Community Guidelines. This alignment is an integral step in supporting and realizing the broader objectives of the IFRC's Strategy 2030.

The audience for this vision and framework is the IFRC, National Red Cross and Red Crescent Societies, their programme managers, as well as other staff involved in planning, designing and implementation of community health programmes and interventions for NCDs.

---

11. https://www.who.int/publications/i/item/what-do-we-know-about-community-health-workers-a-systematic-review-of-existing-reviews
https://www.hrhresourcecenter.org/node/1587.html
12. IFRC. *NCD care in humanitarian settings - a clarion call to civil society*. https://www.ifrc.org/media/13439

PART 1:
BACKGROUND AND RATIONALE

Non-communicable diseases (NCDs) are the leading cause of premature death and ill health globally. Each year, 41 million people die from cardiovascular diseases (such as heart attacks and strokes), cancer, chronic respiratory diseases, diabetes or a mental disorder, constituting 74 per cent of all deaths worldwide[13].

Over three-quarters of global deaths from NCDs occur in low- and middle-income countries (LMICs), and seven out of every ten deaths are caused by NCDs in LMICs[14]. Notably, in all continents except Africa, the number of deaths from NCDs now exceeds the total number of deaths from infectious diseases and maternal, perinatal and nutritional conditions. The worldwide burden and distribution of NCDs therefore constitutes one of the greatest inequalities in global health and presents the most important public health challenge of the modern world[12, 15].

In addition, there is an increasing burden of NCDs in humanitarian settings, a consequence of unprecedented numbers of displaced persons and refugees, increasing NCD prevalence in parts of the world that are prone to emergency situations, and protracted crises or fragile settings which are now impacting high-income countries (HICs). This has forced national governments and humanitarian organizations to adapt their health response, from a focus on treating acute problems, such as infections and injuries, to managing chronic illnesses like NCDs[16, 17, 18].

1.1 ACHIEVING UNIVERSAL HEALTH COVERAGE AND SDG 3

Addressing these challenges is essential for progress towards universal health coverage (UHC) and the Sustainable Development Goals (SDG), especially SDG 3 to "Ensure healthy lives and promote well‑being for all at all ages"13. Indeed, as recognized in the report of the Independent High-level Commission on NCDs in 2017, the world faces the very real possibility that SDG target 3.4 (reducing premature mortality from NCDs) will not be met[19].

Some of the key obstacles to progress in this area include significant inequalities in access to affordable and adequate healthcare across the globe, major health workforce shortages, inadequate skills mix, and uneven geographical distribution of healthcare resources and workers. To address this, WHO and other leading public health organizations have urged governments to reorient and restructure health systems to strengthen community and primary healthcare services to ensure equitable coverage and well-resourced multidisciplinary healthcare teams, including community health workers[20].

13. WHO (2020), *Noncommunicable diseases progress monitor 2020*. https://www.who.int/publications/i/item/9789240000490
14. Wang Y, Wang J. *Modelling and prediction of global non-communicable diseases.* BMC Public Health 20, 822 (2020). https://doi.org/10.1186/s12889-020-08890-4
15. Ezzati M et al. *NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4* Lancet 2020; 396: 918–34. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931761-X
16. Aebischer Perone et al. *Non-communicable diseases in humanitarian settings: ten essential questions.* Conflict and Health (2017) https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-017-0119-8
17. Bausch et al. *Operational considerations for the management of non-communicable diseases in humanitarian emergencies.* Conflict and Health (2021) 15:9 https://doi.org/10.1186/s13031-021-00345-w
18. ICRC, *Managing projects addressing non-communicable diseases: Operational guidelines for field staff.* https://shop.icrc.org/managing-projects-addressing-non-communicable-diseases-operational-guidelines-for-field-staff-pdf-en
19. *Time to deliver: report of the WHO Independent High-level Commission on Noncommunicable Diseases.* Geneva: World Health Organization; 2018. http://apps.who.int/iris/bitstream/handle/10665/272710/9789241514163-eng.pdf?ua=1
20. Ibid.

As community-based humanitarian organizations and auxiliaries to government health services, National Societies are well-positioned to support health systems in this way. The IFRC, along with its National Red Cross and Red Crescent Societies, has a long history of implementing health programmes on NCDs and delivering services at the community level. The Network's extensive volunteer workforce (16 million globally) has close and trusted relationships with communities and understands people's health risks, strengths and vulnerabilities. The Red Cross Red Crescent is therefore uniquely placed to complement health providers and pioneer innovative prevention and care NCD programmes, thereby supporting progress to UHC and achieving SDG target 3[21],[22].

1.2 IMPLEMENTATION ACROSS THE IFRC NETWORK

The IFRC has been supporting and promoting healthy lifestyles and preventing, controlling, managing and providing care and support for NCDs (NCD programming) for decades, working with its network of National Red Cross Red Crescent Societies and partners. The IFRC NCDs programming has evolved in response to the medium- and long-term needs of communities in different settings, with National Red Cross and Red Crescent Societies taking an active role in NCD care and support.

The proportion and scope of National Societies with comprehensive NCD programming varies from one country to other. For example, The Kenya Red Cross Society (KRCS) enabled community health workers to provide NCD drugs and services, and patients were encouraged to join support groups, each led by a community health worker, which provided health information, nutrition counselling and psychosocial support. In the Middle East and North Africa, National Societies have assisted their respective Ministries of Health (MoHs) in the implementation of integrated management of NCDs by distributing medications and educational material for NCD patients, as well as implementing and monitoring peer-support group approaches to generate evidence. The Armenian Red Cross has been supporting older people to prevent diabetes and provide diabetes care, with the aim of filling gaps in the healthcare system, promoting and building skills for self-care of type 2 diabetes at community and health-facility level, and reducing the negative physical and mental repercussions of diabetes through a network of skilled volunteers.

21. IFRC Health and Care Framework 2030. *The IFRC's contribution to healthier, more resilient communities and individuals 2020—2030. https://www.ifrc.org/sites/default/files/IFRC_Brochure_HealthCareFramework_EN_Web.pdf*
22. ICRC/IFRC. World Red Cross and Red Crescent Day 2021: together we are unstoppable. https://www.icrc.org/en/document/red-cross-red-crescent-day-2021#:~:text=Every%20year%2C%208%20May%20marks,founding%20father%20of%20the%20Movement

Through extensive consultation, The IFRC secretariat has worked with subject matter experts from National Societies and external stakeholders and has developed an NCD framework that amalgamates evidence-based NCD interventions into eight core programming modalities (see Figure 1) with supporting operational guidance. This vision and framework will provide uniform approach, guidance and direction for the National Societies' Network in implementing or scaling up community-based NCD programmes. It seeks to underscore the importance of delivering NCD programmes through communities, local volunteers and community health workers that complement and strengthen other parts of the health system and contribute to improved community resilience, health and well-being[23].

1.3 PREVENTION AND CARE IN COMMUNITIES

An individual's risk of NCDs is influenced by a range of complex and interrelated factors. For example, important social determinants of health, such as poverty and access to healthcare, affect one's exposure to the major risk factors for NCDs (i.e. harmful alcohol use, tobacco use, unhealthy diet and physical inactivity) and influence the illness trajectory in those who have an NCD. Additionally, gender influences the development and course of risk factors and conditions such as obesity, cardiovascular diseases and mental health conditions. Biological differences, gender roles and social marginalization in some countries expose women to different NCD risks, impact women's capacity to modify NCD risk behaviours (e.g. diet and physical activity), and determine the success of NCD interventions[24, 25].

This complexity means that effective NCD interventions need to be based on a thorough understanding of gender roles in communities, as well as people's needs and social circumstances and be able to adapt to these ever-changing elements. Red Cross Red Crescent volunteers and staff live and operate in both urban and rural communities and therefore have a unique perspective on the factors which affect people's health and well-being. This sustained presence in communities also means that National Red Cross and Red Crescent Societies have built trust and respect, enabling access to underserved and marginalized groups and supporting them to attain better physical and psychosocial health and well-being.

These are some of the reasons why National Societies have a unique advantage among humanitarian organizations in advocating for and implementing community-based interventions for preventing and controlling NCDs. These close linkages with communities mean that health promotion and NCD prevention activities, with a focus on strengthening the resilience of individuals and communities, are priority workstreams. Additionally, through cooperation with healthcare services, CBHWs including volunteers can be valuable members of multidisciplinary health teams delivering essential care and support services for those living with NCDs.

23. IFRC Community Health Strategy. *Healthier and more resilient communities and individuals 2020—2030*. https://www.ifrc.org/sites/default/files/IFRC_Brochure_HealthCareFramework_EN_Web.pdf
24. PAHO. Non-Communicable Diseases and Gender: Success in NCD prevention and control depends on attention to gender roles. https://www3.paho.org/hq/dmdocuments/2011/gdr-ncd-gender-factsheet-final.pdf
25. WHO European Region. Why using a gender approach can accelerate noncommunicable disease prevention and control in the WHO European Region (2019). https://www.who.int/europe/publications/i/item/WHO-EURO-2019-3645-43404-60944

PART 2:
KEY COMPONENTS OF THE IFRC NCDs FRAMEWORK

© Corrie Butler/IFRC

Figure 1: The IFRC NCDs Framework

2.1 CONTINUUM OF CARE

Core to the work of the IFRC and National Red Cross Red Crescent Societies is facilitating a continuum of healthcare for communities[26], including the provision of timely access to the appropriate level of care and support, regardless of where the communities are on the healthcare spectrum. In addition to the important work currently under way in NCD-related health promotion and prevention, National Societies can also consider delivering or facilitating access to the full continuum of care for NCDs, namely (see Annex 1):

- Healthy lifestyle and behaviour promotion and NCD prevention

- Screening and early detection of NCDs

- Treatment and self-care education for people with NCDs

- Follow-up care and support

- Palliative care

Given the complexity of providing holistic and person-centred care for NCDs, National Societies form a critical link between homes and healthcare facilities via their sustained presence in communities[27]. Bridging this gap is an important enabler of the continuum of care approach, which aims to provide uninterrupted and seamless NCD care across different settings to ensure that people receive the right NCD care at the right time and in the right place.

