

DISCUSSION PAPER

RETHINKING SOCIAL IMPACT

in the context of NCDs to
advance a people-centred
approach to access



ACKNOWLEDGEMENTS

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*At the time of publication of this discussion paper, these are the organisations forming part of the NCD Alliance Supporters Group (in alphabetical order): Access Accelerated, American Cancer Society (ACS), American College of Cardiology (ACC), American Heart Association (AHA), AstraZeneca, Direct Relief, FDI World Dental Federation, Friends of Cancer Patients (FOCP), the International Diabetes Federation (IDF), the International Federation of Psoriasis Association (IFPA), NCD Child, Norwegian Cancer Society (NCS), Resolve to Save Lives, The Fred Hollows Foundation, The George Institute for Global Health, Vital Strategies, the Union for International Cancer Control (UICC), the Union Against Tuberculosis and Lung Diseases (The Union), World Heart Federation (WHF), World Obesity, World Stroke Organisation.

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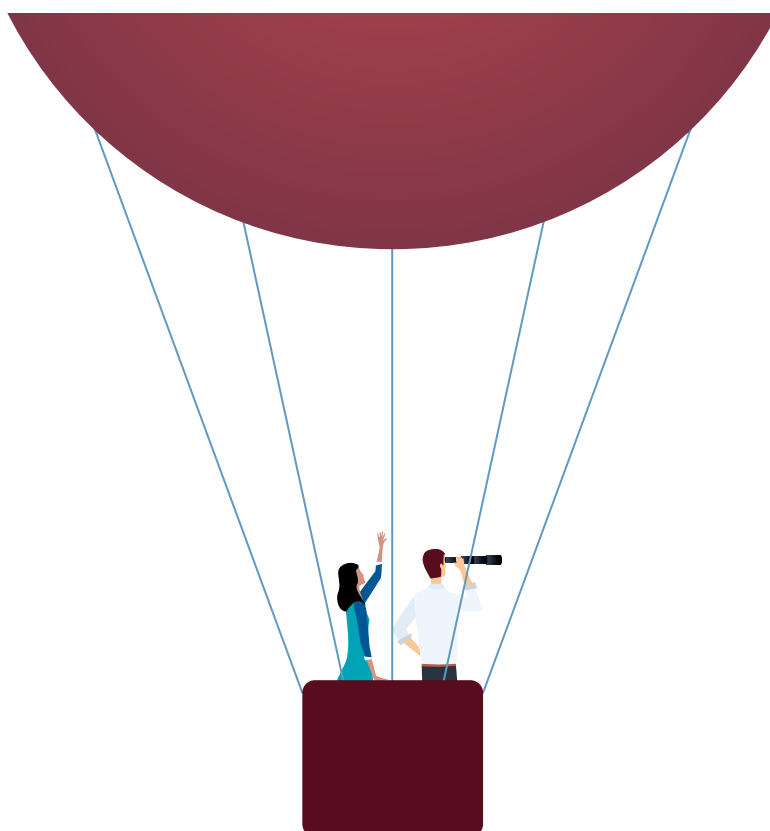


TABLE OF CONTENTS

Scope and purpose	6
Methodology	7
INTRODUCTION	8
 Section 1 THE CHALLENGE	 10
Accelerating access to healthcare for PLWNCDs in light of COVID-19 and the limits of business-as-usual approaches	10
 Section 2 A NEW OPENING	 16
Increasing the impact of novel approaches and business models to deliver shared value and improve access for PLWNCDs in the context of sustainable development	16
 Section 3 THE OPPORTUNITY	 21
Putting PLWNCDs at the centre of social business models for improving NCD access and supporting their meaningful involvement	21
 Section 4 CASE STUDIES	 32
Exploring how the NCD community can use a people-centred approach to enhance shared value creation in health programming for NCDs and improve access for PLWNCDs	32
Shared value initiatives led by private sector companies	33
Novo Nordisk Base of the Pyramid Programme: Building Sustainable Access Solutions Through Shared Value	33
Takeda's Access to Medicines Patient Assistance Programs (PAPs): How to Create Shared Value at Every Stage of the Patient Journey	35
AstraZeneca's Young Health Programme: A People-Centred Approach to Unleash Shared Value	37
Lilly 30x30: Increasing Access to Quality Healthcare through Shared Value and Multi-sectoral Partnerships	39
Novartis Access: Shared Value Creation by Continuously Adapting the Programme to Local Needs	41

Shared value initiatives led by non-profit organisations	43
Supporting National NCD Alliances in Mobilising and Amplifying the Voices of People Living with NCDs – NCD Alliance	43
KHPT's Innovative Community Health Worker Model: A People-Centred Approach to Optimise NCD Outcomes in South India	45
Direct Relief's Risperdal Access Programme to Support Remote-Area Mental Health Services in Central and Northern Ghana: Integrating PLWNCDs in the Multi-Sectoral Approach	47
PATH's Coalition for Access to NCD Medicines and Products: Addressing Access and Affordability of NCD Medicines and Products through a Multi-sectoral Approach	49
Alina Vision, a Social Enterprise to Advance Access to Eye Health Supported by the Fred Hollows Foundation	51
PharmAccess's Programme on Using Mobile Technology to Break Access and Awareness Barriers in Hypertension and Diabetes Care: Linking Shared Value and Self-Management	53
 Section 5	
FRAMEWORK	55
A framework to capture the access challenges and needs of PLWNCDs and achieve shared value in NCD initiatives	55
WHO Framework on Integrated People-Centred Health Services' Strategies and Strategic Approaches	56
Social Impacts & Outcomes for Actors/Stakeholders	62

Scope and purpose

This discussion paper aims to provide a better understanding of how putting a people-centred lens to the concept of social impact and social business models can help drive progress towards sustainable and equitable access to NCD care for all.

Its **OBJECTIVES** are to:

OUTLINE the limitations of existing approaches for improving access to care and emphasise the need to revisit the concept of social impact in the NCD context.

HIGHLIGHT the value of a people-centred lens to deliver strong health programmes to achieve better health outcomes for PLWNCDs.

PROPOSE a conceptual framework to review where and how social impact programmes are adopting a people-centred approach for the implementation or scaling-up of NCD access initiatives or programmes.

Methodology

In the spirit of partnership and with input from its Supporters Group, the NCD Alliance reflected on the concept and role of social impact models in the global NCD response in early 2019.

The aim was to better understand how these models are working to improve access to care for NCDs in LMICs, and to identify some relevant approaches to measuring the social impact of these new models.

It was agreed that a discussion paper would be developed to help inform decision making and programmatic developments and ensure a greater connection between 'social impact' and 'people-centred care'.

The development of the discussion paper was carried out through:

→ **A series of stakeholder consultations including:**

- A high-level roundtable discussion, organised with the support of Eli Lilly and Company and in collaboration with the Access to Medicines Foundation, on the sidelines of the UN General Assembly in September 2019. It gathered more than 60 participants from across sectors to discuss the innovative and inclusive models that have helped deliver better healthcare for PLWNCDs in the poorest countries and communities and a follow-up virtual public event entitled "Revisiting social impact in the COVID-19 era: Achieving greater access for people living with NCDs through people-centred care". This event, held on 22 September 2020, gathered about 140 participants from around the globe to discuss what social impact means in the COVID-19 context.
- A dedicated session with selected participants to discuss a first draft concept that would inform the development of the full paper. This session was chaired with the support of Novo Nordisk, during the Global NCD Alliance Forum in Sharjah on 9 February 2020.
- A focus group organised on 3 September 2020 with PLWNCDs to gather insights and perspectives on how to define impact and how greater people-centredness can contribute to improving access.

→ **A call for case studies to illustrate existing initiatives to support inclusive approaches with a people-centred lens to addressing the needs of communities. These case studies formed the basis of the framework recommendations in this discussion paper.**

→ **Key interviews with experts, including PLWNCDs, to identify priority areas for action and to ensure that first-hand lived experiences shape the framework recommendations.**

INTRODUCTION

Noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer, diabetes, respiratory diseases, and mental and neurological health conditions, are now responsible for 71% of global mortality and take the lives of 41 million people every year.¹

Because they often require long-term or life-long treatment and care, people living with NCDs (PLWNCDs) face some of the most pressing challenges in terms of access to care and out of pocket expenditures. While governments have agreed on a global target of 80% availability of essential medicines and technologies for NCDs in public facilities by 2025, there is a vast gap to bridge in order to reach that goal. So far, only 46% of countries have set national targets related to health systems and treatment for the most prioritised NCDs. Few low-income countries are currently providing care for NCDs in their national health benefit packages, and over 51% of PLWNCDs have experienced catastrophic health expenditure.²

As the world faces the impacts of COVID-19, the pandemic has heightened the vulnerability of PLWNCDs, due to greater health risks and social inequities. Because of its syndemic nature³, the COVID-19 pandemic has exacerbated the adverse effects of each separate disease. It has also compounded inequities in access to care for NCDs, which remains a significant challenge particularly in low- and middle-income countries (LMICs).

Prior to the start of the COVID-19 pandemic, a series of novel and innovative business models were being explored by the healthcare industry to improve access to NCD treatment and care among the most vulnerable and hardest to reach communities, while aiming to be commercially sustainable. If developed, piloted and evaluated effectively, such opportunities and their benefits could create 'shared value'. As defined by Mark R. Kramer and Marc W. Pfitzer, who initiated the reflection on shared value and collective impact in the Harvard Business Review, s is "*creating economic value in a way that also creates value for society by addressing its needs and challenges*."⁴ In parallel, efforts to improve methods for measuring social impact have also been taking place, with the aim of gathering evidence-based data to inform the development of these models.

However, a proliferation of approaches alongside the absence of a commonly agreed framework on measuring progress have highlighted the challenges for such models to generate innovation and growth for all. For social impact to be embraced in the context of NCD prevention and control, it is imperative to ensure it is driven by the needs of affected populations in order to reconcile social objectives and financial viability. The current context has also shown the critical importance of adopting a people-centred approach to enable health systems to respond to emerging challenges posed by NCDs and other health crises, by addressing the needs of communities and PLWNCDs.

1 World Health Organization. Noncommunicable Diseases Progress Monitor 2017. 2018. Available at: <https://apps.who.int/iris/bitstream/handle/10665/258940/9789241513029-eng.pdf?sequence=1>

2 Ibid.

3 R. Horton. Offline: COVID-19 is not a pandemic. The Lancet. 2020;396,10255. Available at: [https://doi.org/10.1016/S0140-6736\(20\)32000-6](https://doi.org/10.1016/S0140-6736(20)32000-6)

4 Porter, M and Kramer, M. The Big Idea: Creating Shared Value. Harvard Business Review. 2011;01. Available at: <https://hbr.org/2011/01/the-big-idea-creating-shared-value>

Powered by a people-centred lens, the concept of social impact can provide a transformational lever to mobilise all sectors – including governments, policymakers, multilateral agencies, civil society, healthcare providers and relevant private sector entities – around the collective role of creating an enabling environment that truly ‘puts people first’ to achieve better health and economic outcomes.

This report explores how the concepts of social impact and a people-centred approach can be applied in the NCD response to ensure both economic success and greater access to care for PLWNCDs.

SECTION 1 outlines the challenges of access to healthcare faced by PLWNCDs and the limits of business-as-usual approaches to tackle these issues in light of COVID-19.

SECTION 2 describes how current efforts to create and deliver shared value could be strengthened to improve access for PLWNCDs in the context of sustainable development.

SECTION 3 highlights opportunities that can result from embedding a people-centred perspective to the concept of shared value to heighten the reach and social impact of health programming for NCDs.

SECTION 4 presents case studies that illustrate existing approaches that adopt a people-centred lens to address the issues of access faced by PLWNCDs.

SECTION 5 offers a framework to measure shared value in NCD programming to inform further thinking.