2.2 PREVENTION

A large proportion of the deaths and disabilities caused by NCDs are avoidable via population-wide prevention strategies that target the major risk factors for NCDs as well as the social, economic and environmental conditions in which people live[28]. This preventive strategy is considered essential in the global effort to achieve SDG target 3.4[29].

Non-communicable disease prevention programmes are therefore recommended as a priority area of focus for National Red Cross Red Crescent Societies engaged in NCD programmes, for all settings. This prioritization is consistent with the IFRC Health and Care Framework 2030, in which disease prevention and health promotion are key areas of focus[30].

A comprehensive approach to NCD prevention is recommended, targeting the primordial, primary, secondary and tertiary levels. Additionally, because National Societies are often best placed to reach geographically and socially isolated communities, these groups can be a focus of NCD prevention programmes[25].

26. IFRC, *Care in Communities.* https://www.ifrc.org/sites/default/files/IFRC_CIC_Guidelines_EN_20200212_Web.pdf
27. IFRC, Community health strategy. https://www.ifrc.org/sites/default/files/2021-07/IFRC%20 CommunityHealthStrategy.pdf
28. WHO, *Global action plan for the prevention and control of noncommunicable diseases* 2013—2020 (Geneva: WHO, 2013), https://apps.who.int/iris/bitstream/handle/10665/94384/9789241506236_eng.pdf?sequence=1
29. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. ttps://www.thelancet.com/ journals/lancet/article/PIIS0140-6736(20)31761-X/fulltext
30. IFRC Health and Care Framework 2030. *The IFRC's contribution to healthier, more resilient communities and individuals.* https://www.ifrc.org/sites/default/files/IFRC_Brochure_HealthCareFramework_EN_Web.pdf

2.3 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) INTEGRATION

Person-centred, sustainable and effective community-based NCD programmes require collaborative care models, where MHPSS is integrated into NCD care[31, 32]. The rationale for this stems from a large body of evidence demonstrating a bidirectional relationship between mental health problems and physical NCDs, i.e. having a mental health condition is a risk factor for developing a physical NCD, and people with a NCD have a much higher risk of having comorbid mental health conditions[33, 34].

Given the higher burden of poor mental health and NCDs in underserved and marginalized populations, addressing people's mental health and psychosocial needs in conjunction with NCD care is a key step in fulfilling the IFRC Network's commitment to reaching the "last mile"[35]. Additionally, it may also address the major shortfall in access to mental health treatment, in which an estimated 75 per cent of people with mental, neurological or substance use disorders do not have access to treatment[33].

2.4 NCD PREVENTION AND CARE IN HUMANITARIAN CRISES

With the change in worldwide demographics and the subsequent shift in NCD epidemiology, humanitarian crises are increasingly occurring in places with a high prevalence of people who are either at-risk of or already have diagnosed NCDs. The risk of acute exacerbations and clinical deterioration substantially increases for people living with NCDs in these contexts. Poor diets and living conditions, inadequate supplies of essential medications, and major disruptions to people's usual chronic care needs all contribute to this[36, 37, 38].

Despite these risks, comprehensive healthcare for people with NCDs in these settings has been neglected. To date, the focus of humanitarian health responses has been managing acute conditions such as those resulting from trauma, injuries and infectious diseases. This care model is short term, reactive and therefore inadequate for proper management of chronic conditions[34].

31. United Nations, 2018. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases. https://digitallibrary.un.org/record/710899?ln=en
32. WHO (2019). *Integrating the prevention, treatment and care of mental health conditions and other noncommunicable diseases within health systems.* WHO European high-level conference on noncommunicable diseases. https://apps.who.int/gb/MSPI/pdf_files/2023/04/Item3_28-04.pdf
33. Stein D J, Benjet C, Gureje O, Lund C, Scott K M, Poznyak V et al. *Integrating mental health with other non-communicable diseases.* https://www.bmj.com/content/364/bmj.l295
34. Ngo VK, Rubinstein A, Ganju V, Kanellis P, Loza N, et al. (2013) *Grand Challenges: Integrating Mental Health Care into the Non-Communicable Disease Agenda.* PLOS Medicine 10(5): e1001443. https://doi.org/10.1371/journal.pmed.1001443
35. IFRC (2020). *Care in Communities: Guidelines for National Red Cross and Red Crescent Societies.* https://www.ifrc.org/sites/default/files/IFRC_CIC_Guidelines_EN_20200212_Web.pdf
36. *NCDs in Emergencies. A clarion call to civil society.* https://www.ifrc.org/media/13439
37. Aebischer Perone et al. 2017. *Non-communicable diseases in humanitarian settings: ten essential questions.* Conflict and Health (2017) https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-017-0119-8
38. Bausch et al. 2021.

Addressing this unmet need presents a unique opportunity for the IFRC Network. There is an urgent need for community-based longer-term programmes that focus on maintaining continuity of care for people with chronic and palliative care needs, mobilizing community resources to strengthen resilience, and reinstating health promotion and NCD prevention activities in the latter stages of crises or in protracted fragile settings[39, 40, 41]. For more resources, National Societies may refer to Package of Essential Non-Communicable Diseases Prevention for Humanitarian Settings (PEN-H)[42], the ICRC operational guidelines[43], and the UN Interagency Task Force on NCDs[44].

2.5 MONITORING AND EVALUATION

Systematic data collection, operational research and regular programme monitoring and evaluation are essential for delivering evidence-based interventions and upholding the principles of "do no harm" and accountability[45]. Further, in contexts with scarce resources (e.g. protracted crises or fragile settings), the government's capacity to undertake systematic population-wide surveys may be limited. In these settings, NCD programmes delivered by National Societies become critical sources of data related to NCD mortality and morbidity.

These interventions require dedicated human resources and investment in technical expertise and tools for data collection, analysis and dissemination. Technical guidance on community-based programme monitoring, evaluation and reporting can be found on the IFRC Monitoring and Evaluation webpage[46].

2.6 PARTNERSHIPS

A multisectoral approach, encompassing partnerships and coordination among multiple stakeholders, is paramount to controlling NCDs worldwide. Such an approach is required to address the complex and multifaceted determinants of NCDs, to avoid duplication of initiatives, and to optimize resource availability[47, 48, 49]. It is therefore critical that National Red Cross Red Crescent Societies continue to forge partnerships with multiple stakeholders including MoH, the WHO, academic institutions, the private sector and other civil society organizations.

39. N*CDs in Emergencies. A clarion call to civil society.*
40. ICRC, *Managing projects addressing non-communicable diseases.* https://shop.icrc.org/managing-projects-addressing-non-communicable-diseases-operational-guidelines-for-field-staff-pdf-en.html
41. Bausch et al. 2021.
42. https://www.rescue.org/report/package-essential-non-communicable-diseases-interventions-humanitarian-settings-pen-h
43. https://shop.icrc.org/managing-projects-addressing-non-communicable-diseases-operational-guidelines-for-field-staff-pdf-en.html
44. https://uniatf.who.int/
45. IFRC, *Health and Care Framework 2030.*
46. IFRC, Monitoring and Evaluation webpage. https://www.ifrc.org/sites/default/files/2021-09/IFRC-ME-Guide-8-2011.pdf
47. Collins T et al. *Interact, engage or partner? Working with the private sector for the prevention and control of noncommunicable diseases.* https://cdt.amegroups.com/article/view/20806/23570
48. WHO, *Global action plan for the prevention and control of noncommunicable diseases 2013—2020.*
49. *Political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs.*

2.7 INNOVATION AND RESEARCH

It has been recognized at the highest political level that innovative strategies are needed to overcome the major challenges that NCDs present[44]. This is crucial for all countries, but even more so for LMICs where the burden of NCDs continues to rise disproportionately. Furthermore, given the fact that many humanitarian crises occur in countries where NCDs are now the leading causes of disability and premature death, national governments, humanitarian organizations, and other actors have needed to adjust their health response and re-examine the types of interventions employed in these settings[50, 51].

Technological advances, including the digitalization of many areas of healthcare, present unique opportunities for National Societies to trial and employ novel methods of delivering NCD prevention and care. Such methods, from robust and user-friendly health information systems to safer and more accessible medications, will likely be critical for overcoming the significant challenges facing healthcare systems in LMICs[52].

2.8 ADVOCACY

Advocacy is a key programming modality in the IFRC Health and Care Framework 2030. As community-based humanitarian organizations which are auxiliaries to the public authorities, National Societies are well positioned to understand and advocate for the needs of communities. Advocacy at global, regional, national and local levels is paramount for ensuring effective community-based NCD programmes, creating health-promoting environments, and ensuring access to healthcare for vulnerable communities.