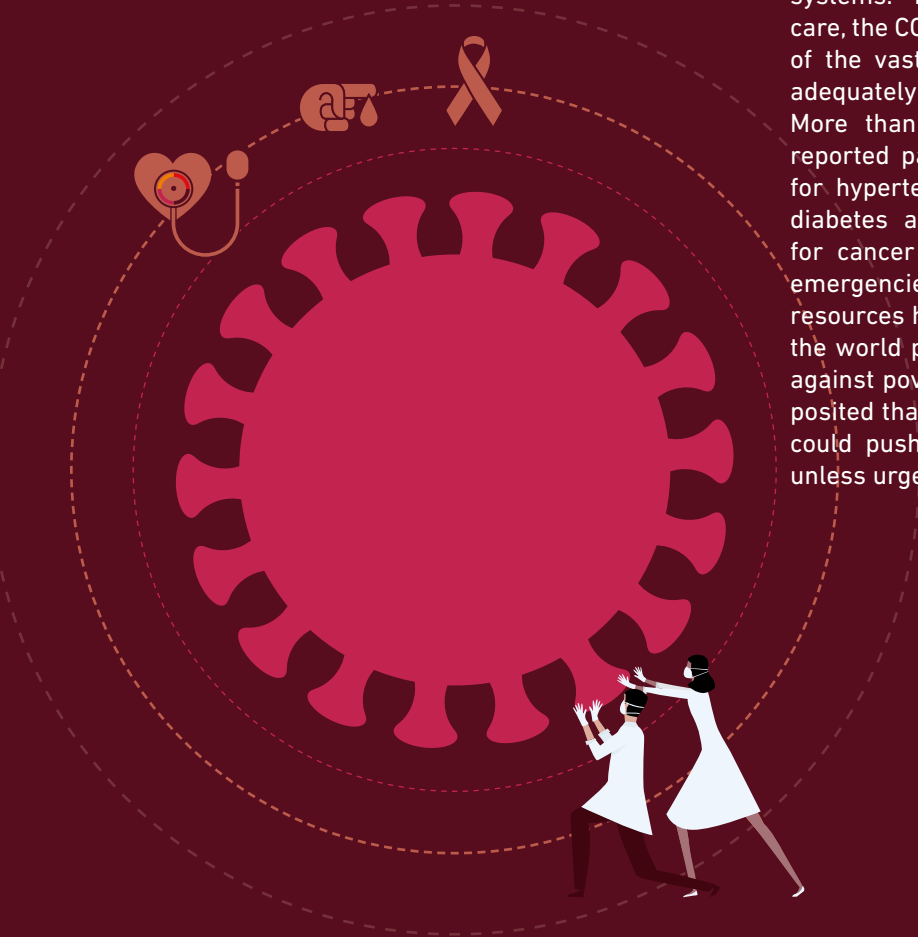
SECTION 1

THE CHALLENGE

Accelerating access to healthcare for PLWNCDs in light of COVID-19 and the limits of business-as-usual approaches

By exacerbating disruptions to health systems, societies and economies, the COVID-19 pandemic has profoundly impacted the lives of the most vulnerable, making universal health coverage a distant reality in many countries.

Despite numerous political commitments and targets set at the global level, many countries are failing to deliver on the promise of Universal Health Coverage (UHC) to ensure comprehensive access to affordable and high-quality medicines and technologies for all. Today, at least half of the world's population still does not have full coverage of essential health services, and two billion people are living without access to basic medicines and technologies or robust health systems.⁵ Through disruption of NCD treatment and care, the COVID-19 pandemic has laid bare the failure of the vast majority of governments worldwide to adequately guarantee the health of their citizens. More than half (53%) of the countries surveyed reported partially or completely disrupted services for hypertension treatment; 49% for treatment for diabetes and diabetes-related complications; 42% for cancer treatment, and 31% for cardiovascular emergencies.⁶ Moreover, a sharp decrease in financial resources has been predicted for a very large part of the world population, which could set back the fight against poverty by a decade.⁷ A report by Oxfam has posited that the economic crisis caused by COVID-19 could push over half a billion people into poverty unless urgent and dramatic action is taken.⁸



5 World Health Organization. Universal Health Coverage: Key Facts. 2019. Available at: [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

6 World Health Organization. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic. 2020. Available at: <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic>

7 A. Sumner, C. Hoy and E. Ortiz-Juarez. Estimates of the Impact of COVID-19 on Global Poverty. UNU-WIDER Working Paper. UNU-WIDER:2020/43. Available at: <https://doi.org/10.35188/UNU-WIDER/2020/800-9>

8 Oxfam. Dignity not Destitution: An 'Economic Rescue Plan For All' to tackle the Coronavirus crisis and rebuild a more equal world. April 2020. Available at: <https://www.oxfam.org/en/research/dignity-not-destitution>

BOX 1

Perspectives on the broader impact of COVID-19⁹

“

The disruption to health systems threatens to unwind decades of progress against maternal and child mortality, HIV, malaria, tuberculosis, noncommunicable diseases, mental health, polio and many other of the most urgent health threats.”

“

COVID-19 is not just a global health emergency, it is a vivid demonstration of the fact that there is no health security without resilient health systems, or without addressing the social, economic, commercial and environmental determinants of health.”

Dr Tedros Adhanom Ghebreyesus, Director General, World Health Organisation, Address at the 73rd World Health Assembly, 18 May 2020

“

Even with the pandemic we must not drop the ball on those other global health priorities that are critical to our overall development. I refer specifically to the chronic NCDs – the silent killers (diabetes and cardiovascular disease, hypertension)... For our populations, these challenges remain real and continue to present a silent but real and present danger.”

Honourable Mia Mottley, Prime Minister of Barbados, Keynote Address at the 73rd World Health Assembly, 18 May 2020

“

Choices we make today will shape our society, economy, health, and climate for decades to come. We, the undersigned, call for a united global response to this COVID-19 pandemic that ensures a just recovery and transition to a better future for those most in need in the wake of this crisis.”

Joint Civil Society Letter on Principles for a Just Recovery⁹

As ever during global health crises, the most vulnerable and poorest groups are being hit the hardest.. The COVID-19 pandemic is occurring against a backdrop of social and economic inequalities that are deeply embedded in our societies, and that are exacerbated by the pandemic. Simultaneously, these inequalities are exacerbating the impact of NCDs and the associated social determinants of health.¹⁰ NCDs have also been recognised as a key risk factor for COVID-19 patients,¹¹ and PLWNCDs with comorbidities and more severe social and economic deprivation are less likely to access health services during this pandemic.¹² As a result, “for the most disadvantaged communities, COVID-19 is experienced as a syndemic—a co-occurring, synergistic pandemic that interacts with and exacerbates their existing NCDs and social conditions”.¹³

9 350. Open letter: Principles for a Just Recovery from COVID-19. 2020. Available at: <https://350.org/just-recovery/>

10 Bambra C, Riordan R, Ford J, et al The COVID-19 pandemic and health inequalities. *J Epidemiol Community Health* 2020;74:964-968. Available at: <https://jech.bmj.com/content/74/11/964.info>

11 Wang B, Li R, Lu Z, Huang Y. Does comorbidity increase the risk of patients with COVID-19: evidence from meta-analysis. *Aging*. 2020;12:6049-57. Available at: <https://pubmed.ncbi.nlm.nih.gov/32267833/>

12 Yadav, Uday Narayan et al. Syndemic Perspective on the Management of Non-communicable Diseases Amid the COVID-19 Pandemic in Low- and Middle-Income Countries. *Frontiers in Public Health*. 2020;8. Available at: <https://www.frontiersin.org/article/10.3389/fpubh.2020.00508>

13 Bambra C, et al. Ibid.

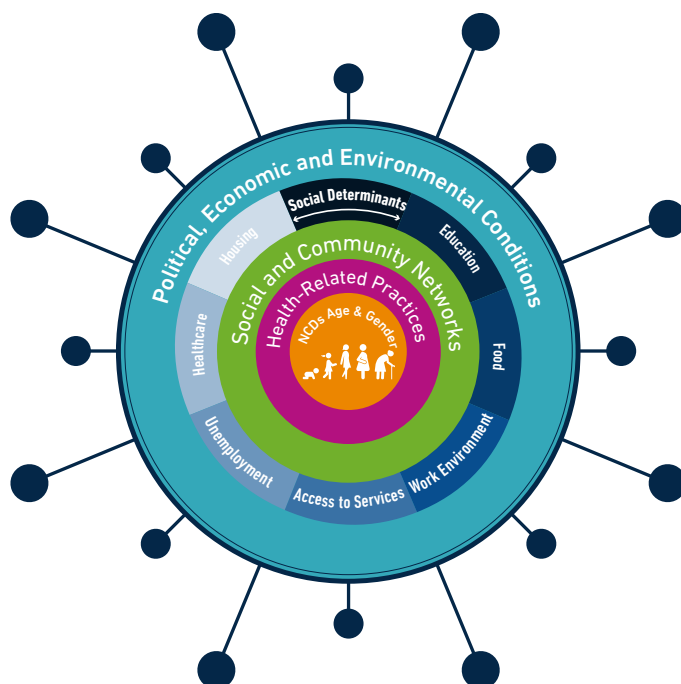


Figure 1¹⁵. The syndemic of COVID-19, NCDs and the social determinants of health (adapted from Singer¹⁶ and Dahlgren and Whitehead¹⁷)

“

Inequalities in COVID-19 infection and mortality rates are therefore arising as a result of a syndemic of COVID-19, inequalities in chronic diseases and the social determinants of health. (...) A syndemic exists when risk factors or comorbidities are intertwined, interactive and cumulative—adversely exacerbating the disease burden and additively increasing its negative effects: ‘A syndemic is a set of closely intertwined and mutually enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of noxious social conditions’.

Bambra C, Riordan R, Ford J, et al, June 2020¹⁴

Governments in various countries have made efforts to focus on NCD services while tackling COVID-19, but only 42% of LMICs have done so compared to 72% of high-income countries (HICs).¹⁸ The syndemic nature of the threat posed by COVID-19 means that a more nuanced approach is required if we are to protect the health of communities and individuals. As countries seek to build back better, adopting a people-centred approach is particularly important to ensure that health systems can respond to the complex challenges beyond health that are posed by NCDs.¹⁹

The COVID-19 crisis has increased the pre-existing access challenges faced by PLWNCDs around the world and exposed the reality that access models are not optimally responsive to their needs.

14 Bambra C, et al. Ibid.

15 Bambra C, et al. Ibid.

16 Singer, M. Introduction to syndemics: a systems approach to public and community health. *Medical Anthropology Quarterly*. 2012;26(4):643–645. Available at: https://www.researchgate.net/publication/262093767_Introduction_to_Syndemics_A_Critical_Systems_Approach_to_Public_and_Community_Health_by_Merrill_Singer

17 Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Institute for Future Studies. 1991. Available at: https://ideas.repec.org/p/hhs/ifswps/2007_014.html

18 World Health Organization. COVID-19 Significantly Impacts Health Services for Noncommunicable Diseases. 2020. Available at: <https://www.who.int/news-room/detail/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases>

19 World Health Organization. Framework on integrated, people-centred health services. 2016. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1

“

Due to the exclusive focus of health authorities on the pandemic, COVID-19 has led many people living with NCDs to distrust hospitals and face a series of health service disruptions, with some hospitals being turned into COVID-19 medical centres or specialised care appointments being cancelled. While it is essential to respect the customs and traditions of all communities, it is concerning to see many finding a misleading answer to their problems in miracle products (advertised even on television or radio!) that are not suitable for their health and can even be severely detrimental and negatively affect their condition management.”

Francis Zaballa Roquero, Our Views, Our Voices Global Advisory Committee, Mexico

Five years ahead of the 2025 global NCD targets and ten years ahead of the SDGs deadline of 2030, international commitments on NCDs have not translated into local action, and the vast majority of countries are off-track to meet these targets.²⁰ By compounding the increased vulnerability of PLWNCDs, the COVID-19 pandemic has shone a spotlight on the devastating barriers they face when trying to access the medical care, life sustaining medications, and health products, such as insulin, syringes, blood glucose monitors, and test strips, that are needed to manage their chronic condition.

While many of these obstacles are not new, the increased challenges faced by communities around the world have shown that business-as-usual approaches have not been working. It has also shed light on the limits of traditional access models to deliver better healthcare for PLWNCDs, especially for those living in LMICs.

Barriers to access to NCD care in LMICs are complex and multifaceted. For access initiatives, tackling these barriers means focusing on challenges of affordability, inadequate health system infrastructure, weak supply chains, inefficient procurement practices, inadequate human resources for health, and lack of public information and relevant training and education for PLWNCDs.

“

In communities around the world, PLWNCDs are afraid to seek routine care for their chronic condition for fear of acquiring the virus while at the clinic or hospital. Short prescription cycles mean that individuals must make a choice between staying home to protect themselves from infection and regularly accessing their medication. As a result of new local laws, many pharmacies are closed or have altered hours, thus impacting people's ability to access their medications. Many individuals who have travelled from urban areas back to rural areas to be with their families are likely to be unable to access care. Experience tells us that stockouts of NCD medicines and products will be an increased challenge if supply chains are disrupted and as resources within a facility/country are being redirected to the COVID-19 response.”

Molly Guy, Senior Program Officer, PATH²¹

20 NCD Alliance. NCD Atlas: Bridging the Gap on NCDs through Civil Society Action – Initiatives of national and regional NCD alliances. 2020. Available at: <https://ncdalliance.org/resources/ncd-atlas-bridging-the-gap-on-ncds-through-civil-society-action>

21 Guy, M. Taking critical action on NCDs during the COVID-19 response and beyond. NCD Alliance. 2020. Available at: <https://ncdalliance.org/news-events/blog/taking-critical-action-on-ncds-during-the-covid-19-response-and-beyond>

Given the complexity of NCDs, there are a number of limitations that traditional access initiatives have confronted when seeking to improve access for PLWNCDs. Some of these have been highlighted during stakeholder consultations and events organised by the NCD Alliance, as presented in the table below.

Cross-sectoral coordination and country ownership are dimensions that are sometimes overlooked

Many access initiatives remain dependent on the willingness of each stakeholder to keep it running. Often, they have been developed as a series of uncoordinated and competing pilots led by different companies, occasionally in the same countries but without country ownership by in-country stakeholders such as governments and civil society. A similar trend can be observed among multilaterals and development agencies, which have often structured their health programmes based on grant schemes rather than on the needs of the beneficiaries.

Stakeholders engaged in access initiatives are most likely to succeed by taking a systemic approach that recognises competing interests across all levels of the health system and engages complementary expertise from across civil society, academia, and private sector, including non-traditional players such as the IT industry. Sharing the same vision of success can help prevent the development of uncoordinated initiatives that are working in the same region and with the same public health facilities, and ensure that interventions are appropriate for the communities they serve and for the health system into which they will be integrated. This can also allow the development of comprehensive NCD access models that encompass prevention measures.

The needs of communities and PLWNCDs are not always perceived as vital for initiatives enabling access

Most of the time, access initiatives have been driven and shaped by company priorities and business growth rather than local needs, or are driven by corporate social responsibility (CSR) motivations, which can make them unsustainable since they are often detached from a company's core business.^{22,23}

Yet to be successful, scalable and sustainable, such models need to be aligned with national priorities, co-owned with governments, and shaped by and able to respond to the needs of PLWNCDs. They must also provide incentives for stakeholders to take them forward and sustain them.

The absence of clear accountability frameworks can confuse stakeholders on their respective roles

As many stakeholders have an interest in accelerating access for PLWNCDs, broad-based partnerships between governments and development agencies, relevant private sector companies, foundations and NGOs are essential, all having distinct competencies to bring in a collaborative response to act. However, the responsibility of all stakeholders to create sustainable ecosystems for access is multifaceted and complex. Very often, there is a limited understanding of the role that the many stakeholders involved in addressing access barriers must play.

Defining roles and responsibilities based on the unique skills and resources brought by governments, multilateral or development agencies, and the non-profit and private sectors is essential for accountability purposes and to ensure these efforts support a stable ecosystem that will facilitate sustainability in the long term.

22 Peterson, K et al. Measuring Shared Value Innovation and Impact in Health. FSG. Available at: <https://www.fsg.org/tools-and-resources/measuring-shared-value-innovation-and-impact-health>

23 Lilly. Global Health Programs Report. 2015. Available at: http://assets.ctfassets.net/srys4ukjcerm/6gOq251fmCarjzaGwh8h1r/3f3a5c89f5ab35464c4c1e644ce636c4/Lilly_2015_Global_Health_Programs_Report.pdf

The absence of common and harmonised metrics to monitor and evaluate access programmes can prevent the adoption of approaches that truly focus on value

The existence of measurement instruments that capture the complexity and variability of access from both the supply and demand sides and that look at the influence and characteristics of local health systems and individuals can make access initiatives more likely to achieve success, help define the initial targets, identify where these have to be adapted to local contexts, and establish corresponding accountability and reporting mechanisms.

It can also allow companies to move from financial performance indicators to include additional data that focus on patient outcomes and think through how this should be cascaded through all commercial processes and business functions and across their whole portfolio. It can inform approaches to move from philanthropic to market-based programmes, which is important to assess when those transitions are most likely to succeed.

The lack of data on the impact of current approaches limits transparency and sharing of best practices

The lack of data limits the ability to measure impact and adapt strategies for country-level action. Supporting greater investment in country assessments to prepare the launch of access initiatives should be encouraged as a good way to gather critical data on existing barriers. It is important to consider how these assessments can be brought to scale and involve more companies, so they can become more sustainable and nationally-relevant.

Data, methodology and the findings of analyses resulting from impact assessments should be made publicly available to allow other stakeholders to learn from and build upon these learnings. When made a public good, impact measurement can become more affordable for stakeholders to carry out, as they can draw from existing methodologies and models that have already proven effective and reliable.

SECTION 2

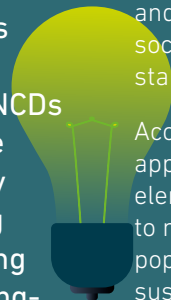
A NEW OPENING

Increasing the impact of novel approaches and business models to deliver shared value and improve access for PLWNCDs in the context of sustainable development

In recent years and in light of obstacles faced, it has become apparent that access for NCDs will not be achieved in a sustainable and equitable way through piecemeal approaches, nor by efforts that solely focus on profit. Efforts should not be limited to developing innovative models for companies to reach new populations affected by NCDs within LMICs. To be successful, novel business models for NCDs should aim to create a compelling value proposition for communities affected by NCDs by going beyond pricing, licensing and philanthropic initiatives and adapting to local conditions in order to ensure long-term and sustainable access to quality products and healthcare services for all (social impact case).

As a result, the development of new business models focused on 'shared value' has been a first step to rethinking the impact of efforts to address NCDs and help bring countries closer to achieving UHC goals. A number of healthcare companies have started to revisit their definition of 'access' to put people at the centre of the strategies – or become more 'patient centric' – in order to achieve commercial viability in LMICs and align their broader business performance and social impact with the expectations of shareholders, stakeholders and society at large.

According to the Access to Medicines Index, these approaches and innovative models share three main elements – they provide a clear improvement in access to medicines; they focus on meeting the needs of poor populations; and they clearly show how financial sustainability can be achieved in the long-term. In practice, they seek to put a greater focus on patient needs by proposing comprehensive approaches encompassing, for instance, more affordable price models, education on NCDs for PLWNCDs and healthcare providers, adapted product packaging and stronger local supply chains.



How businesses are creating shared value and measuring social impact in health: An overview of key concepts

Defining social impact and shared value in health

The idea of social impact is closely related to the shared value produced by organisations.²⁴ Defined as “investments made with the intention to generate positive, measurable social and environmental impact alongside a financial return”²⁵, impact investing aims to raise the bar for how investments can positively impact society.²⁶ It describes how capital can be directed to businesses that are serving societal needs; that is, how these companies create shared value.

“

A new wave of investors is using impact investing to address some of the greatest challenges of our time — from climate change and water scarcity to lack of access to health care, education, and affordable housing — with the intention of also generating a financial return.”

Judith Rodin, *The Power of Impact Investing* ²⁷

About the concept of shared value

Creating shared value is a recent concept, first set out in January 2011 in an article entitled “*Creating Shared Value: Redefining Capitalism and the Role of the Corporation in Society*”.²⁸ Written by Michael E. Porter, a leading authority on competitive strategy and head of the Institute for Strategy and Competitiveness at Harvard Business School, and Mark R. Kramer, leading researcher, writer, speaker and consultant on strategies for social impact and senior fellow at the Kennedy School of Government, Harvard University, the article provides insights and relevant examples of companies that have developed deep links between their business strategies and corporate social responsibility. In 2012, Kramer and Porter, through the global not-for-profit advisory firm FSG, founded the Shared Value Initiative to enhance knowledge sharing and practice surrounding creating shared value, globally.

Shared value is a business concept that describes how a company “*enhance[s] [its] competitiveness while simultaneously advancing the economic and social conditions in the communities in which it operates*”.²⁹

24 Bassi A. How to measure the intangible? Towards a system of indicators (S.A.V.E.) for the measurement of the performance of social enterprises. *Challenge Social Innovation*. 2012; 326-350. Available at: https://www.researchgate.net/publication/287127574_How_to_Measure_the_Intangibles_Towards_a_System_of_Indicators_SAVE_for_the_Measurement_of_the_Performance_of_Social_Enterprises

25 Global Impact Investing Network. What you need to know about impact investing. Available at: <https://thegiin.org/impact-investing/need-to-know/#what-is-impact-investing>

26 Global Impact Investing Network. Roadmap for the future of impact investing: Reshaping financial markets. 2018. Available at: https://thegiin.org/assets/GIIN_Roadmap%20for%20the%20Future%20of%20Impact%20Investing.pdf

27 Rodin, J and Brandenburg, M. *The Power of Impact Investing: Putting Markets to Work for Profit and Global Good*. Wharton School Press. 2014. Available at: <https://wsp.wharton.upenn.edu/book/the-power-of-impact-investing/>

28 Porter, M and Kramer, M. Creating Shared Value. *Harvard Business Review*. 2011;01. Available at: <https://hbr.org/2011/01/the-big-idea-creating-shared-value>

29 Peterson, K et al. *Measuring Shared Value Innovation and Impact in Health. A Guide for Corporate Practitioners*. 2014. Available at: <https://www.fsg.org/tools-and-resources/measuring-shared-value-innovation-and-impact-health#download-area>

The process of shared value creation at a glance

In health, shared value can be created through an innovative, multi-level approach.³⁰ The first level involves reconceiving products and markets by adapting existing products to reduce their overall cost and complexity, tailoring products to meet local market conditions and needs, and strengthening R&D to create vaccines, medicines, and/or devices that can fill unmet health needs.³¹ Redefining productivity in value chains encompasses the second level, as effective collaboration aimed at the enhancement of local supply chains and manufacturing can improve sales and distribution, reduce production cost and risk, and open new markets.³² This is further supported in the third level, as there is a focus on enabling local cluster development through health system strengthening, awareness campaigns for increased access to healthcare, and effective advocacy for a supportive environment.³³ The creation of shared value within health, utilising innovations across the three levels, is an opportunity to build multi-stakeholder partnerships and develop novel solutions to address complex public health threats.

When it comes to impact investing and health, it is now well-established that companies can positively impact the health of communities and PLWNCDs. For instance, evidence shows that when there is a focus on the early detection and prevention of NCDs, companies can play an unprecedented role in improving health outcomes for PLWNCDs and reducing overall costs to communities and society. Companies can also create shared value in global health as they compete in improving health outcomes for the underserved.³⁴ Instead of competing for market shares, companies determine success based on their ability to improve health outcomes by building and serving new markets.

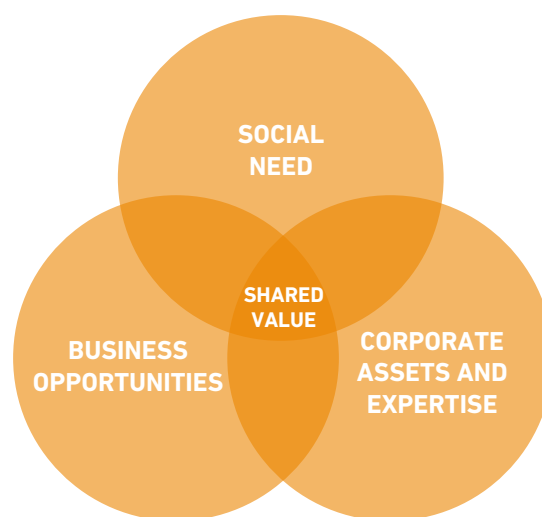


Figure 2. The components of shared value

Why is measurement critical to create shared value?

Measuring social impact has been an ongoing challenge for companies in regard to assessing whether their interventions have had the intended impact.³⁵ Because shared value initiatives are often considered risky experiments by companies, evidence of social and business value creation – gathered through measurement – is needed to convince corporate decision makers and their investors of their strategic and commercial relevance.

In this context, shared value measurement plays a key role in informing strategic decisions and resource allocation and in making the case internally within companies to pursue these approaches.³⁶ It also provides evidence of a company's commitment to the underserved, an important component in multistakeholder partnerships in which transparent measurement and reporting are needed.

30 Kramer, M and Pfitzer, M. The Ecosystem of Shared Value. Harvard Business Review. 2016;10. Available at: <https://hbr.org/2016/10/the-ecosystem-of-shared-value>

31 Peterson, K et al. Measuring Shared Value Innovation and Impact in Health. A Guide for Corporate Practitioners. 2014. Available at: <https://www.fsg.org/tools-and-resources/measuring-shared-value-innovation-and-impact-health#download-area>

32 Ibid.

33 Ibid.

34 Kramer, M and Porter, M. Competing by Saving Lives: How Pharmaceutical and Medical Device Companies Create Shared Value in Global Health. FSG. 2012. Available at: <https://www.hbs.edu/faculty/Pages/item.aspx?num=46696>

35 Rockers, P et al. Effect of Novartis Access on availability and price of NCD medicines in Kenya. The Lancet. 2019. Available at: [https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(18\)30563-1.pdf](https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(18)30563-1.pdf)

36 Hills, G and Pfitzer, M. Measuring the impact of shared value. The Guardian. 2012. Available at: <https://www.theguardian.com/sustainable-business/shared-value-measuring-impact-social-problems>

Two fundamental components of measurement are needed for companies and partners to achieve shared value success³⁷:

1. **Measuring the Innovation:** Through new products, operations, and contributions to health systems, companies are improving coverage and ensuring appropriate use with new tiers of customers. Training health workers and increasing awareness for a disease, for example, are two common areas for innovation. In all cases, companies must understand whether their efforts are in fact improving coverage and use, and therefore increasing demand for the company's products and services.
2. **Measuring the Impact:** Impact is the extent to which shared value investments actually result in better health outcomes, as well as the extent to which these outcomes grow business prospects, such as sales growth or product differentiation, over time. In other words, how business interests intersect with societal needs.

In order to better understand how business interests intersect with societal needs, measurement frameworks need to be anchored in a robust initial analysis of unmet needs, and of the behavioural and system barriers requiring investment and innovation. This is critical to setting explicit targets and articulating a clear pathway to social and business value creation.