50. Aebischer Perone et al. 2017.
51. Bausch et al. 2021.
52. Mishra S et al. 'Combating non-communicable diseases: potentials and challenges for community health workers in a digital age, a narrative review of the literature'. Health Policy and Planning, 34, 2019, 55–66. https://publichealth.ku.dk/staff/?pure=en%2Fpublications%2Fcombating-noncommunicable-diseases(d305ce1b-60a5-44e5-a780-7b411a1819d1).html

PART 3:
GUIDE TO OPERATIONALIZING THE IFRC NCDs FRAMEWORK

3.1 INTERVENTION PRIORITIES

For efficient and sustainable use of resources, National Red Cross Red Crescent Societies should initially identify and scale up selected priorities from evidence-based interventions for NCD prevention and care in communities. These interventions may be selected from the Community Health Services Delivery Package for NCDs and then adapted to the local context. Identifying priority interventions is preferred to trying to implement all recommended strategies at once.

Selected intervention priorities should stem from a systematic community engagement process, in which the community's needs, strengths and challenges are identified (see IFRC CEA[53]). In addition, these priorities should be based upon robust NCD-related morbidity and mortality data for the geographical area of interest. Coordination with government and MoH officials should also be undertaken to analyse service gaps, identify underserved communities, and to formulate an agreed work plan to address these shortfalls[54].

In humanitarian crises, the above considerations also apply. Owing, however, to the challenges of securing adequate supplies and the limited availability of health services in these settings, some NCD interventions need to be deprioritized during the initial phases and then integrated later. A framework describing this process is described in Annex 2.

3.2 VOLUNTEER MANAGEMENT

Effective community-based programmes for the prevention and care of NCDs will largely depend on the quality of services delivered by Red Cross Red Crescent volunteers. National Societies can ensure high standards of health services by developing robust processes for managing and supporting their volunteer workforce.

For general guidance on selection, recruitment, retention, training and supervision of volunteers working as CBHWs, National Societies should use the IFRC Care in Communities guidelines[48]. In addition, National Societies should align these processes with national policies on volunteering. This section provides additional guidance, specific for the management of volunteers working in community-based NCD programmes.

CBHWS Roles

To aid recruitment, retention, and training of CBHWs including volunteers, clearly defined roles, expectations and scope of practice should be developed. This should include specific indicators to monitor and evaluate volunteer performance in NCD programmes. Guidance for developing roles specific for community-based care of NCDs can be found in the IFRC Care in Communities guidelines and the Community Health Services Delivery Package for NCDs. Importantly, such roles should be aligned with the mandate of the National Society and be approved by the MoH.

---

53. https://www.ifrc.org/our-work/inclusion-protection-and-engagement/community-engagement-and-accountability
54. IFRC, *Care in Communities.*

CBHW Skills, Training and Supervision

It is critical that National Societies invest in training and skills development of volunteers and ensure regular supporting supervision. Recommendations for training and skill development of CBHWs including volunteers are:

Where feasible, utilize a mixed-team approach where Red Cross Red Crescent volunteers that work as CBHWs collaborate closely with medical practitioners, nurses and allied healthcare professionals. This approach facilitates task-sharing and task-shifting, enables on-the-job supervision, and promotes professional development of CBHWs due to the presence of more experienced practitioners.

- Include nurses from the formal sector in CBHW training and supervision programmes. This process may facilitate improved coordination with local healthcare providers, develop collegiality between nurses and CBHWs, allow participants to understand each other's roles and responsibilities, facilitate more efficient referral processes between nurses and CBHWs, and help to legitimize the roles of CBHWs.

- Where possible, develop and promote the use of standardized care guidelines and algorithms. Such guidelines should cover the continuum of care for NCDs and be specific for CBHW skill levels.

- Non-communicable diseases training curricula should include mental health and psychosocial support, and CBHWs should be able to understand different expressions of psychosocial needs, psychological distress and mental health disorders, provide basic psychosocial support, and be sensitized to establish networks for referrals, or otherwise advocate for services where these are non-existent.

- Incorporate scenario-based training and role-play activities.

- Supportive supervision should involve monthly meetings in which the CBHWs can raise concerns and ask questions. Important sources of feedback for CBHWs are updates on the progress of specific clients/patients they have supported, as well as feedback from community leaders.

3.3 FACILITATING CONTINUUM OF CARE

As mentioned, with support from the formal health system, National Societies can implement community-based interventions that aim to address all dimensions of the care continuum. In addition, National Societies may support people to maintain continuity in the delivery of healthcare across different practitioners (e.g. specialist doctors, nurses, physiotherapists) and facilities. People who are more likely to experience poor continuity of care include those with multiple comorbidities e.g. older persons, displaced persons and other people on the move, and socially and geographically isolated communities[55].

Strategies for Promoting Continuum of Care:

- Mapping and assessing the capacity of available healthcare services and key stakeholders in the area to identify gaps and unmet needs in the community, and to find sustainable solutions.

- Strengthening referral pathways between healthcare services, including feedback processes that inform the referring practitioner of the outcome (i.e. whether the patient was assessed and treated).

- Utilizing health information systems (e.g. mHealth) for appointment reminders, tracking and follow-up of patients.

- Scaling up healthcare services delivered by volunteers working as CBHWs to include roles such as screening and early detection of NCDs, providing information on healthy behaviours, medication management, home-based follow-up, monitoring and care.

- Identifying synergies in existing chronic care platforms, such as TB and HIV programmes, and integrating NCD interventions accordingly.

- Developing and promoting the use of *personal health records* (PHR) which patients may keep and use at subsequent healthcare appointments.

- Advocating for the strengthening of primary healthcare in communities so that patients have a single point of care (managed by a primary healthcare doctor or nurse) whereby healthcare services can be efficiently coordinated.

55. Thapa R, Zengin A, Thrift AG. Continuum of care approach for managing non-communicable diseases in low- and middle-income countries. J Glob Health. 2020 Jun;10(1):010337. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211412/

Continuum of Care in Humanitarian Crises

Maintaining a continuum of care for people living with NCDs in humanitarian crises is challenging. Communities in these settings typically face major challenges accessing timely, quality, and people-centred healthcare and essential medications. National Societies could prioritize care and support for displaced persons and other people on the move, as these groups have a high risk of experiencing disrupted care. Strategies to maintain continuum of care in humanitarian crises include:

- Developing patient registries during preparedness phases for identifying and providing care to high-risk people with NCDs (e.g. people with type-1 diabetes).

- Mapping and informing on the available health services for people with NCDs.

- Integrating NCDs into emergency response plans and adapting protocols for screening and managing NCDs in emergency settings.

- Ensuring emergency response kits have the essential NCD supplies/medications and equipment to last long periods (e.g. three months).

- Where feasible, adopting new methods of improving access to medicines, via the implementation of cash transfer cards for medicine.

- Developing and promoting the use of PHRs for displaced persons and other people on the move[56, 57, 58, 59].

3.4 LIFE COURSE APPROACH

The life course approach states that each stage of an individual's life – from infancy to old age – influences the next stage. Prevention and care of NCDs in communities requires the implementation of holistic and comprehensive interventions through a life course approach. This approach is central to the IFRC Health and Care Framework 2030[60] and is endorsed by the World Health Organization as the primary method of controlling NCDs. A life course approach is inclusive, considering the health and social needs of people of all ages, and targets NCD prevention and care in its earliest stages. The following points aim to help National Societies with adopting a life course approach in community-based NCD programmes[61, 62].

56. Aebischer Perone et al. 2017.
57. ICRC, *Managing projects addressing non-communicable diseases.*
58. Bausch et al. 2021.
59. UNHCR, *Integrating Non-Communicable Disease Care in Humanitarian Settings. An operational guide*. UNHCR, IRC and the Informal Inter-Agency Group on NCDs in Humanitarian Settings. 2020. https://www.unhcr.org/uk/media/integrating-non-communicable-disease-care-humanitarian-settings-2020-pdf
60. IFRC *Health and Care Framework 2030. The IFRC's contribution to healthier, more resilient communities and individuals.*
61. Mikklesen B. *Life course approach to prevention and control of non-communicable diseases. BMJ* 2019; 364 doi: https://doi.org/10.1136/bmj.l257
62. WHO, *Global action plan for the prevention and control of noncommunicable diseases* 2013—2020 https://apps.who.int/iris/bitstream/handle/10665/94384/9789241506236_eng.pdf?sequence=1

Focus on Early Life Interventions:

- Early life includes the preconception and prenatal stage, infancy, childhood and adolescence. An estimated 70 per cent of NCDs and mental illnesses in later life are associated with exposures to risk factors in these earlier years.

- Engaging parents in health education programmes is critical to creating healthy environments in which children can thrive.

- Interventions for pregnant mothers (and their spouses) could target known risk factors for the development of NCDs in the unborn child (e.g. alcohol, tobacco and illicit drug use, exposure to air pollution).

- During infancy, interventions could address enablers of exclusive breastfeeding and immunization (e.g. HBV vaccine to protect against liver cancer).

- During childhood and adolescence, the focus of NCD prevention could be enabling healthy environments (e.g. healthy eating choices in schools, engaging parents in health education), developing health literacy, promoting the importance of making healthy choices and avoiding risky behaviours.

- Early life interventions will be greatly enhanced by the participation and leadership of youth in planning and implementation[55, 63, 64].

Integrate HealthY Ageing and NCD Interventions:

- The WHO defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age".

- Rapidly ageing populations are a major driver of the increasing burden of NCDs in low- and middle-income countries.

- Programmes addressing NCDs in older persons should be holistic and integrated, with a focus on facilitating access to care and support services, advocating for accessible places of leisure and physical activity, combating ageism in societies, and addressing psychosocial challenges such as bereavement, social isolation and financial stress.

- A healthy ageing model recognizes and utilizes the knowledge, resources and leadership of older persons in planning community-based health programmes[65, 66].

Note: More information is available on *Healthy Ageing* in IFRC Fednet.

---

63. The NCD Alliance. *The Early Life-Course Approach to Non-Communicable Diseases in the Post-2015 Sustainable Development Goal Context.* https://ncdalliance.org/sites/default/files/resource_files/Early%20Lifecourse%20Approach%20to%20NCDs%20in%20Post-2015.pdf
64. IFRC, *Care in Communities.*
65. Kämpfen, F., Wijemunige, N. and Evangelista, B. Aging, non-communicable diseases, and old-age disability in low- and middle-income countries: a challenge for global health. Int J Public Health 63, 1011–1012 (2018). https://doi.org/10.1007/s00038-018-1137-z
66. WHO, Ageing and Health. Key Facts. 2018. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

3.5 PREVENTION OF NCDs

Effective control of NCDs in communities requires strategies that address the four main disease prevention levels, *primordial, primary, secondary* and *tertiary* (see Annex 3). Such an approach enables consideration of the multiple and interrelated factors that influence people's exposure to the major risk factors for NCDs and the wellness trajectory for people living with NCDs.

It is acknowledged that National Societies may not have the capacity to target all prevention levels. A realistic scope of work that addresses priority service gaps and perceived needs can be developed from community engagement and coordination with stakeholders in the formal health sector and non-government health organizations.

In conjunction with the NCD prevention module available via the IFRC eCBHFA portal, National Societies could also utilize the WHO's "best buys"[67] interventions as a framework to select evidence-based NCD prevention activities. These interventions are recommended by the WHO to address the four key risk factors for NCDs (tobacco, harmful use of alcohol, unhealthy diet and physical inactivity) based on their cost-effectiveness, implementation feasibility, and evidence for effectiveness[68].

Integrating prevention programmes

As recommended in the IFRC Health and Care Framework 2030, community-based health programmes are most effective when they are integrated into other healthcare initiatives. In practice, this means that NCD prevention programmes should not be instituted as stand-alone interventions but rather as a component of larger cross-cutting initiatives which address risk- and enabling factors across a range of health areas[69]. For example, health literacy interventions aiming to improve knowledge on the main risk factors for NCDs could be integrated into women's health programmes.

Prevention in Humanitarian Crises

Programmes targeting the prevention of NCDs are challenging in humanitarian crises, and they are often deprioritized as resources are initially directed to providing treatment for people with more immediate and life-threatening conditions. However, prevention activities are possible during the following situations:

- Programmes aiming to improve self-care of NCDs (e.g. COPD action plans, medication adherence, diabetic foot care) are important interventions during the preparedness phase.

- Support with healthcare navigation[70] for those with established NCDs is important at all phases of a crisis.

---

67. World Health Organization (2017). Tackling NCDs: "best buys" and other recommended interventions for the prevention and control of noncommunicable diseases. https://iris.who.int/handle/10665/259232
68. Ibid.
69. IFRC, Health and Care Framework 2030.
70. Healthcare navigation refers to measures that aim to support a patient's journey through the healthcare system.

- Interventions which aim to prevent disease progression and severe complications in people with established NCDs (e.g. treating diabetic foot ulcers) are important at all phases.

- During the initial phases of an emergency, the provision of adequate food supplies catering to the unique needs of those with diabetes, hypertension or cardiovascular disease is critical.

- Primary prevention strategies such as community education on NCD risk-factors and immunization programmes (e.g. HPV and HBV vaccine) may be implemented in the post-crisis phases or once the situation has stabilized, as well as in protracted crises.

- Screening for NCDs in asymptomatic persons is generally not recommended in emergency contexts; rather, case-finding for NCDs in people who have presented to a healthcare clinic is preferred[71, 72].

3.6 PROGRAMMING CONSIDERATIONS FOR MHPSS SERVICE INTEGRATION

To support National Societies in integrating MHPSS services into NCD programmes, the following key considerations are recommended:

- Integration of MHPSS into other NCD programmes is not an event, rather it is a long-term and step-wise process which will vary across settings[73].

- Community-based integrative care models can include psychosocial support initiatives such as peer-support, social activities, livelihood and life-skills programmes with the goal of reducing stigma surrounding mental illness and strengthening individual, family and community resilience[74].

- Integrative care considers the psychosocial well-being and needs of families and caregivers as well as the person living with NCDs.

- Programmers can adopt a life-course approach, recognizing the increasing burden of mental health problems in childhood and adolescence, as well as the impact of early onset mental health conditions and early childhood abuse and adversity on the development of physical NCDs in later life[75].

71. ICRC, Managing projects addressing non-communicable diseases: Operational guidelines for field staff. https://shop.icrc.org/managing-projects-addressing-non-communicable-diseases-operational-guidelines-for-field-staff-pdf-en
72. Aebischer Perone et al.
73. IMC Mental Health Toolkit. https://www.mhinnovation.net/collaborations/toolkit-integration-mental-health-general-healthcare-humanitarian-settings
74. IFRC (2014), Strengthening Resilience: A global selection of psychosocial interventions. International Federation Reference Centre for Psychosocial Support. https://pscentre.org/?resource=strengthening-resilience-a-global-selection-of-psychosocial-interventions-english
75. WHO, *Integrating the prevention, treatment and care of mental health conditions and other noncommunicable diseases within health systems.*

- Ensuring all volunteers and staff are trained in psychological first aid, self-care and lay counselling (provided that supervision is available) can ensure people living in resource-limited settings have access to some level of mental health care[76].

- As with other NCDs, referral systems and closely working with other service providers is key for ensuring that the continuum of care for mental health and psychosocial needs is covered.

- Community-based primary prevention strategies for reducing NCDs can be expanded to include mental health promotion, as many of the risk factors for physical NCDs are also risk factors for poor mental health (e.g. substance abuse, physical inactivity and unhealthy diets)[77].

- Generating evidence from MHPSS services for people living with NCDs is important for maintaining accountability to communities, donors and national governments.

Integration of MHPSS in Humanitarian Crises

The prevalence of mental health conditions and psychosocial challenges rises significantly humanitarian crises. Further, poor mental health and psychosocial well-being has a negative impact on peoples' self-management of NCDs, increasing the risk of worsening disease progression. In addition, common mental health problems that might have arisen secondary to the crisis increase the risk of NCDs later in life[78, 79].

It is therefore important that MHPSS services are also integrated into NCD programmes when operating in humanitarian crises. National Societies can consider the following key principles when planning MHPSS in humanitarian crises:

- Mental health and psychosocial conditions in crisis settings encompass more than depression and post-traumatic stress disorder: they typically involve a range of social and psychological challenges.

- While it is known that prevalence of mild, moderate and severe mental health disorders will increase in such circumstances, it is also clear that early interventions help to address and reduce the likelihood of negative clinical outcomes of psychological distress.

- Many of the sources of distress and suffering are linked to problems which need to be addressed by other sectors (accommodation, livelihoods, family reunification, etc.). Therefore, the services need to be delivered in close collaboration with other sector providers, within or outside the National Society.

76. IFRC, *Care in Communities.*
77. Stein D J et al. 2019.
78. Bausch et al. 2021.
79. IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010.
    Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?
    https://interagencystandingcommittee.org/sites/default/files/migrated/2018-10/IASC%20RG%20doc%20health%20audience.pdf

- Community-based MHPSS options for people with NCDs should focus on building local capacities, supporting self-help, and strengthening resources already present.

- Care for caregivers interventions should be a priority area for volunteers and staff.

- Training local staff and volunteers in psychological first aid (PFA) can be an effective strategy for providing vital psychosocial support in resource-limited and challenging environments70,71.

Resources: The IFRC Psychosocial Centre's remote PM+ Training of Helpers manual and related resources[80].

3.7 PRIORITIZED ADVOCACY FOR NCDs

This section provides National Societies with options for targeted advocacy, based on WHO recommendations and the strategic focuses of the IFRC Network.

Creating Health-Promoting Environments

The IFRC Network has a central role in advocating for the creation of health-promoting environments. This requires government action to address the modifiable risk factors for NCDs, as well as the social determinants of NCDs. This is highlighted in the WHO Global Action Plan for NCDs[81] and the Political Declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs[82].

Advocacy for government action in this area could be based on the WHO "best buys" framework, which recommends:

- Enacting legislation to reduce tobacco and harmful use of alcohol.

- Implementing the global strategy on diet, physical activity and health.

- Implementing WHO recommendations on the marketing of foods and non-alcoholic beverages to children.

- Strengthening and orientating health systems to address the prevention and control of non-communicable diseases and the underlying social determinants through people-centred primary healthcare and universal health coverage[83].

80. https://pscentre.org/?resource=10695
81. WHO, Global action plan for the prevention and control of noncommunicable diseases 2013—2020.
82. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs.
83. World Health Organization. Tackling NCDs: "best buys" and other recommended interventions for the prevention and control of noncommunicable diseases.