“

The bar to build back better has been set higher with the COVID-19 pandemic (...) and this raises questions for the private sector on how to best allocate resources to contribute. There are 2 gaps to social impact measurement in particular that will need to be addressed urgently to guide investments. The first one is to better understand the causality linkages between upstream investments in health systems through access programmes and how these translate into real life patient outcomes for individuals and populations. The second opportunity is to quantify how the resulting societal outcomes are linked to business performance to inform how a company can more intentionally connect social and financial objectives and deliver value in a mutually reinforcing way”.

Dr Sebastien Mazzuri, Managing Director, FSG, at the virtual event on 'Revisiting social impact in the COVID-19 era: Achieving greater access for people living with NCDs through people-centred care' held on 22nd September 2020

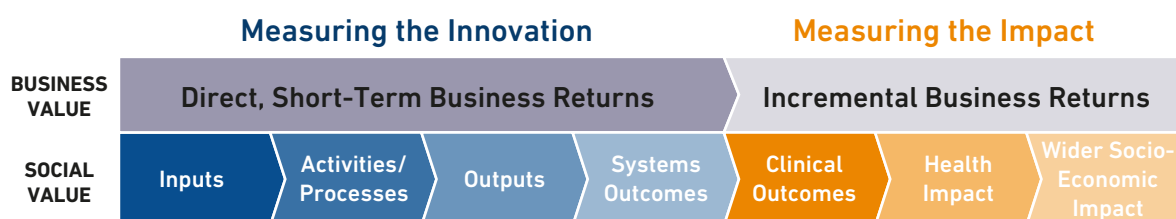


Figure 3. Component of shared value measurement³⁸

37 Porter, M et al. Measuring Shared Value: How to Unlock Value by Linking Social and Business Results. FSG. 2011. Available at: https://www.hbs.edu/faculty/publication%20files/measuring_shared_value_57032487-9e5c-46a1-9bd8-90bd7f1f9cef.pdf

38 Peterson, K et al. Measuring Shared Value Innovation and Impact in Health. A Guide for Corporate Practitioners. 2014. Available at: <https://www.fsg.org/tools-and-resources/measuring-shared-value-innovation-and-impact-health#download-area>

How social impact and shared value programmes can help inform approaches to improve access for PLWNCDs beyond businesses

As NCDs continue to challenge the integrity of health systems, the concept of shared value offers a new way of thinking for companies. Not only does it offer a framework to effectively generate economic value while meeting the needs of low-resource populations, but it also presents opportunities for how companies can collaborate and play a critical role in the healthcare ecosystem to contribute to overcoming existing barriers, especially in terms of access. More than a reporting tool, shared value measurement has the potential to help inform multistakeholder initiatives in a positive manner.³⁹ In this sense, achieving social impact in the field of NCDs should not be seen solely as the prerogative of private sector companies. Beyond businesses, it can serve to engage sectors, such as non-profit and multilaterals, to inform the development of sustainable and scalable programmatic strategies focused on achieving social impact. In that sense, thinking through how social impact can collectively be achieved can help build a compelling value proposition, both for generating investments to address the needs of PLWNCDs and ensuring long-term and sustainable access to healthcare for communities.

While on paper there are many benefits of combining a business case with a social impact case, it is evident from early examples that it remains a challenging balancing act. These models are still relatively new in the field of NCD access, and so are ways they are being rolled out and measured for outcomes and impact. To date, shared value discussions have not explored the implications for health care, and these types of models have not featured prominently in sustainability and integrated corporate reporting, or the development of related indices. In the absence of a guiding framework for social impact to inform how to best serve the needs and priorities of PLWNCDs, companies have been adopting a variety of different uncoordinated approaches, limiting their reach and impact. With the heterogeneity of methodologies and indicators used, there is also no single impact measure that can be widely applied across these various business models, in particular in terms of how the needs of PLWNCDs are met. The complex NCD environment makes it even more challenging to demonstrate that interventions have the intended social impact for communities.



If the pharmaceutical industry truly wishes to give back to society, it must measure what the society needs, which is affordability. Pharmaceutical companies should promote meeting the social Key Performance Indicators as much as the financial Key Performance Indicators.”

Participant at a roundtable event entitled ‘Partnering for Impact: Innovative Solutions & Novel Business Models to Accelerate Access to NCD Care in LMICs’ organised on the sidelines of the 73rd UN General Assembly, September 2019

To address these challenges, there is a need to ensure that access models are driven by the needs of the affected populations, so that PLWNCDs’ interests are at the centre of the shared value strategies that seek to reconcile social objectives and financial viability. In this way, they do not seem to be at odds, but are complementary, propelling and informing each other. To achieve this, it is important to understand how the concept of social impact originating from the corporate world can offer an avenue for all stakeholders to work together and maximise the impact of existing and future multistakeholder initiatives.

³⁹ OECD and European Commission. Policy Brief on Social Impact Measurement for Social Enterprises. Publications Office of the European Union. 2015. Available at: https://www.oecd.org/social/PB-SIM-Web_FINAL.pdf

SECTION 3

THE OPPORTUNITY

Putting PLWNCDs at the centre of social business models for improving NCD access and supporting their meaningful involvement

The concept of social impact has essentially been seen by some as a business concept used by private sector companies to describe access strategies that seek to strike a balance between financial and social objectives. As such, shared value has been approached mainly through a corporate lens, without giving the opportunity for PLWNCDs to help articulate and define the social issues that affect them and prevent universal access to NCD care.

In response to this, it is essential to ensure that these strategies adopt a people-centred approach to flip their focus towards the needs of people. In addition, for social impact to be utilised to its full potential in the context of NCD prevention and control, it is important to see how it can serve to facilitate the development of a common vision and a shared purpose across sectors and stakeholders, acknowledging their different drivers and keeping in mind the ultimate goals of achieving sustainable access for PLWNCDs. Embedding a people-centred approach more intentionally and systematically at the foundation of NCD programming can yield the greatest social impact to PLWNCDs while ensuring sustainability.

“

People must understand that we have been looking for engagement with the private sector for a long time. They need to understand the clear image and stats, know the numbers, what the situation is; but we should not wait for people to come and ask you.”

Individual with lived experience of NCDs at the NCDA-led Focus Group Discussion (4 September 2020) to consult with PLWNCDs for the discussion paper



Addressing the limitations of shared value approaches by building a theory of change based on people-centred models for NCDs

The importance of people-centred care models for NCDs

Delivering people-centred healthcare has been widely recognised as a core aim of health systems around the world. According to WHO, the realisation of integrated people-centred health services will depend on achieving a compelling vision in which *“all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment.”*⁴⁰

BOX 2

WHO's Framework on Integrated, People-centred Services

WHO's Framework on Integrated, People-centred Services defines five interdependent strategies. They are: (1) involving people and communities; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment. The attainment of each strategy is underpinned by an approach to care that is “co-produced” and consciously includes the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that are organised around the comprehensive needs of people rather than individual diseases, and respects social preferences.

It is based on the prerequisite that individuals are equipped with the information, education and support they need to make decisions and participate in their own care, and that carers are able to attain their optimal function within a supportive working environment.

The concept of people-centred care has become a central consideration in the healthcare experience of PLWNCDs in terms of how they experience access. It has also become a key component of strategic planning for health care providers. People-centred care is broader than patient-centred care, as it encompasses health promotion and prevention for all people within the community and recognises their crucial role in shaping health policy and services beyond the health system.

In the context of NCDs, adopting a people-centred approach to healthcare delivery requires the adaptation of delivery models to the changing needs of PLWNCDs, across the care pathway and the life course. For a people-centred approach, it is also key to change the relationship that PLWNCDs have with their health system, and create a supportive environment where they feel supported in addressing their conditions and have the information and tools they need to manage their own health. In this way, it becomes possible to deliver better care and strengthen the underlying health system, thereby expanding access and improving outcomes.



It is essential we invest in educating PLWNCDs to eradicate the stigma as well as negative mindsets towards NCDs (...). As long as PLWNCDs feel ashamed of our conditions, we won't be empowered enough to accept our conditions and manage them as would be required in a people-centred approach. PLWNCDs are ambassadors in the community and it's important they have the right mindset and are disseminating accurate information.”

Individual with lived experience of NCDs at the NCDA-led Focus Group Discussion (4 September 2020) to consult with PLWNCDs for the discussion paper.

40 World Health Organization. Framework on integrated, people-centred health services. 2016. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1

The Global Advocacy Agenda of People Living with NCDs: Recommendations of PLWNCDs that provide a compass for NCD-related action

Often affected by multiple conditions, PLWNCDs have regular interactions with the health system, throughout their life, which makes them into experts in recognising gaps and barriers in accessing healthcare. Consulting PLWNCDs about their expectations and needs of health services and care is essential when designing and implementing initiatives and programmes to improve health outcomes.

Acknowledging the value of the lived experience, the NCD Alliance consulted PLWNCDs from around the world on their needs, challenges and priorities. The consultation efforts, which included an online survey and 72 in-person community conversations, resulted in the Advocacy Agenda of People Living with NCDs. It is comprised of the insights and recommendations of nearly 2000 PLWNCDs, and is based on four key pillars: human rights and social justice; treatment, support and care; prevention; and meaningful involvement. The Advocacy Agenda serves as a compass for the NCD response, dedicated to promoting meaningful involvement of PLWNCDs and calling for a people-centred response. Drawing from the recommendations highlighted in the Advocacy Agenda, stakeholders are prompted to meaningfully involve PLWNCDs and consider how they can achieve social impact for communities affected by NCDs.⁴¹

“

No measure of technical knowledge can replace the insight of the lived experience.”

Advocacy Agenda of People Living with NCDs

BOX 3

The Global Advocacy Agenda of People Living with NCDs

We, people living with NCDs, call for:

Increased availability, access, and funding for early diagnosis of NCDs.

Affordability of treatment and financial protection for those affected by NCDs.

Access to trained quality healthcare providers at all levels specifically on NCDs.

Quality and up to date training on NCDs for health care providers.

Ensuring universal and equitable access to treatment for NCDs.

Comprehensive care (combined medical, psychological, and social support) for those with NCDs.

Improved access to new treatment options and clinical trials for NCDs.

Disease management education and counselling for self-care skills for those with NCDs.

The creation of standards and guidelines to link clinical and community support programs for NCDs.

Improved access to psychological care for those with NCDs.

Addressing end of life and palliative care for NCDs.

We, care partners, call for:

Increased access to respite care for care partners of people living with NCDs.

Providing access to affordable treatment, care, and support for those living with NCDs.

Providing care partners with information and assistance, counselling and support groups, and training on skills needed for caring for those living with NCDs.

41 NCD Alliance. Advocacy Agenda of People Living with NCDs. 2018. Available at: <https://ncdalliance.org/resources/advocacy-agenda-of-people-living-with-ncds-0#:~:text=The%20Advocacy%20Agenda%20of%20People,Views%2C%20Our%20Voices%20consultation%20efforts.&text=It%20is%20intended%20to%20guide,improve%20NCD%20prevention%20and%20control.>

Treatment, care and support within national advocacy agendas of People Living with NCDs: the examples of India, Mexico, Ghana and Kenya

The **Ghana Advocacy Agenda of People Living with NCDs** was built with inputs from over 100 PLWNCDs in Ghana in 2018



TREATMENT CARE and SUPPORT



CONTEXT

We, people living with NCDs, endure long-term contact with health delivery systems at multiple levels. We live with chronic conditions and disabilities that require regular treatments and this pose tremendous financial burdens on our families.

We deserve to be supported by government institutions, healthcare providers, families and friends. We are not simply our conditions and disabilities, we are human beings.

We need more information of our disease conditions in order to manage them better, ensure treatment adherence, and ensure our self-improvement.

We have seen that many health professionals are not trained to give proper care and our health facilities are not affable towards meeting our needs. We need friendly healthcare professionals, we need our opinions to be respected and an enabling environment to freely ask questions.

People living with NCDs bear severe out-of-pocket expenditures due to lack of insurance and adequate financial risk protection. Given the fear of going to hospitals, we seek healing and treatment at unapproved centers. Awareness related to modernized and science-based treatment is critical to ensure that everyone with NCDs can access quality services.

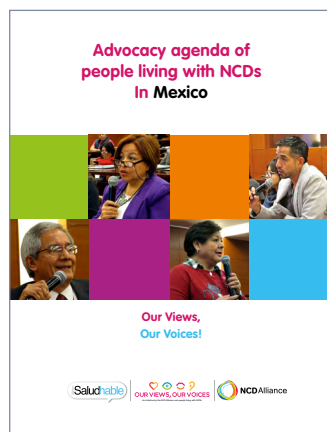
The huge costs associated with the treatment and care of NCDs have caused many people living with NCDs to lose their businesses and income, leading to total neglect by their families and friends.

Opportunities to create an affordable, integrated and people-centered healthcare system, that respond to our 'real needs' exist and must be harnessed.