Promoting and Enabling Community-based Interventions

Health workforce shortages and disparities in access to healthcare providers between urban and rural areas are major barriers to effectively controlling NCDs, particularly for low- and middle-income countries. Community-based prevention and care is recommended as a strategy to overcome these issues, but such a model requires supportive legislation and mobilization of health resources. Suggested advocacy to support community-based care models, include:

- Promoting the unique strengths of National Red Cross Red Crescent Societies and other civil society organizations, including providing essential health and social services to hard-to-reach and marginalized communities.

- Promoting the evidence base which supports the effectiveness of community-based interventions for prevention and care of NCDs and the importance of CBHWs including volunteers in such activities (see Annex 4).

- Renewing agreements/MoUs with national governments to enable expanded NCD programmes with increased scope of practice and engagement for Red Cross Red Crescent volunteers.

- Implementing national policies which permit an increased scope of practice for volunteers working as CBHWs, including roles in screening, early detection and treatment of NCDs.

- Ensuring adequate supply of medications for NCDs, especially for hard-to-reach populations.

- Providing equipment and technology to enable increased scope of practice for volunteers working as CBHWs, including automated blood pressure machines, mHealth for clinical decision support tools, and user-friendly health information systems to allow efficient reporting of health data to the formal health system[84, 85, 86, 87].

Commercial determinants of health

The IFRC Network plays an important role in advocating for increased awareness of the *commercial determinants of health,* defined as the "strategies and approaches used by the private sector to promote products and choices that are detrimental to health"[88]. Substantial research has demonstrated that key risk factors for NCDs are strongly associated with patterns of consumption and unhealthy choices, both of which are often influenced by the corporate sector. With increased awareness, constructive engagement and partnerships may be facilitated with the private sector to ensure coordinated and multisectoral action on NCDs[89]. Such activities should closely follow the Red Cross Red Crescent principles and values.

84. WHO, *Global action plan for the prevention and control of noncommunicable diseases 2013—2020.*
85. Joshi R, Alim M, Kengne AP, Jan S, Maulik PK, et al. (2014) *Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries – A Systematic Review.* PLoS ONE 9(8): e103754. doi:10.1371/journal.pone.0103754.
86. Joshi R, Thrift AG, Smith C, et al. *Task-shifting for cardiovascular risk factor management: lessons from the Global Alliance for Chronic Diseases. BMJ Glob Health* 2018;3:e001092. doi:10.1136/bmjgh-2018-001092
87. IFRC, *Care in Communities.*
88. Kickbusch I, Allen L, Franz C. *The commercial determinants of health.* Lancet Glob Health 2016;4:e895-6. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(16)30217-0/fulltext
89. Collins T et al. Interact, engage or partner? *Working with the private sector for the prevention and control of noncommunicable diseases.* https://cdt.amegroups.com/article/view/20806/23570

3.8 ENABLING PARTNERSHIPS

To facilitate partnership building within the IFRC Network and with external stakeholders, this section provides guidance on the following key areas:

- Key stakeholders and potential areas of collaboration in NCD programming.

- Considerations for partnering with the private sector, including types of engagement.

- Resources to support multistakeholder partnerships.

Table 1: Key stakeholders in addressing NCDs and potential areas of collaboration.

Stakeholder	Area of collaboration
National MoH	• Defining scope/terms of work and coordination. • Identifying respective roles and responsibilities in NCD prevention and care. • Identifying shared commitments and goals and establishing a roadmap for realizing these. • Establishing supply chain and logistics for provision of medications and equipment. • Defining unmet needs and service gaps as well as how the IFRC Network could address these areas.
Private sector[90]	• Funding/sponsoring of events, activities or long-term projects. • Collaborating to create new and innovative technologies e.g. mHealth and telemedicine. • Supplying medications and equipment, including diagnostics. • Delivering health workforce training. • Promoting quality assurance.
Academic institutions	• Providing technical support for supportive supervision, monitoring and evaluation, community engagement, NCDs prevalence surveys. • Conducting systematic reviews of evidence pertaining to NCD interventions and innovative solutions. • Identifying and testing evidence-based strategies and tools for preventing and treating NCDs in communities.
WHO and other UN agencies	• Supporting NCDs assessments, e.g. WHO STEPwise. • Supporting national and global NCDs advocacy campaigns. • Provision of technical guidance and standardized guidelines. • Provision of essential NCD kits for humanitarian crises. • Facilitating multi-stakeholder engagement and cross-sectoral collaboration.

---

90. Includes privately funded not-for-profit organizations or foundations.

Stakeholder	Area of collaboration
Civil society organizations	• Creating alliances to coordinate and amplify advocacy for prioritizing NCDs in national and global agendas, to provide a voice for people living with NCDs, and to demand increased funding for NCD initiatives and equitable access to NCD health services.
Community groups/ leaders/committees	• Facilitating community engagement and accountability. • Developing trust. • Identifying unmet needs, strengths and resources.

Private sector partnerships

The private sector is now viewed as a key partner in global efforts to combat NCDs. With clear rules of engagement and sensitivity to avoid potential conflicts of interest, such partnerships may present the following opportunities for the IFRC Network:

- Multi-year and un-earmarked funding, providing more predictable income and greater flexibility for programme planning and upscaling community-based NCD projects.

- Strengthening supply chains for essential medications and equipment.

- Developing innovative technology through research and pilot studies to enhance programme efficiency and enable task-shifting of more roles to CBHWs including volunteers, e.g. innovative mHealth technology for healthcare navigation support, efficient and easy to use health information system (HIS)[91],[92].

Important considerations for engaging in private partnerships, include:

- Establish type of engagement with the private sector (see Annex 5), e.g. corporate sponsorship, collaborative research, training CBHWs.

- Ensure the right type of partner for the goals of the programme, e.g. traditionally, the biopharmaceutical industry has been the key partner for NCD initiatives.

- Establish agreed upon principles, targets and implementation plans from the outset with participation from the intended recipients i.e. community members.

- Ensure inclusive and transparent governance.

- Implement process to ensure quality assurance.

91. Laryea D, Cueni T. *Including the private sector in partnerships to tackle non-communicable diseases.* The BMJ Opinion 2019. https://blogs.bmj.com/bmj/2019/12/06/including-the-private-sector-in-partnerships-to-tackle-non-communicable-diseases/
92. Collins T et al, 2019.

- Establish processes for monitoring goals and targets[93],[94].

- Establish mechanisms for redressals

Resources for facilitating multi-stakeholder partnerships:

- **IFRC "Multilateral partners and international financial institutions"** – overview of working agreements and types of partners[95].

- **"Access Accelerated"** – platform of multiple stakeholders (including private and public entities) to devise solutions for scaling up NCD programmes in low- and middle-income countries[96].

- **WHO Global Coordination Mechanism on NCDs (GCM/NCD**) – works to "enhance coordination of activities, multi-stakeholder engagement and action across sectors at the local, national, regional and global levels"[97].

- **Partnerships Analysis Tool** – a tool for assessing, monitoring and maximizing effectiveness of partnerships in health[98].

- **PPP Knowledge Lab** – platform of resources and tools to facilitate effective public-private partnerships[99].

93. Collins T et al, 2019.
94. VicHealth. Resource for organizations. *Partnerships analysis tool*. (Victoria: VicHealth, 2016). https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool
95. IFRC, *Multilateral donors and international financial institutions*. https://www.ifrc.org/get-involved/partner-us/multilateral-donors-and-international-financial-institutions
96. Access Accelerated. https://accessaccelerated.org/
97. World Health Assembly. A67/14 Add1. *Terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases*. 2014
98. VicHealth, *Partnerships analysis tool*.
99. https://pppknowledgelab.org/

3.9 INNOVATION AND RESEARCH

Participatory research, community consultation and adaptation of emerging technology and innovative tools are all necessary to avoid harm and to target identified needs. The close and trusted relationships National Red Cross Red Crescent Societies have with communities means they are integral to this adaptation process as well as facilitating and scaling-up community-driven solutions.

This section is intended to support National Societies in this process by providing recommendations for facilitating programme innovation, describing key considerations for utilizing digital health technology, and outlining potential areas for further research.

Facilitating Programme Innovation

a. **Create a culture of innovation:**

- Involve youth in decision-making and strategic goal setting – youth are inherently innovative and typically have high levels of digital literacy.
- Offer research fellowships (via partnering with universities and think-tanks) to young people to develop innovative solutions.
- Hold competitions and provide awards for outstanding innovation[100].
- Hold conferences and exhibitions, allowing staff and volunteers to express ideas and demonstrate pilot projects.
- Run "NCDs innovation labs" e.g. WHO NCD Lab[101].
- Employ/recruit staff and volunteers from diverse backgrounds, experiences and sectors, e.g. engineering, software development, economics, arts.

b. **Engage communities:**

- Ask community members what they need.
- Ask communities for available and sustainable solutions to the problems they face.
- Involve communities in project development and piloting of new tools and processes.
- Ask communities for their feedback and engage in decision-making
- Update communities regularly.
- Plan for the future and develop seamless time bound exit strategies.
- Factor in sustainability by building capacity and skills of community members.

c. **Form or join multi-stakeholder alliances:**

- Examples include GCM/NCD[102], The Defeat-NCD Partnership[103], NCD Alliance[104], Be He@lthy, Be Mobile[105], Access Accelerated[106].

100. See an example here: https://limitless.solferinoacademy.com/
101. WHO NCD Lab – *First call for innovative cross-cutting initiatives*. (Geneva: WHO, 2021). https://www.who.int/news-room/articles-detail/ncd-lab-first-call
102. World Health Assembly. A67/14 Add1. *Terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases*. 2014
103. https://defeat-ncd.org/
104. https://ncdalliance.org/
105. Global Health Progress. *Be He@lthy, Be Mobile* https://globalhealthprogress.org/collaboration/be-helthy-be-mobile/
106. Access Accelerated. https://accessaccelerated.org/

IFRC-related resource:

- Solferino Academy – "IFRC Innovation Academy"[107],

- Community engagement and accountability[108].

Innovation IN NCD Programmes

To facilitate innovative solutions, Figure 2 provides examples of programming areas where innovation can be developed and the types of solutions that are possible in this area.

Figure 2: Programmatic areas (with examples) for introducing innovative solutions

CREATING HEALTH-PROMOTING ENVIRONMENTS	ORGANIZATIONAL SOLUTIONS	PRIMARY PREVENTION SOLUTIONS
• Working with governments and green-technology entrepreneurs to introducew novel solutions to the NCD problem e.g., air pollution reduction measures, providing internet network access to the whole population	• Utilising the Red Cross Health Information -System (RCHIS) for data collection/analysis/reporting • mHealtl strategies for appointment scheduling, patient reminder/tracking e.g., post-screening follow-up. • Digital technology for supply chain management	• Smart-phone for exercice and sleep monitoring. • Population-wide text-messaging for diet, exercice, tobacco and alcohol advice. • Smat-phone apps for point of purchase advice on food choices.

SECONDARY PREVENTION SOLUTIONS	SUPPORTING VOLUNTEERS	INTEGRATIVE CARE SOLUTIONS
• Smart-phone apps or wrist watch monitoring of medication adherence. • mHealth tools for CVD risk assessment. • Centralised clinic-monitoring of home blood pressure and glucose measurements.	• Home-based training via online tools. • Smart-phone/tablet clinical decision support tools. • Collaborating with nurses from formal sector for supervision and training.	• Leveraging HIV care platforms to deliver NCD care. • Adopting "Primary Care Home" with community and clinical care, social support, childcare etc.

---

107. https://solferinoacademy.com/
108. https://www.ifrc.org/our-work/inclusion-protection-and-engagement/community-engagement-and-accountability

Examples of piloted digital technology:

- FoodSwitch app – point of sale information on nutritional content of foods[109].

- CONNECT - integrated ehealth tool for people with, or at high risk of, cardiovascular disease[110].

- TEXT ME - text message-based intervention for secondary prevention in people with cardiovascular disease.

Key considerstions for Digital Health Technology

Implementing digital health technology into community-based programmes has unique challenges and the potential to cause unintentional harm. For example, new technology may increase health inequalities if certain groups in society are unable to access it due to affordability or a lack of digital literacy (e.g. older persons).

Such risks will be different for each community, so careful planning and consultation with key stakeholders is necessary prior to implementation. As a part of this process, programme planners should consider the following mitigation strategies:

- Have clear objectives for each new tool and identify the target users for each type of technology.

- Digital tools should not be implemented simply for the sake of transitioning from non-digital NCD management; rather, the new technology should have demonstrated capacity to enhance care.

- Healthcare practitioners, caregivers, and people living with NCDs need to be involved in the development of digital health tools to improve accessibility, usability and acceptability in communities.

- Ensure there is a non-digital alternative available so that people who are unable or unmotivated to use the digital tool have an equally effective method.

- Ensure digital health tools are available in multiple languages and adapted versions exist for people with sensory impairments (e.g. hearing, visual).

- Data protection and security must be prioritized and safeguards communicated to users to build trust and acceptability[111].

109. Dunford, E, Trevena, H, Goodsell, C et al. (2014) FoodSwitch: a mobile phone app to enable consumers to make healthier food choices and crowdsourcing of national food composition data. *JMIR Mhealth Uhealth* 2, e37. https://pubmed.ncbi.nlm.nih.gov/25147135/
110. Neubeck, L, Coorey, G, Peiris, D et al. (2016) Development of an integrated e-health tool for people with, or at high risk of, cardiovascular disease: The Consumer Navigation of Electronic Cardiovascular Tools (CONNECT) web application. *Int J Med Inf 96, 24–37.* https://pubmed.ncbi.nlm.nih.gov/26847070/
111. Monaco A, Palmer K, Holm Ravn Faber N, Kohler I, Silva M, Vatland A, van Griensven J, Votta M, Walsh D, Clay V, Yazicioglu MC, Ducinskiene D, Donde S. Digital Health Tools for Managing Noncommunicable Diseases During and After the COVID-19 Pandemic: Perspectives of Patients and Caregivers. J Med Internet Res 2021;23(1):e25652. https://www.jmir.org/2021/1/e25652/

Note: to assess the suitability and applicability of innovative diagnostic tools in LMICs, National Societies may use the WHO's REASSURED criteria[112].

Research

The centrality of National Societies in communities means they can play a leading role in undertaking and coordinating research to address gaps in the evidence base. Table 2 outlines examples of priority research areas to improve and scale-up community-based NCD programmes.

Table 2: Priority research areas

Programming area	Priority research topics
Human resources	• Innovative strategies for volunteer retention e.g. non-monetary incentives, qualification certificates. • Alternative models for providing supportive supervision of volunteers e.g. nurses or CBHWs from the formal healthcare sector.
Models of care	• Innovative strategies for integrating NCD prevention and care into other community-based health programmes (including MHPSS). • Innovative strategies for improving access to essential NCD services and medications for "last mile" communities. • Developing and testing new methods of encouraging behaviour change (e.g. digital health tools, social media) for NCD risk-factor reduction. • Increasing palliative care accessibility in low- and middle-income countries.
CBHWs and task-shifting/sharing	• Understanding barriers to increasing scope of practice for volunteers working as CBHWs across diverse settings e.g. development, humanitarian crises. • CBHWs' roles and responsibilities in delivering NCD services in high-income country contexts e.g. priority needs, how to utilize CBHWs efficiently and effectively in these settings. • Understanding communities' perceptions (e.g. acceptance, willingness to seek care) of CBHWs delivering NCD care and prevention. • Developing and testing clinical care algorithms for CBHW use. • Developing and testing digital health technologies to enhance CBHW skills and capacities.
Sustainable project financing	• Understanding the value and ethical implications of partnering with the private sector to deliver NCD health services. • Determining how to align incentives and develop cooperation with private enterprises, foundations and philanthropists. • Examining strategies to leverage and link with investors and enterprises operating within the "Green/Clean Technology" sector.

---

112. Bernabé-Ortiz, A., Zafra-Tanaka, J.H., Moscoso-Porras, M. et al. *Diagnostics and monitoring tools for noncommunicable diseases: a missing component in the global response.* Global Health 17, 26 (2021). https://doi.org/10.1186/s12992-021-00676-6.

3.10 KEY CONSIDERATIONS FOR MONITORING AND EVALUATION

Indicators for NCD programmes

Indicators for monitoring and evaluating community-based NCD programmes should measure an intervention's *inputs, processes, outputs and outcomes* (see Annex 6)[113]. Where feasible and relevant, indicators should capture information related to each dimension of the continuum of care – health promotion and disease prevention (e.g. risk-factor exposure and prevalence), screening, diagnosis, treatment and follow up.

Further, indicators for measuring key organizational dimensions and service delivery (e.g. expenditure, efficiency, staff and volunteer performance, availability of medications and equipment) should be included. The Community Health Services Delivery Package for NCDs has indicator sets covering these dimensions.

Assessing health inequalities

Fundamental to the work of the IFRC Network is improving health inequalities within and between communities. This objective needs to be considered when planning for the monitoring and evaluation of NCD-related interventions. For instance, programme planners should ask themselves: "How do we know that our intervention has improved the inequality in access to healthcare for people with diabetes in our community?"

To be able to answer this question, methodologies for data collection and analysis need to include not only information related to the person's health (e.g. diabetes care access) but also information related to the dimension of *inequality.* Data related to inequality typically only include information related to *economic status*. Other important variables, however, should be captured as well. The WHO recommends the "PROGRESS" method to collect data related to health inequalities (see Annex 7)[114].

Note: Detailed guidance for monitoring and evaluating health inequalities can be found in WHO's *Handbook on Health Inequality Monitoring*[101].

113. Krishnan A, Gupta V, Ritvik, Nongkynrih B, Thakur J. *How to Effectively Monitor and Evaluate NCD Programmes in India.* Indian J Community Med. 2011;36(Suppl 1):S57-S62. doi:10.4103/0970-0218.94710
114. WHO (2013), *Handbook on Health Inequality Monitoring: with a special focus on low- and middle-income countries.* https://www.who.int/docs/default-source/gho-documents/health-equity/handbook-on-health-inequality-monitoring/handbook-on-health-inequality-monitoring.pdf

Indicators for M&E in humanitarian crises

Monitoring and evaluation NCD interventions in humanitarian crises are more complex due to resource constraints, challenges accessing patients and competing priorities. In general, National Societies should use indicators for monitoring the following types of information:

- Availability of health services addressing NCD care and prevention (i.e. preventive services are most relevant to post-emergency settings and protracted crises).

- Accessibility of NCD-related health services.