We, people living with NCDs in Ghana, call for:

- Availability of comprehensive services for early detection, diagnosis, treatment, psychological, rehabilitative, palliative care for those with NCDs
- Mandatory general/periodic health screening covering all kinds of cancers, blood pressure, diabetes, body mass index for early detection of NCDs cases
- Access to safe, and quality approved medicines, treatment and care
- Access to new treatment options for NCDs
- Affordability of treatment and financial risk protection for those affected by NCDs
- Expansion of the National Health Insurance Scheme to cover no less than 50% of comprehensive services, treatment and care of NCDs
- Quality training on NCDs and continued professional development for health care providers
- Prohibition on the sale of unapproved herbal remedies for NCDs
- Decentralized healthcare services that enable access at the local level including equipping Community-based Health Planning and Services (CHPS) compounds and health centers with physiotherapy facilities, especially in hard to reach places
- Training, counseling and support for people living with NCDs and disabilities on self-management
- Total adherence to medical treatment and care by people living with NCDs as against spiritual and superstitious belief in treating NCDs
- Respect for informed choice on available treatment options for people living with NCDs

The **Advocacy Agenda of People Living with NCDs in Mexico** was built in 2018 following consultations with people living with a wide range of NCDs in Mexico



II. About Treatment, Care and Support



Protect the health budget against the reduction and diversion of resources.

Earmark the revenue collected from the taxes on tobacco, alcohol and ultra-processed foods and beverages for the strengthening of NCD prevention and treatment programmes.

Provide needed and timely treatment to PLWNCDs, always based on scientific evidence.

Strengthen primary care actions in national and sub-national health systems.

Sensitise and train health professionals to provide humane, dignified and respectful treatment.

Establish measures to promote bulk or consolidated purchasing of medicines and medical equipment, in order to avoid corruption.

Guarantee universal and equitable access to the continuum of care for NCDs, from preventive services, timely diagnosis, psychological care, rehabilitation, to palliative care.

Promote access to and availability of medicines in health facilities to reduce out-of-pocket expenses.

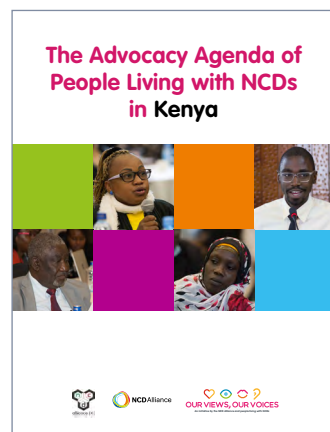
Guarantee the multidisciplinary training of health professionals with the necessary skills to address NCDs at all levels.

Provide information, assistance and psychological attention to caregivers of PLWNCDs.

Improve access to new therapeutic options for the treatment of NCDs.

Facilitate the right of patients to obtain a second medical opinion.

The **Advocacy Agenda of People Living with NCDs in Kenya** was built in March 2018 as a result of a two-day consultative process involving 135 people, including 52 PLWNCDs, caregivers, Kenyan Ministry of Health officials, Country First Ladies, NCD Alliance of Kenya members as well as other stakeholders.



LEVEL PLWNCD groups and individuals



ADVOCACY ASKS

- Offer Peer-to-peer support at various levels
- Coordinate with health workers and health facilities to avoid duplication of efforts to maximize resources
- Break silence and address stigma and discrimination
- Adhere to treatment and self-management good practices
- Harness power of personal testimonies
- Take any opportunity available to champion the NCDs agenda
- Power Drive change at the household level

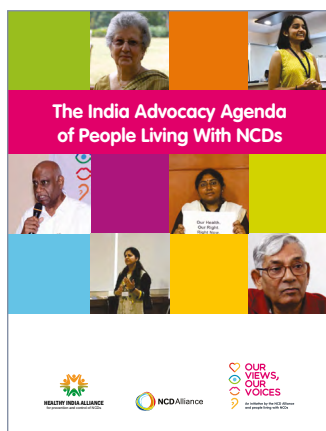
LEVEL Business Community



ADVOCACY ASKS

- Forge Long-term commitment to support NCDs
- Establish Workplace wellness programmes
- Private insurance**
 - Explore models to ensure insurance coverage for PLWNCDs
- Pharma**
 - Reduce the cost of treatment to enable access to the poor
 - Support health system strengthening
 - Support empowerment of PLWNCDs
 - Invest in evidence generation and use
- Employers**
 - Job security
 - Negotiate for better insurance packages for their employees

The **India Advocacy Agenda of People Living with NCDs** was built in December 2019 following consultations with 82 PLWNCDs and 43 CSOs working on issues related to people centred care.



Treatment, Care, and Support

The chronic and often lifelong nature of NCDs demands an integrated, responsive and person-centered health systems approach. People living with NCDs have multiple ongoing interactions with the health system over long periods of time and may require disability management, such as rehabilitation and long-term care. We, PLWNCDs have to manage our conditions on a daily basis, making decisions at every step of the way. Thus, education is a key component in achieving person-centered care and enabling us to make informed decisions.

We have the right to receive comprehensive and integrated treatment, care, and support services so that we also lead productive lives and contribute to our societies. We demand universal and equitable access to treatment and inclusivity across all socio-economic strata. We demand to be treated with humanity and dignity in our health systems which must be equipped with the knowledge and tools to understand and actively manage our NCDs. There is ample evidence to show that lives have been saved by cost-effective interventions and solutions for NCDs. We have waited long enough and will not bear the human and economic price of inaction anymore.

We refuse to let our situation be ignored, as more of us die each day.

We, people living with NCDs, call for:

Promoting palliative care services to ease out the conditions, symptoms and stress due to NCD management, especially in geriatric care.

Integration of palliative care training as a part of medical curriculum to transfer a deep sense of empathy to build a system of comprehensive care which includes medical, psychological and social support.

Recognising the role of care partners as the major therapeutic force in supporting PLWNCDs in their NCD journey.

Affordable and accessible medicines, vaccines, treatment and financial protection for those affected by NCDs including formation of robust national health insurance policies.

Availability of early screening, diagnosis and treatment services.

Access to information on side effects of a treatment and an opportunity to make a selection of the kind of treatment to be opted.

We, care partners, call for:

Support (emotional and financial) and counseling to deal with the stress.

Improved attitude and behaviours of health care providers to impart empathy.

Human rights-based approach to NCD treatment and care.

Increased access to respite care for care partners of PLWNCDs.

Creating a safe space to seek support when dealing with NCDs.

People first: Resetting the concept of social impact

Promoting a people-centred approach depends on giving highest importance to the subjective aspects of health conditions. While many business models have been underpinned by ‘patient-centricity’ or ‘people-centredness’, the proliferation of approaches that resulted from the absence of a commonly agreed guiding framework on measuring progress have led to piecemeal approaches, highlighting the challenges for such models to generate innovation and value for all.

In order for all organisations, beyond businesses, that are involved in health programming for NCDs to see the value of supporting social impact, an understanding is needed of what it is, why it is important and how to practice it. This will lead to improved health service delivery, provided in a way that better meets the needs of PLWNCDs and facilitates the adoption of context-relevant approaches and initiatives for organisations.

To do so, there is a need to put people at the centre of social impact approaches. By reflecting on PLWNCDs’ recommendations and their role in shaping how long-term and sustainable access to healthcare for NCDs should be achieved, the Advocacy Agenda is a key resource to further build on the priorities of PLWNCDs. It can inform a broader framework to support the adoption of people-centred approaches by stakeholders involved in health programming for NCDs and hold them to account. Such a framework should serve to identify key challenges or greatest needs across the continuum of care in order to improve the functioning of the system in a way that not only reflects people’s well-being, but also provides a broader understanding of areas where social impact can be achieved. Ultimately, the framework should provide a tool to encourage and guide organisations in building their efforts to create a compelling value proposition that will expand access to healthcare for PLWNCDs.

“

There is a trend of putting PLWNCDs on advisory boards to express what their demands are. However, PLWNCDs will react more naturally in a peer group, where they will not feel intimidated by the environment. Ensuring PLWNCDs are able to speak in a context where they feel safe/comfortable is critical to ensure a fair representation of their needs.”

Individual with lived experience of NCDs at the NCDA-led Focus Group Discussion (4 September 2020) to consult with PLWNCDs for the discussion paper.

Applying a people-centred lens to social impact: linking the success of health programmes to achieving better outcomes for PLWNCDs

Achieving people-centred care for NCDs

The challenges faced by PLWNCDs highlight a number of complexities that can arise at multiple levels across a particular healthcare ecosystem, including prevention, screening, diagnosis, treatment, care and support. Access has been a shorthand term to describe this broad set of concerns that focus on the ability of individuals to obtain needed services from the health systems. In most cases, the reasons for inadequate healthcare services for NCDs stem from factors including underdeveloped healthcare infrastructures, often geared towards siloed care or acute infectious diseases; systemic bottlenecks; affordability issues; and inadequate financing systems. Due to poor quality control and procurement practices, and inconsistent regulation policies, another challenge for NCDs is ensuring safe, quality essential medicines and technologies. Shortages of skilled healthcare professionals pose additional barriers to accessing specialist care for NCDs.

Access has been conceptualised as “the fit between the patient and the health care system”.⁴² This means to say, the better the fit, the better the access.⁴³ Access is about enabling individuals to receive the right care, from the right provider, at the right time, and in the right place, dependent on context. In the context of NCDs, access needs to be considered from a holistic perspective, taking into account local health system infrastructure and individuals’ socio-economic context. It also needs to be considered as part of a broader UHC agenda.

“

Universal Health Coverage is fair, effective and the only way to ensure equitable access to NCD prevention and care.”

Our Views, Our Voices UHC consultation participant with lived experience of cancer and autoimmune disorder

Through this approach, access is seen as resulting from the interface between people, households, social and physical environments and the characteristics of health systems, organisations and providers. It can be defined as the opportunity to understand and identify healthcare needs; to seek, obtain or use healthcare services; and to have the need for healthcare services fulfilled without suffering financial hardship.

Conceptualising access at the interface of health systems and PLWNCDs

As a multi-dimensional concept, existing approaches often fail to reflect the experiences and realities of PLWNCDs in accessing the healthcare services they need. As a result, most organisations use a wide variety of performance metrics that vary considerably from one access programme to another, limiting both the potential to compare the impacts of these initiatives and their ability to truly address the needs of those they serve. Therefore, there is a need to better identify the indicators that should underpin efforts to expand access to healthcare.

“

We need to understand how these models serve the interests of PLWNCDs by looking at their effectiveness to address the different dimensions of access. PLWNCDs are the true resource you need to drive social impact.”

Christopher Agbega, Member of Our Views Our Voices committee, at the virtual event on ‘Revisiting social impact in the COVID-19 era: Achieving greater access for people living with NCDs through people-centred care’, held 22 September 2020

⁴² Penchansky R, Thomas WJ. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19:127–140. doi: 10.1097/00005650-198102000-00001.

⁴³ Penchansky R, Thomas WJ. *Ibid*.

The conceptual framework of access to healthcare⁴⁴ that is built upon the 5A's of Access has helped to better understand the different dimensions that organisations involved in health programming for NCDs should seek to address. It also provides insight to understand how the case studies presented in the following section generate value for people first.

For the purpose of this paper, an adapted version of this model is used, which adds a sixth dimension to the existing five:

1 Approachability (ability to perceive)



Relates to the ability of people with health needs to identify that some form of service exists, can be reached, and can have a positive impact on their health. Various elements contribute to facilitating PLWNCDs' awareness of services, such as health literacy, knowledge about health and sickness, transparency, trust and expectations.

“

Healthcare workers cannot provide counselling all the time, especially during COVID-19, and you become a doctor on your own, but it's not your job and you should receive training for that. That type of information and training would be invaluable.”

Participant at the NCDA-led Focus Group Discussion organised on 3 September 2020 to consult with PPLWNCDs for the present report.

2 Acceptability (ability to seek)



Relates to cultural and social factors determining people's ability to accept different aspects of the health service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the perceived appropriateness of people seeking care. In other words, the extent to which PLWNCDs are comfortable with the characteristics of their providers (and vice-versa) and their health options.

“

Some healthcare workers at the national referral hospital only see you depending on your socio-economic status. If you look like you have money, they will happily attend to you.”

Our Views, Our Voices Advocacy Agenda 2017 consultation participant, Uganda

3 Availability (ability to reach)



Constitutes the physical existence of health resources with sufficient capacity to provide services. It results from characteristics of facilities, individuals (e.g. duration and flexibility of working hours), providers (e.g. presence of HCPs, qualification) and modes of service provision.

“

...at the health centre they announce it to your face 'there are no drugs.' So I call upon the government to put plenty of drugs in the health centres, so that we can be served.”

Our Views, Our Voices 2017 consultation participant, Uganda

44 Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*. 2013;12:18. doi:10.1186/1475-9276-12-18.

4 Affordability (ability to pay)



The measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). It is influenced by the wider health financing system and by household income.

“

I was due for treatment but missed out on the appointment due to lack of funding. The mental torture of not knowing if you will be able to afford the treatment and the consequences of stopping halfway before achieving remission [is terrible].”

Our Views, Our Voices UHC consultation participant, Kenya

5 Appropriateness (ability to engage)



The extent to which the provider's operation is able to meet people's preferences (hours of operation, scheduling practices, communication options). It relates to the fit between services and need, timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided.

“

Sometimes, health programmes are addressing the perceived needs, but not meeting the actual needs. As a result, you have to go through a lot to find the right point of care. Access to [the] healthcare system doesn't really give you the access you want, and it affects your mental health.”

Participant at the NCDA-led Focus Group Discussion organised on 3 September 2020 to consult with PLWNCDs for the present report.

6 Actors (ability to mobilise)



To best address the above dimensions, successful models will need to support the development of a sustainable ecosystem of actors and partners, as part of a whole of society approach to NCDs that calls on all sectors to step up and highlight the central role that civil society and people living with NCDs play within health governance, planning, accountability and multisectoral partnerships.

“

People living with NCDs need to be strong in voicing of needs of the general society in terms of access to treatment, awareness, prevention and control. There is a need to push the government on policies affecting the general health welfare in our community. The civil society plays a big role in engaging the government. Dialogue is key.”

Our Views, Our Voices 2017 consultation participant, Kenya

Building on this conceptual framework, it is key to understand how these dimensions can translate into reality and be incorporated into initiatives that seek to increase access for communities affected by NCDs and ensure programme implementation is driven by the needs of affected communities. The framework has served as a basis to better identify the dimensions that organisations involved in health programming for NCDs should seek to address (see section 3 on case studies) and how they can translate into more concrete indicators (see section 4 on the framework).

SECTION 4

CASE STUDIES

Exploring how the NCD community can use a people-centred approach to enhance shared value creation in health programming for NCDs and improve access for PLWNCDs

The case studies presented below offer examples of how the different dimensions of the 6As of Access framework can be applied to a diversity of NCD access initiatives. They explore how the framework can serve to design and implement relevant pathways to generate value for communities affected by NCDs in the long-term.

The case studies described are all multi-sectoral, with implementing partners from the public and private sectors, and civil society.

The first series of case studies present initiatives led and implemented directly by private sector companies, while the second series highlights examples of initiatives led and implemented by non-profit organisations to support an environment enabling greater access for PLWNCDs.

In RED:
Shared value initiatives led by private sector companies

In GREEN:
Shared value initiatives led by non-profit organisations

Key features of each programme are described under the highlights section—including the disease area and the barriers that PLWNCDs face when accessing health services in each context, and what steps each programme has taken to address these challenges. The insights section describes the impact the programme is having on PLWNCDs and explains how each case study is adopting a shared value and/or people-centric approach. In some cases, additional analysis is given on how a shared value and/or people-centric approach could be taken further.

Shared value initiatives led by private sector companies

Novo Nordisk Base of the Pyramid Programme: Building Sustainable Access Solutions Through Shared Value⁴⁵

For the many people living with diabetes in LMICs, access to quality diabetes care comes with many barriers, often complex and going beyond medicines. Drawing from experience over many years with differential pricing for its human insulins, Novo Nordisk has had to recognise that there are many other elements that need to be in place for the medicine to actually reach the patient at an affordable level, and improve the management of their diabetes. The Base of the Pyramid (BoP) programme was created in 2010 with the purpose of identifying sustainable business models to increase access to diabetes diagnosis, treatment and control for people living at the base of the economic pyramid, in a way that was meaningful for both patients and the partners involved.

OBJECTIVE

To provide a stable and affordable insulin supply, access to quality care, and support improved self-management for patients at the base of the economic pyramid.

PARTNERS

BoP works through public–private partnerships to improve access to diabetes care.

COUNTRIES

Kenya, Nigeria, Ghana, Senegal, and Morocco

DATE

2010 – ongoing

HIGHLIGHTS

At least half of the world's population cannot obtain essential health services, including essential medicines such as insulin⁴⁶. This is especially true in LMICs where the majority of people with diabetes live. As diabetes is often not a recognised healthcare priority, access to diabetes care is impacted by many different factors (see Fig. 4). Only less than half of the 38 million people living with diabetes in Africa are diagnosed⁴⁷, and it is, hence, not surprising that many develop serious complications and related conditions. As the world's largest provider of insulin, Novo Nordisk sees it as both a responsibility and a business opportunity to support local health authorities and other stakeholders in making sure that insulin reaches those who need it.

Figure 4. Typical barriers to access to diabetes care



⁴⁵ Penchansky, R and Thomas, JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127-40. doi: 10.1097/00005650-198102000-00001.

⁴⁶ Joint WHO/World Bank Group. Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development / The World Bank. 2017.

⁴⁷ International Diabetes Federation. IDF Diabetes Atlas, 9 ed. Brussels, Belgium: International Diabetes Federation. 2019.

When starting out in Kenya, Novo Nordisk conducted several rounds of stakeholder consultations to map the challenges, which needed to be addressed. This was the beginning of a co-creation and involvement process that has been one of the programme principles in each of the five implementation countries. It was clear that, to ensure that people with diabetes get diagnosed and are able to access the care they needed, and ultimately manage their condition, a holistic, sustainable approach was required. The BoP programme is therefore implemented through five intervention tracks, all essential to address the unmet needs of the patient:

- Awareness and screening
- Strengthened physical infrastructure
- Improved healthcare professional capacity
- Stable and affordable insulin supply
- Patient education and self-management.

INSIGHTS

In all countries, Novo Nordisk works in close partnership with the Ministries of Health and local champions and stakeholders, and all BoP facilities are established within the existing public health system. Patient associations play a critical role, as they drive community outreach, patient support groups and awareness and educating activities. The BoP programme tracks are adapted to the local contexts, addressing barriers and unmet patient needs in the specific stakeholder environments, aiming to define the most appropriate intervention in each setting.

In Kenya, Ghana and Nigeria, Novo Nordisk partnered with national faith-based networks, who provide health care to large populations in these countries, and are critical to reach people in remote areas, far away from major hospitals. To ensure a stable supply of affordable insulin at community level, a critical element of the BoP programme, both commercial and faith-based local distributors and wholesalers were brought on board from the beginning as equal partners. In Kenya, the partners discussed the supply and affordability of insulin, agreeing on a patient price point that was seen as a balance between charity and profit, but also ensured the financial sustainability of the programme, allowing each actor to make a profit – a key element of shared value. Today, insulin is consistently available at this affordable price across Kenya (USD \$5 per vial, corresponding to one month's consumption).⁴⁸

An independent assessment study by University College London (UCL) found that the programme has managed to increase access to diagnosis and treatment, but also to raise awareness and provide a stable supply of insulin in Kenya.

As of 2019, more than 80,100 people have accessed care through the BoP facilities, more than 6,100 health workers have been trained in diabetes care, and more than 2 million people were reached through diabetes awareness campaigns. 23 diabetes support centres and centres of excellence have been established, with an additional 405 faith-based facilities running capacity-building and patient education activities.



One strength of BoP is the ability to price-regulate vials of insulin to 500 Kenyan shilling at consumer level. This has ensured a more consistent demand and supply cycle."

UCL, evaluating Novo Nordisk's Base of the Pyramid programme in Kenya.

The programmes in Nigeria, Ghana and Senegal are planned to be evaluated by Dalberg Kenya end 2020 – beginning of 2021.



We firmly believe that multi-stakeholder partnerships are needed to find sustainable solutions to improve access to care, adding value to both society, PLWNCDs and private sector. Working in partnership with patient associations ensures that we can achieve the desired impact."

Soraya Ramoul, Senior Director, Global Access to Care, Novo Nordisk.

⁴⁸ Novo Nordisk. Base of the Pyramid programme. 2017. Available at: https://www.novonordisk.com/content/dam/Denmark/HQ/sustainablebusiness/performance-on-tbl/Acess%20to%20care/BoP/BoPevaluationbyUCL_2017.pdf

Takeda's Access to Medicines Patient Assistance Programs (PAPs): How to Create Shared Value at Every Stage of the Patient Journey^{49,50}

As a cornerstone of its Access to Medicines strategy, Takeda has pioneered its Patient Assistance Programs (PAPs) to increase access to some of its most innovative medicines through collaborative financing models designed around individual patients.

OBJECTIVE

To maximise medical benefits and ensure optimal treatment for patients with rare and complex diseases by making it possible for them to receive their entire course of treatment, even if they cannot pay for it in full.

PARTNERS

Patients, Takeda, and, at times, local authorities, foundations, local medical associations, charities and other parties.

COUNTRIES

Ukraine, Mexico, Peru, Brazil, Egypt, Kenya, Lebanon, United Arab Emirates, Singapore, Thailand, Hong Kong, Malaysia, Philippines, Indonesia.

DATE

Started 2017 – ongoing

HIGHLIGHTS

“

Providing patients with access to medicines, especially for complex and life-long conditions, cannot be a 'one-size-fits-all' model. It requires a more personalised and collaborative approach”

Susanne Weissbäcker, Takeda's Global Head of Access to Medicines.

The PAPs address affordability barriers through an innovative, tailored affordability solution. Individuals share in the cost of treatment according to their means, with Takeda and its partners stepping in to cover the rest. This enables patients to receive their full, prescribed course of treatment — a pragmatic example of a people-centred approach. In addition, patients receive ongoing support from PAP staff to ensure they follow the correct treatment protocol with no disruption.

Takeda has employed the use of a means-based assessment tool to determine a personalised financial support plan for each patient. Takeda's PAP implementation partner created the tool specifically for developing-country settings to assess three factors – standard of living, income, and assets. This helps ensure the results are as accurate as possible, particularly in countries with informal economies where income cannot be solely relied on to determine affordability.

49 Takeda. Access to Medicines Progress Report. 2018. Available at: https://www.takeda.com/4a26a9/siteassets/system/what-we-do/access-to-medicines/progressreport_2018.pdf

50 Ibid.

If everyone pays according to their ability to do so, funds can be committed to patients with lower levels of income, which substantially increases the number of patients who benefit.

The PAPs are also tailored to each of the countries where they operate, so they fit with – and address gaps in – the local economic and healthcare context. For example, in health systems where patients are reimbursed for medical expenses much later than their treatment, the PAPs provide 'bridge' funding to help patients manage their finances until they receive insurance pay-outs.

Takeda PAPs have improved access for around 1,500 patients with Hodgkin lymphoma and large cell lymphoma, multiple myeloma, haemophilia, and ulcerative colitis, in 14 countries across Asia, Africa, Latin America, Middle East, and Eastern Europe.



© Takeda

INSIGHTS

Takeda recognises that increasing access to medicines for patients with complex and rare diseases isn't just about addressing treatment affordability barriers. This is why the PAPs run in parallel to other Access to Medicines initiatives which address healthcare capacity challenges around disease awareness, diagnosis, treatment, and ongoing patient care and support. The overarching ambition is to catalyse deep collaboration that helps communities, societies, and healthcare providers to strengthen their health systems across the entire patient journey and improve the effective and efficient deployment of resources.

Measuring and benchmarking the impact of its Access to Medicines initiatives is of crucial importance to Takeda. The company has worked with Duke University's Innovations in Healthcare and BroadReach to create the Access to Health Impact Measurement Framework that has been validated by leaders in the pharmaceutical industry, implementing partners, academics, and clinicians. The model is designed not just to measure the direct impact of initiatives on patients, but also to monitor the difference the programmes are making to healthcare systems more broadly—which can be assimilated to measuring social impact.

Moving forward, Takeda will give attention to both the effectiveness of its interventions and the impact at the population level of its PAPs when implementing its Access to Health Impact Measurement Framework.

“

Takeda's commitment to invest in the impact framework and implement it with multiple partners allows significantly stronger program design that goes beyond the many one-off training programs that exist in today's landscape.”

AstraZeneca's Young Health Programme: A People-Centred Approach to Unleash Shared Value^{51,52,53}

AstraZeneca's Young Health Programme (YHP) is an NCD prevention programme targeting adolescent health, developed in partnership with Johns Hopkins Bloomberg School of Public Health and Plan International. 70% of premature deaths from NCDs are linked to behaviours that began in adolescence.

OBJECTIVE

To reduce the uptake of unhealthy behaviours in young people in order to improve their health outcomes as adults, and help address the growing burden of NCDs on health systems.

PARTNERS

Plan International UK (Plan), United Nations Children's Fund (Unicef), One Young World, the Population Reference Bureau, Imperial College London, RTI International, NCD Child, NCD Alliance, and various national partners.

COUNTRIES

25 countries across 6 continents

DATE

2010 – ongoing

HIGHLIGHTS

AstraZeneca works with partners to achieve long-term behaviour change in disadvantaged and marginal communities in 26 countries across six continents. It uses peer-education widely to reach young people and is continually innovating to find what works best and share good practice. Moreover, AstraZeneca provides sustained funding for the development of policy papers, to support calls for more action on NCDs and ensure that young people are heard by policy makers.

To date, the programme has reached more than four million people globally ; trained over 50,000 young people as peer educators; trained almost 20,000 people as frontline health providers in adolescent health; reached 60 million people through awareness and media campaigns; worked with almost 5,000 AstraZeneca volunteers; and provided 75 scholarships for inspiring young people to attend One Young World summits to build up their skills and networks.