- Staff and volunteers trained in addressing NCDs (including MHPSS services) during humanitarian crises.

- Availability of essential medicines and supplies for prevention and care of NCDs.

The Sphere Handbook 2018[115] lists four indicators which may be used to assess the information described above. These are:
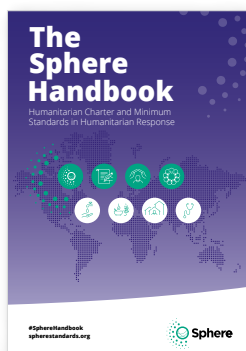
1. Percentage of primary healthcare facilities providing care for priority NCDs.

2. Number of days essential medicines for NCDs were not available in the past 30 days (<4d).

3. Number of days for which basic equipment for NCDs was not available (or not functional) in the past 30 days (< 4d).

4. Percentage of healthcare workers providing NCDs treatment are trained in NCD management (100 per cent).

115. Sphere Association. *The sphere handbook. The Humanitarian Charter and Minimum Standards in Humanitarian Response.* 2018 Edition. CHS Alliance, Sphere Association and Groupe URD, 2018 https://handbook.spherestandards.org/en/sphere/#ch009_005_001

3.11 PROGRAMMING CONSIDERATIONS IN THE CONTEXT OF PUBLIC HEALTH EMERGENCIES

Programming considerations in the context of public health emergencies, such as COVID-19, are critical to ensure that essential community health services continue to operate without disruption. If healthcare services are disrupted, it can have a greater impact on people living with NCDs, who may struggle to access critical healthcare services, including cancer screening and diagnostic services, outpatient and rehabilitation services, and essential medicines.

Impact of public health emergencies

Public health emergencies such as the COVID-19 pandemic have had a profound effect on frontline community health services which are essential for meeting people's ongoing health needs. People living in poverty, hard-to-reach and marginalized groups, and those in LMICs are particularly affected by these disruptions in services[116]. In the context of public health emergencies, the following specific challenges arise in relation to healthcare for people living with NCDs:

- Limited access to critical healthcare, including screening and diagnostic services for cancer, elective procedures and outpatient and rehabilitation services.

- Reluctance to attend appointments: people living with NCDs may be hesitant to attend scheduled appointments due to concerns about contracting the infectious disease associated with the public health emergency, like COVID-19.

- Shortages of essential medicines for people living with NCDs.

- Control measures like lockdowns implemented during public health emergencies may lead to limited access to community-based health and social services for all people living in affected areas, especially refugees and migrants, displaced persons, and people affected by poverty.

- Control measures implemented during public health emergencies, including restriction on movement and social distancing, may lead to a decrease in physical activity levels. This reduction can contribute to an increased incidence of lifestyle-related chronic diseases.

- Overabundance of information — some accurate and some not — makes it hard for people living with NCDs to find trustworthy sources and reliable guidance when they need it[117, 118, 119, 120].

116. WHO and UNICEF (2020) *Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic*. https://www.who.int/publications/i/item/WHO-2019-nCoV-Comm_health_care-2020.1
117. WHO (2020). *COVID-19 and NCDs: Conceptual framework for the WHO NCD/WIN Technical Working Group*. https://cdn.who.int/media/docs/default-source/ncds/ncd-covid-19/wg-covid19-and-ncds---conceptual-framework---final-(for-web).pdf?sfvrsn=73049954_2&download=true
118. WHO (2020). *The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment*. https://www.who.int/teams/noncommunicable-diseases/covid-19
119. CORE Group (2020). *Home-based care reference guide for COVID-19*. https://preparecenter.org/wp-content/uploads/2021/02/Home-Based-Care-Reference-Guide-for-COVID-19-update-july-2020.pdf
120. Muhammad D, Abubakar I. COVID-19 lockdown may increase cardiovascular risk factors. Egyptian Heart J. 2021. 73:2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7783488/

Specific considerations

In addition to using national policies and guidelines, National Red Cross and Red Crescent Societies may consider the following recommendations:

- Ensure staff and volunteers are trained in infection control and prevention, and on the vulnerabilities of people with NCDs to experiencing severe illness during the specific public health emergency, like COVID-19. Additionally, strategies to support communities during the pandemic should be included in the training.

- Volunteers working as CBHWs can provide important education and support to people with NCDs, including:
  - Assisting people with understanding how, where and when they should seek healthcare e.g. explaining early warning signs and symptoms that warrant assessment in healthcare facilities.
  - Supporting people to avoid healthcare facilities by connecting them with telemedicine clinics, establishing health hotlines, home visits, facilitating access to medications, and educating them on self-care strategies (e.g. blood pressure and blood glucose monitoring).
  - Community engagement to improve awareness of the importance of maintaining treatment for NCDs and explanations of how disrupted treatment may be harmful, as well as raising awareness about the risk of the specific infectious disease associated with the emergency, such as COVID-19, to people with NCDs and disabilities. Additionally, educate the community about the impact of risk factors such as smoking and harmful alcohol consumption on the severity of the infectious disease. Provide strategies for preventing infection in oneself and others [116, 121, 122].

Resources for training and providing community-based support for people with NCDs:

- Home-based care reference guide reference guide for COVID-19[106].

- Interim guidance for staff and volunteers working with older people during COVID-19[108].

- Community-based healthcare, including outreach and campaigns, in the context of the COVID-19 pandemic[109].

121. IFRC (2020). *Interim guidance for Staff and Volunteers working with Older people during COVID-19.* https://preparecenter.org/wp-content/uploads/2020/07/Interim_guidance_working_w_older_people_for_staff_and_volunteers_during_COV_kzIifS4.pdf
122. WHO and UNICEF, *Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic.*

ANNEXES

© Yoshi Shimizu/IFRC

ANNEX 1: CONTINUUM OF CARE FOR NCDs
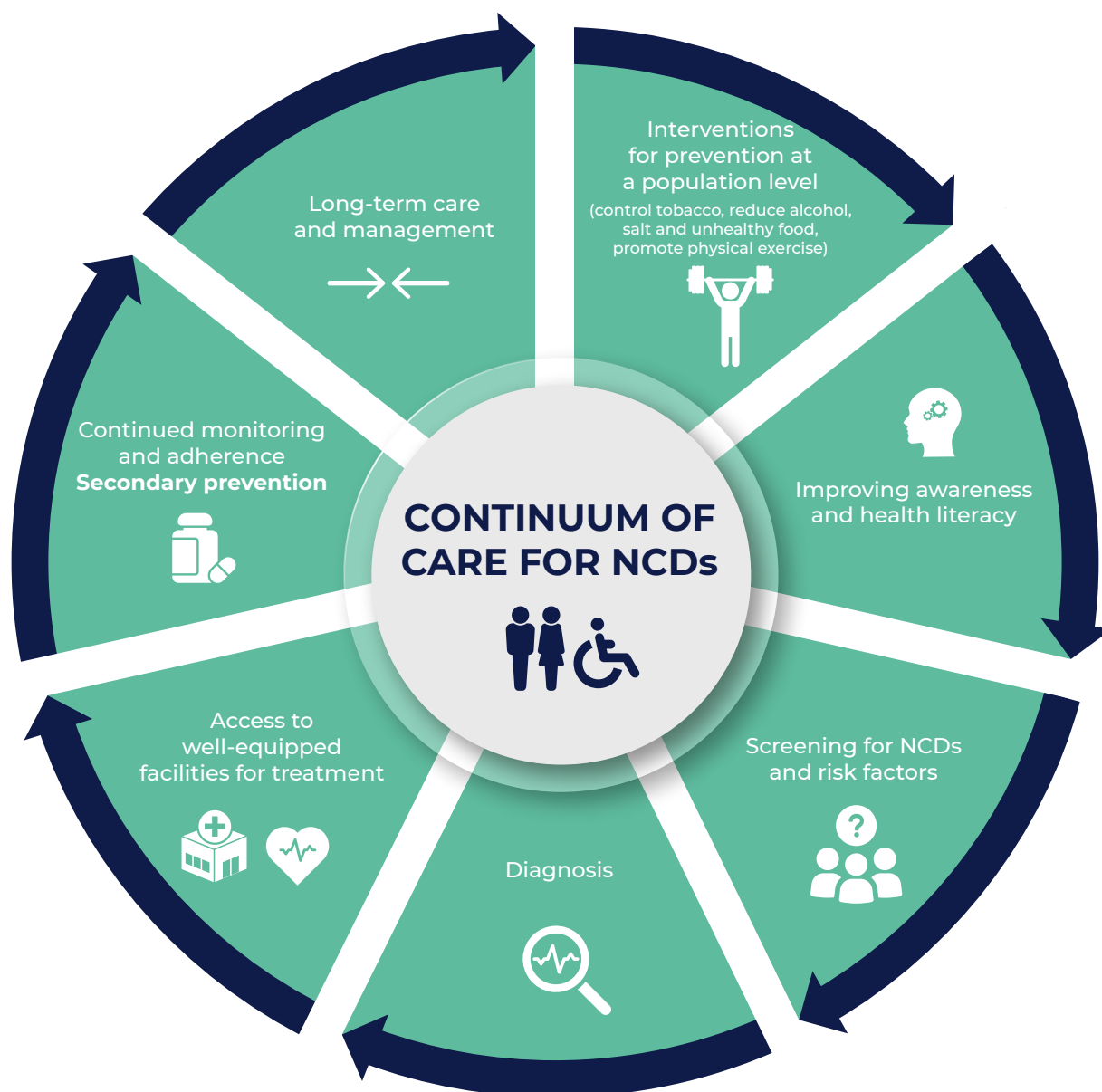
Source: Adapted from Rayshree Thapa et al.[123]

---

123. Rajshree Thapa, Ayse Zengin and Amanda G Thrift, «Continuum Of Care Approach".

ANNEX 2: PRIORITISATION OF CARE

Figure 1: Framework for for prioritizing care for NCDs in humanitarian crises.