INSIGHTS

Programmes and services will always work better if the group they are being designed for is involved in the process. That is why youth lead the programme advocacy efforts, write their own education activities and speak up for what they need—a key element of a people-centred approach. For example, the YHP Youth run scorecarding exercises help local health clinics become more adolescent-friendly. In Kibera, Kenya, one clinic added a side entrance so that youth, especially girls, have a more private entrance—making care more accessible to them. Most importantly, the YHP perfectly illustrates the need to switch from a “patient-centred” to “people-centred” approach, as it focuses on prevention and targets a population of young people rather than patients.

51 AstraZeneca. Young Health Programme. 2020. Available at: <https://www.astrazeneca.com/sustainability/access-to-healthcare/young-health-programme.html>

52 AstraZeneca. Young Health Programme. 2020. Available at: <https://www.younghealthprogrammeyhp.com/>

53 Ibid.



© Julien Hameis

Moreover, AstraZeneca's YHP supports young people as health promoters and advocates through mentorship and skills training that helps build their confidence and capabilities, and gives them the resources to deliver their message. For example, one of AstraZeneca's medical advisors built a technical training curriculum for peer educators, thereby adding a layer of knowledge on the science and physiology behind different NCDs that has strengthened their ability to deliver great health messages. The programme also supports research targeting adolescents specifically, to collect more data and information about their risk behaviour profiles and what they think about their own health. Johns Hopkins Bloomberg School of Public Health, co-founder of the YHP, asked young people directly what impacts their health most, and found that not having a safe and clean environment are the two top barriers that stop them from being or feeling healthy.

In addition to working directly with young people, the YHP works with partners including experts in communities, schools, clinics, universities and research institutes, and on the frontlines of health policy action. Overall, the programme adopts a shared value approach, as it engages with each stakeholder in the areas where they can add the most value; or in other words, where the activities they offer can be most efficient and effective.

Lilly 30x30:

Increasing Access to Quality Healthcare through Shared Value and Multi-sectoral Partnerships

To accelerate its global health efforts, Lilly has established Lilly 30x30 – a bold programme to increase access to quality healthcare in communities with limited resources for 30 million people by 2030. Lilly 30x30 is a companywide effort that uses a mix of both shared value and philanthropic approaches to achieve this goal.

OBJECTIVE

A companywide effort to increase access to quality healthcare in communities with limited resources for 30 million people by 2030

PARTNERS

Leading health organisations, NGO's, governments

COUNTRIES

Resource-limited settings around the globe

DATE

2017-2030

HIGHLIGHTS

Lilly 30x30 initiatives include activities across three key areas: Pipeline, Programs, and Partnerships. In each of these areas, Lilly is developing, piloting, and measuring high-impact, scalable projects.

Through **30x30 Pipeline efforts**, Lilly is finding new medicines or new indications for existing medications to treat diseases that disproportionately affect people living in resource-limited settings. This means reviewing new and legacy products, as well as research and development (R&D) activities, through the 30x30 lens. Lilly is also exploring partnerships and business development models that support this aim.

Through **30x30 Program efforts**, Lilly is strengthening existing programmes and developing new approaches that help people in resource-limited settings get greater access to Lilly products and services. These efforts include exploring and expanding alternative business models and pricing strategies that create shared value for society and Lilly, patient support programmes, and product donations.

Through **30x30 Partnership efforts**, Lilly and the Eli Lilly and Company Foundation (a private, tax-exempt organisation) work to advance government priorities, strengthen local healthcare systems, and improve access to care. Lilly uses its technology and expertise in collaborations with other organisations to find solutions to pressing global health concerns, including diabetes and cancer. Lilly's current Global Health Partnership portfolio showcases work in India, Mexico, several countries across Sub-Saharan Africa, and the US – which includes a partnership to combat type 2 diabetes in three of the most at-risk neighbourhoods in the city of Indianapolis, home of Lilly's corporate headquarters.

INSIGHTS

Lilly's Global Health Partnerships advance more than two decades of global health work that seeks to improve access to care. This work is centred on developing collaborations with a variety of partners to expand access to care for people living in areas with limited resources. Understanding that real change happens over time, Lilly has made long-standing commitments to trusted organisations in order to make a sustainable and lasting impact.

One of those partnerships is with AMPATH (Academic Model Providing Access to Healthcare). For nearly twenty years, Lilly and the Lilly Foundation have partnered with AMPATH, an African medical consortium, providing support and funding to help AMPATH provide medicines and quality health care to people living in western Kenya.

AMPATH, officially established in 2001 in response to the HIV/AIDS epidemic in western Kenya, is a partnership with Moi Teaching and Referral Hospital and the Moi University School of Medicine, and a consortium of North American academic health centres, led by Indiana University.

AMPATH has continually expanded its successful approach in treating HIV/ AIDS (including diagnosis, treatment, and patient support) to more diseases, including diabetes, hypertension, and cancer. Today, AMPATH serves a population of more than 8 million people in Kenya at more than 500 clinical sites—from village health centres and dispensaries, to county hospitals, to the Moi Teaching and Referral Hospital in Eldoret, where the organisation is headquartered. As of June 2020, AMPATH has trained 2,600 Kenyan medical professionals and community health workers, building local knowledge and service capacity.

Lilly and the Lilly Foundation committed to improving cancer care in western Kenya by enabling AMPATH to screen, treat, and provide palliative care to more people with cancer than ever before. Part of this vital support was directed to AMPATH's Oncology Institute, which opened in 2009 with a single physician and nurse offering services in a tent in an alley behind AMPATH's main building. Public-private partnerships, including Lilly's support with a US \$1 million training-and-education grant over four years, have allowed the institute to expand into a permanent facility, including 14 additional clinics and numerous oncology-trained clinicians.

In 2018, the institute received more than 10,000 patient visits. But the institute is one of only two cancer centres in Kenya, meaning that nearly half of the country's 49 million people must rely on it for screening and care. Breast and cervical cancer are the most prevalent types of cancer in Kenya – but they are also the most preventable with access to timely and effective care.

To help address this gap, and as part of Lilly 30x30, the Lilly Foundation committed an additional US \$3.5 million to bring screening for breast and cervical cancer to closer to three rural counties – with the goal of screening 100,000 women over the course of this 5-year partnership.

In the first three years of this partnership, nearly 98,000 women have been screened through mobile outreach in rural areas. In addition, each patient who is due for a rescreening is called or visited by a nurse. This helps prevent loss to follow-up due to barriers including a lack of transportation funds, a lack of medical insurance, and the use of traditional healers. With two years still left, AMPATH will far surpass its goal of reaching 100,000 women.



COVID-19 has reinforced the need for a combination of approaches that intersect between philanthropy and business models. Philanthropy alone can't change the world's biggest problems. Real systemic changes come from policy and advocacy that social impact needs to support. This work must be led in partnership with those who are impacted by NCDs, that is: PLWNCDs."

Courtney Roberts, Director, Global Health Partnerships, Eli Lilly and Company, at the virtual event on 'Revisiting social impact in the COVID-19 era: Achieving greater access for people living with NCDs through people-centred care' held on 22 September 2020

Novartis Access: Shared Value Creation by Continuously Adapting the Programme to Local Needs^{54,55}

Conscious of the need to strengthen public healthcare systems for the long-term with business models that don't rely on donations, Novartis developed a pricing strategy enabling the company to operate a social and sustainable business over time. The Novartis Access programme provides a portfolio of 15 medicines at US\$1 per treatment, per month to the public sector, accompanied with capacity-building activities to address key access barriers. Products include treatment for cardiovascular diseases, diabetes, respiratory illnesses, and breast cancer.⁵⁶ The programme is part of Novartis Social Business, which supports global public health through novel, sustainable business models to support access to medicines in lower-income settings. Novartis has invested in a robust monitoring and evaluation (M&E) strategy to not only better analyse and learn from programme results, but also to improve the approach along the way.⁵⁷

OBJECTIVE

Increase availability and affordability of treatments for cardiovascular diseases, diabetes, respiratory illnesses, and breast cancer in LMICs.

PARTNERS

Novartis looks to governments to assess whether Novartis Access meets their healthcare needs and can be implemented in compliance with their national policies. It partners with governments and NGOs to distribute its medicines on the ground and to raise awareness and strengthen healthcare system capabilities in key NCDs, including training on diagnosis and treatment.

COUNTRIES

Pakistan, Vietnam, Colombia, El Salvador, Cameroon, Ethiopia, Kenya, Nigeria, Rwanda, Uganda

DATE

2015 – ongoing

HIGHLIGHTS

The Novartis Access portfolio includes products from Novartis Pharmaceuticals and Sandoz, which are selected based on three criteria: significant health needs, medical relevance, and lack of local access programmes. It aims to offer various treatment options, including well-proven and standard first-line treatments, as well as some of the latest treatment choices.⁵⁸ In addition to providing medicines, Novartis also supports governments in updating national treatment guidelines on NCDs, in line with WHO recommendations and partners.

Novartis is collaborating with Boston University to measure and gather evidence of the impact of its initiative on the affordability and availability of essential NCD products and treatments. An impact evaluation in Kenya, the first country being evaluated, showed that after 15 months, the programme had a positive effect on the availability of two drugs, one for hypertension and the other for diabetes, the two most prevalent noncommunicable diseases in the study population.⁵⁹ Novartis also developed a methodology to measure the value of the social impact of selected products, calculating quality adjusted life years (QALY) and factoring in the effect of being healthy and able to pursue productive work. For Kenya, the social impact value measured in 2016 amounted to US\$632,000.^{60,61}

54 Access Accelerated. Access Accelerated in Action. 2019. Available at: <https://accessaccelerated.org/wp-content/uploads/2020/04/Access-Accelerated-in-Action.pdf>

55 Novartis. Novartis in Society. ESG Report 2019. Available at: <https://www.novartis.com/sites/www.novartis.com/files/novartis-in-society-report-2019.pdf>

56 Novartis. Novartis Access 2017 Two-Year Report. Available at: <https://www.novartis.com/sites/www.novartis.com/files/novartis-access-report-2017.pdf>

57 Access Accelerated. Ibid.

58 Novartis. Factsheet Novartis Access. 2018. Available at: <https://www.novartis.com/sites/www.novartis.com/files/factsheet-novartis-access.pdf>

59 Rocker, P et al. Effect of Novartis Access on availability and price of non-communicable disease medicines in Kenya: a cluster-randomised controlled trial. *The Lancet Global Health*. 2019;7:4.e492-e502. Available at: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(18\)30563-1/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30563-1/fulltext)

60 Novartis. Novartis Access 2017 Two-Year Report. Available at: <https://www.novartis.com/sites/www.novartis.com/files/novartis-access-report-2017.pdf>

61 Novartis. Novartis Social Business Report. 2018. Available at: <https://www.novartis.com/sites/www.novartis.com/files/novartis-social-business-report-2018.pdf>



© Novartis

Essential medicines being delivered in Kenya

INSIGHTS

One key challenge that the global health community faces in addressing the growing NCD burden and achieving universal health coverage is a lack of infrastructure for measuring the state of medicine access in low- and middle-income countries. Novartis quickly realised that measuring social impact requires a longer-term horizon and a focus on outcomes at patient or household level. In the first year of Novartis Access, the company also realised that the portfolio approach, rather than a product-by-product approach, while commercially attractive, posed a set of implementation hurdles for procurement agencies, NGOs and government clinics. Therefore, while it is important to maintain a commercial balance between cost and value, Novartis has become more flexible regarding the portfolio composition to respond to country requirements.⁶²

This approach fits the definition of shared value, as the programme is “enhancing the competitiveness of a company while simultaneously advancing the economic and social conditions in the communities in which it operates”. A central piece of the Novartis Access shared value approach is adapting the programme to respond to local population needs after a rigorous evaluation of its impact, relying on the many partnerships the company has established with governments, counties and local NGOs. This demonstrates that when setting

up and running programmes for access to NCDs medicines, multistakeholder partnerships work best. Most importantly, the programme is economically sustainable, which is also a key component of a shared value approach.

Through this approach, the company discovered that most patients pay for treatment in for-profit, private sector facilities, and subsequently offered products through the private sector. The analysis also found that there are many cases of undiagnosed diabetes and hypertension. The company recently adopted a new metric for patient reach, with the primary objective of driving access to medicines in Africa.⁶³ Pivoting from traditional business metrics such as profits and margins, to metrics that improve access and patient reach across the full income pyramid in the region is a crucial step to keep building shared value and social impact in the countries where the programme is running.

Moving forward, as Novartis keeps adapting its programme, it will be critical to include PLWNCDs to ensure that key findings are integrated into the company’s NCDs response.