Prioritization of care	Management	Stratification of individuals with NCDs based on risk of complications
URGENT PRIORITY ⬆️⬇️ **LOW PRIORITY**	Immediate	People with **acute life-threatening** conditions (e.g.severe asthma crisis, myocardial infarction, diabetic decompensation)
	Days	People at **immediate risk** if care or treatment is interrupted (e.g. type 1 diabetes, unstable NCDs (e.g. unstable angina), pregnant women)
	Weeks	People with **treated and stable** chronic diseases (e.g. high blood pressure, COPD, diabetes mellitus type 2)
	Months	People without know chronic diseases but with cardiovascular **risk factors** (e.g. obesity, dyslipidaemia, tabacco use, alcohol use)
	Years	**Undiagnosed** conditions, patients unaware of their status
		General population

Source: Adapted with permission from Bausch et al, 2021.[124]

124. Bausch et al, 2021

ANNEX 3: COMPREHENSIVE PREVENTION OF NCDs

Box 1: Prevention levels and NCDs

I. Primordial prevention:

At this level, prevention activities address the upstream factors impacting health. A social determinants approach is often used at this level. This approach analyses and targets the non-medical factors that impact health and well-being, including social norms and customs, environmental conditions, housing quality, political factors (e.g. conflict) and economic conditions. Examples of interventions include high-level advocacy for legislation that creates health-promoting environments e.g. effective tobacco control policies, safe access to sidewalks for pedestrian use, accessible public parks for recreation and sporting activities (in rural and urban areas).

II. Primary prevention:

This approach aims to prevent the onset of disease in susceptible populations by reducing people's exposure to risk factors. The four main risk factorsi for NCDs are *tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol*. Examples of activities at this level of prevention include community-wide education on the importance of physical activity and healthy diets. Other interventions are detailed in the *Community-Based Health and First Aid* (CBHFA) module on NCDs.

III. Secondary prevention:

Interventions at this level of prevention aim to detect disease in its earliest stages (before signs or symptoms), to prevent disease progression and involve NCD screening and early diagnosis programmes. Examples include cardiovascular disease (CVD) risk-assessments and population-wide cancer screening programmes. Community-based secondary prevention strategies for National Societies are described in the *Community-health services delivery package for NCDs*.

IV. Tertiary prevention:

Interventions at this level aim to reduce the effects of established disease. Examples of tertiary prevention activities for NCDs are controlling blood pressure in people with hypertension to prevent complications such as coronary heart disease, kidney disease, and cerebrovascular disease. Community-based health workers can play an instrumental role at this level of prevention via supporting patients with medication adherence, healthcare navigation, and providing psychosocial support.

WHO is also recommending that air pollution be considered as a major risk factor.
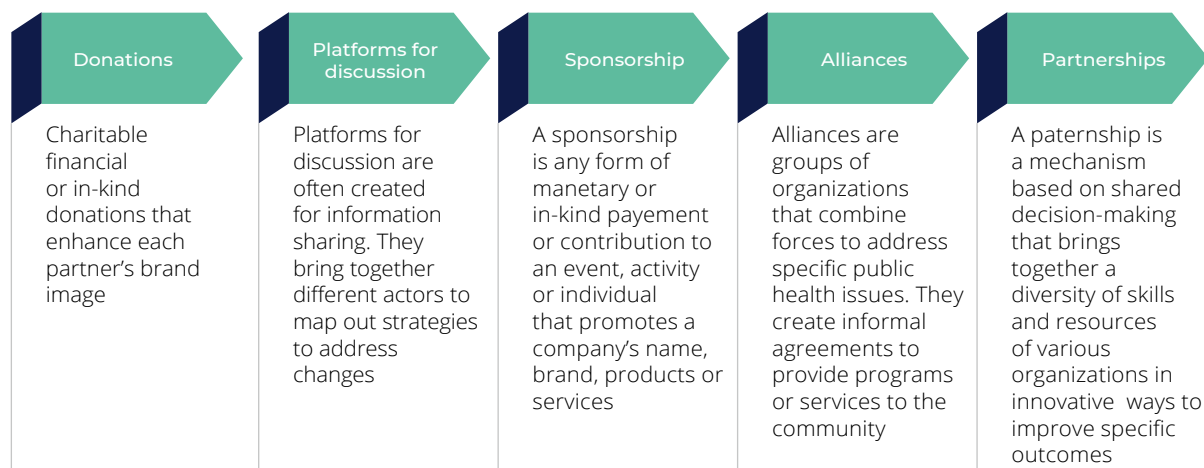
ANNEX 4: EVIDENCE-BASE FOR COMMUNITY-BASED NCD INTERVENTIONS

List of resources:

- Package of Essential Non-Communicable Diseases Interventions for Humanitarian Settings (PEN-H): https://www.rescue.org/report/package-essential-non-communicable-diseases-interventions-humanitarian-settings-pen-h

- Managing projects addressing non-communicable diseases: Operational guidelines for field staff: https://shop.icrc.org/managing-projects-addressing-non-communicable-diseases-operational-guidelines-for-field-staff-pdf-en.html

- UN Interagency Task Force on NCDs: https://uniatf.who.int/

- Task-shifting to CBHWs for CVD risk-management: https://gh.bmj.com/content/3/Suppl_3/e001092

- Task-shifting for NCD management in LMICs: https://pubmed.ncbi.nlm.nih.gov/25121789/

- Global call for involving CBHWs in NCD prevention and care, published in The Lancet: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2814%2970303-1/fulltext

- WHO SEARO article on the use of CBHWs to manage and prevent NCDs: http://www.searo.who.int/entity/asia_pacific_observatory/publications/policy_briefs/policy_brief_Coach/en/

- Involving CBHWs in NCD prevention and control in Uganda: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00653-5

- Mitigation of NCDs in developing countries using CBHWs: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-015-0129-5

- Models of care for patients with hypertension and diabetes in humanitarian crises: a systematic review: https://academic.oup.com/heapol/article/36/4/509/6166268

ANNEX 5: ENGAGEMENT WITH PRIVATE SECTOR.

Figure 2: Forms of engagement with the private sector.

Donations	Platforms for discussion	Sponsorship	Alliances	Partnerships
Charitable financial or in-kind donations that enhance each partner's brand image	Platforms for discussion are often created for information sharing. They bring together different actors to map out strategies to address changes	A sponsorship is any form of manetary or in-kind payement or contribution to an event, activity or individual that promotes a company's name, brand, products or services	Alliances are groups of organizations that combine forces to address specific public health issues. They create informal agreements to provide programs or services to the community	A paternship is a mechanism based on shared decision-making that brings together a diversity of skills and resources of various organizations in innovative ways to improve specific outcomes

Source: Adapted with permission from Collins T et al.[125]

ANNEX 6: INDICATORS FOR NCD PROGRAMME M&E

Table 1: Framework for developing indicators relevant to NCD programmes

Indicators	Inputs	Process	Output	Outcome	Impact
Definition	Measure resources devoted to an intervention.	Measure ways in which programme services are delivered.	Measure the quantity of services delivered indicating efficiency.	Measure the results achieved from delivery of services.	Measure the change in NCD-related mortality and morbidity.
Description	Human resources, supplies, financial resources.	Collection of activities to be undertaken to achieve outcomes.	Immediate, short-term, tangible products.	Changes to health services or intermediate results of services.	Long-term change in health and wellbeing of the population.
Example indicators	% of volunteers trained to deliver CVD risk-assessment.	% of volunteers who can accurately measure blood pressure.	% of target population with completed CVD risk assessment.	% of people classified as high-risk initiated on therapy.	Decrease in mortality due to CVDs.

Source: Adapted with permission from Krishnan A, et al [126]

125. Collins T et al,
126. Krishnan A, et al. 2011.

ANNEX 7: MEASURING HEALTH INEQUALITIES

World Health Organization '**PROGRESS METHOD**':[127]

- **P**lace of residence (rural, urban, internally displaced person, etc.)

- **R**ace or ethnicity or nationality

- **O**ccupation

- **G**ender (and 'age')

- **R**eligion

- **E**ducation

- **S**ocioeconomic status

- **S**ocial capital or resources

---

127. WHO, *Handbook health inequality monitoring: with a special focus on low- and middle-income countries.* (Geneva: World Health Organization, 2013).

THE FUNDAMENTAL PRINCIPLES
OF THE INTERNATIONAL RED CROSS
AND RED CRESCENT MOVEMENT

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

The **International Federation of Red Cross and Red Crescent Societies (IFRC)** is the world's largest humanitarian network, with **191 National Red Cross and Red Crescent Societies** and around **16 million volunteers**. Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard to reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient places where people can live safe and healthy lives, and have opportunities to thrive.

For more information on this IFRC publication, please contact:
International Federation of Red Cross and Red Crescent Societies

twitter.com/ifrc | facebook.com/ifrc | instagram.com/ifrc | youtube.com/ifrc