⁶² Novartis. Novartis Social Business Report. 2018. Available at: <https://www.novartis.com/sites/www.novartis.com/files/novartis-social-business-report-2018.pdf>

⁶³ Novartis. Novartis announces new strategy to provide innovative medicines to more patients in sub-Saharan Africa. 2019. <https://www.novartis.com/news/media-releases/novartis-announces-new-strategy-provide-innovative-medicines-more-patients-sub-saharan-africa>

Shared value initiatives led by non-profit organisations

Supporting National NCD Alliances in Mobilising and Amplifying the Voices of People Living with NCDs – NCD Alliance

Meaningful involvement of people living with noncommunicable diseases (PLWNCDs), particularly in decision making processes stands to make the NCD response more urgent, more accountable, more robust and effective. National NCD alliances in Ghana and Kenya have been supporting PLWNCDs to share their lived experiences and be meaningfully involved in the national NCD responses. This case study explores the involvement of PLWNCDs in building and leveraging national advocacy agendas of PLWNCDs to catalyse the development of people-centred care models for NCDs.

OBJECTIVE

To facilitate the meaningful involvement of PLWNCDs in the policy-making and health systems strengthening processes and channel the power of the lived experience into effective action against NCDs.

PARTNERS

Access Accelerated, people living with NCDs including care partners, Ministries of Health, NCD alliances of Ghana and Kenya, health services, parliamentarians.

COUNTRIES

Ghana and Kenya

DATE

2018 - present

HIGHLIGHTS

“

Meaningful involvement is the only way that barriers between policymakers and people living with NCDs can be removed”

Joshua Makubu, Our Views, Our Voices advocate, Ghana

National NCD alliances, supported by the NCD Alliance as part of a broader partnership with Access Accelerated in Kenya and Ghana, have demonstrated the importance of strengthened civil society capacity in amplifying views and voices of PLWNCDs and providing a platform for their sustained and meaningful involvement in advocacy, policy shaping and governance. The partnership has contributed to strengthen the organizational capacity of the national NCD alliances to facilitate the adoption of strategic plans related to advocating for NCDs and meaningfully involving PLWNCDs in civil society initiatives. Alongside national multistakeholder meetings on NCDs and strengthening of civil society, the partnership has also supported the deepening of community level engagement and heightened media attention on NCDs with PLWNCDs as powerful advocates and spokespersons.

In 2018, the Ghana NCD Alliance conducted an online consultation process and convened a two-day national meeting, bringing together representatives from 8 regions of Ghana. The meeting sought to highlight the importance of meaningfully involve PLWNCDs in the national NCD response and served as an opportunity to consolidate the recommendations of nearly 100 PLWNCDs to inform the building of the Ghana Advocacy Agenda of People Living with NCDs.

With the aim to reduce the nation's burden of NCDs, Ghana Advocacy Agenda of PLWNCDs focused on four key pillars (Human Rights and Social Justice; Prevention; Treatment, Care and Support; Meaningful involvement) to demand action from decision makers to improve NCD prevention and control. The Ghana Advocacy Agenda of PLWNCDs was launched in 2019. In 2020, as a recognition of its contribution to fostering multistakeholder partnership in accelerating action on NCDs, the Ghana NCD Alliance won the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases Award.

Also in 2018, the NCD Alliance of Kenya organised a two-day national workshop including over 50 people living with NCDs. Alongside these representatives, the workshop convened over 50 diverse stakeholders (including Kenyan Ministry of Health officials, Country First Ladies and NCD Alliance of Kenya members) engaged in the NCD response in Kenya. Drawing strength from the diversity of experience and expertise represented at this workshop, the PLWNCDs in attendance and the NCD Alliance of Kenya identified key issues and advocacy asks for the different NCD stakeholders, which resulted in the Kenya Advocacy Agenda of PLWNCDs. The NCD Alliance of Kenya was invited to co-chair Kenya's Intersectoral Coordination Committee on NCDs along with the Ministry of Health and has leveraged the Kenya Advocacy Agenda to advocate for a people-centred and multi-sectoral NCD response in Kenya.

By consulting and mobilising communities on their needs, challenges and recommendations, the NCD alliances of Kenya and Ghana have facilitated dialogue across sectors, including policy makers, academia and relevant private sector.

INSIGHTS

The experience in both these countries has catalysed a model to produce a National Advocacy Agenda of People living with NCDs that can help drive sustainable action through advocacy, community mobilisation and media engagement efforts and be applied to other countries. By providing a compass for civil society to take action, they also provided an efficient vehicle for advocates to demand that NCDs are addressed at the highest political levels and all stakeholders support a people-centred approach to building and strengthening integrated health systems and achieve a greater social impact for NCDs.

The process, driven by the priorities and recommendations of those with lived experiences, has facilitated a broad and inclusive consultation on key priorities and demands of PLWNCDs to ensure an NCD response that meaningfully involves PLWNCDs. The resulting national advocacy agendas have highlighted a broad range of dimensions to strengthen treatment, support and care and prevention efforts at the national and local levels, including from an access perspective, and made the case for incorporating a human rights and social justice approach to NCDs to address their needs in a comprehensive manner.

In addition, this process has helped mobilise a wide range of stakeholders across sectors, including policy makers, academia and relevant private sector, to better understand the different aspects and dimensions of the needs of PLWNCDs and facilitated a robust multistakeholder engagement to help shape the call to 'put people first' in national NCD responses.

The opportunity presented by the national advocacy agendas to raise the profile of NCDs at the political level demonstrate their value as a potent advocacy tool to enable advocates to achieve greater social impact. Perspectives of people with first hand experiences of NCDs can help to shape health systems that deliver the appropriate services people need, when they need it. As living documents, they also can serve as platform to facilitate an ongoing and open dialogue between people living with NCDs and key stakeholders involved in addressing these asks, beyond governments.

“

People living with NCDs need to be strong in voicing of needs of the general society in terms of access to treatment, awareness, prevention and control. There is a need to push the government on policies affecting the general health welfare in our community. The civil society plays a big role in engaging the government. Dialogue is key.”

Caroline Njagi, advocate with lived experience of cancer from Kenya

KHPT's Innovative Community Health Worker Model: A People-Centred Approach to Optimise NCD Outcomes in South India

Karnataka Health Promotion Trust (KHPT), in partnership with the Government of Karnataka and Medtronic Foundation, is implementing an innovative public-private partnership for training community health workers in South India, to help incorporate people-centricity within the existing health systems to improve NCD outcomes. With about 5.8 million deaths due to NCDs every year, this people-centric approach will be key for achieving Sustainable Development Goal 3 targets for reducing NCDs and NCD deaths.

OBJECTIVE

To test the feasibility of a contractual, incentive-based community health worker model, embedded and sustained within the existing urban health system, aimed to achieve improved NCD outcomes for a minimum of 60% of the population with a focus on the underserved using a people-centric approach.

PARTNERS

Medtronic Foundation and Government of Karnataka, India

COUNTRIES

India (Urban neighbourhood of Mysore city, Southern India)

DATE

January 2020 – ongoing

HIGHLIGHTS

Initial research explored people's engagement, misconceptions and behaviours related to NCDs, alongside population-wide assessments of gaps in access, coverage and quality at primary health care level. Fear of side effects of medications, stigma related to chronic diseases, and cultural and social factors emerged as key reasons for people not treating or preventing NCDs properly.

Health screenings were carried out among 35,000 adults, revealing that 12% had high blood sugar and 19% had high blood pressure. 40% reported inadequate physical activity and 81% inappropriate diet. Facility audits were also carried out, showing gaps in diagnostics, drug shortages, and linkage with specialist services in government facilities. Private facilities lacked comprehensive service packages and patients reported high out-of-pocket expenses.

After the initial research, community health workers (CHWs) were selected from the local community and provided with training, tools and support to assess patient needs, plan consultations and link them to care. CHWs assessed patient needs and risk (both bio-medical and social) with a wide array of tools, including a mobile-based microplanning tool (Fig 1), enhanced counselling, electronic client records that are linked with CHW records, integrated voice response system (IVRS) messaging and patient alerts, and real-time monitoring systems, as well as peer support groups and health and wellness centres. In the COVID-19 context, the CHW training modules were amended to add content related to the epidemic, to address anxiety and stress, and about protective measures and comorbidities.

Today, the programme caters to a total population of 58,000, which has 3100 patients with confirmed NCDs (diabetes and/or hypertension) and approximately 5000 that are living with high risk (elevated blood sugar and blood pressure). 21 CHWs are trained to deliver customised outreach and education. At the beginning of the programme (January 2020), 38% of the clients had demonstrated optimal disease control (48% for hypertension and 29% for diabetes)

and the aim is to increase this number to 43% (52% for hypertension and 34% for diabetes) by the end of programme period (December 2020). Programme strategies are continuously reviewed and refined, to develop a model that is feasible and effective in an urban setting. In years 2 and 3, the programme will be scaled up to a population of 240,000 and then – in phases – to the entire city, which has a population of 1.1 million.

INSIGHTS

The programme is located within the population catchment area of an urban primary care centre, which is important for replicating the lessons across urban cities where a strategic response to NCDs is currently missing. Generally speaking, embedding the programme within the health systems and bringing community needs to the centre of the programme's response has been key to achieve government ownership, confidence and accountability. The use of real time, high quality data for programme planning and management is also critical for achieving an optimal impact. Scaling people centric approaches requires demonstration on the ground with the help of data, constant advocacy with stakeholders, and identifying the right collaborators for implementation. The different programme stakeholders all need to be considered individually, as well as in an integrated manner:

- Comprehensive needs assessments of patients and their families around both health and social issues helps to better classify risk and plan services. This also raises patient engagement and coverage. Engaging families as a whole, as well as leveraging social structures within urban slums, facilitates higher participation.
- As for the CHWs, they need orientation not just on the technical areas, but on social issues as well. Support and supervision are always available to help them overcome field-level challenges, and simple tools are extremely helpful to them for planning consultations.
- Within facilities, it became clear that eliciting responsive and respectful care requires persistent effort and quality improvement approaches. Technology was also helpful in aiding continuity of care and data transmission between the community and facilities.
- Involving the government actively in the design, implementation and review of pilot programs is critical for ownership and evidence-based decision making for scale and sustainability.
- In urban India, private sector is another key player that needs to be engaged proactively while building confidence for a programme.

“

With the support of Medtronic Foundation, the Karnataka Health Promotion Trust (KHPT) has been able to bring in a stronger emphasis on the importance of community centricity in its programmes. To do so, we have adapted our frameworks to the NCD context through the organisation of community consultations as well as the mapping of community structures at grassroots level for instance, but also via the inclusion of both biological and social vulnerability assessments into risk assessments. This has facilitated the development of technology-based tools for community health workers to plan engagement and outreach based on the individuals' needs. As we worked to embed community centricity in our work, we also realised it is key to build capacities of community members in monitoring of the service utilisation so they truly are partners on the ground”.

Dr Krishnamurthy Jayanna. M.D, Senior Technical Advisor,
Karnataka Health Promotion Trust

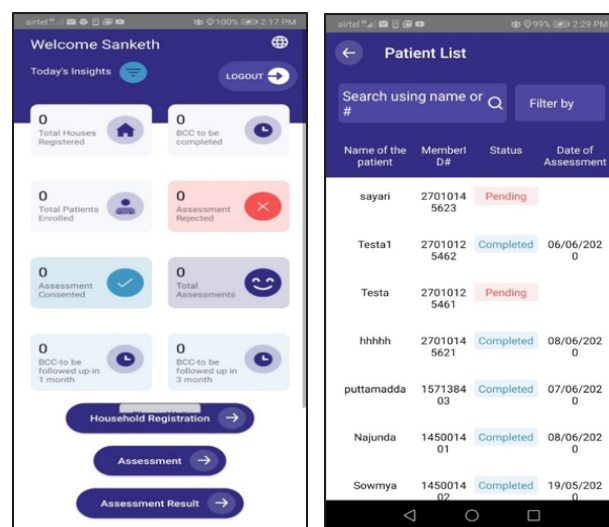


Figure 5. The mobile-based CHW microplanning tool

Direct Relief's Risperdal Access Programme to Support Remote-Area Mental Health Services in Central and Northern Ghana: Integrating PLWNCDs in the Multi-Sectoral Approach

Direct Relief (DR) aimed to meet the significant need for resource support to improve access to essential drugs, training of healthcare workers, and services for mental health patients in Ghana.

OBJECTIVE

To improve therapy access and treatment outcomes for disadvantaged and underserved patients suffering from schizophrenia or bipolar disorder.

PARTNERS

Direct Relief, Johnson & Johnson, Basic Needs-Ghana (BNGh), Breast Care International (BCI), and the Ghanaian Ministry of Health.

COUNTRIES

Ghana

DATE

Started 2017 – 2020

HIGHLIGHTS

This programme focused on providing support in the central and northern parts of the country, which historically have had extremely limited resources for psychiatric care, by distributing supplies of risperidone for between 1000 and 3000 patients annually across dozens of healthcare facilities.

DR carried out two surveys based upon the WHO-AIMS survey instrument, which generated the first comprehensive view of mental health services in the country in 2012, to establish baseline conditions of mental health care in targeted regions.

In Year 1, the initiative established a channel for the distribution of risperidone to northern regions of Ghana, helping nearly 1000 individuals access these needed medications. Programme representatives met with the Minister of Health and other local government officials to familiarise them with the initiative and its local impact. Year 2 built upon the previous year in providing a more stable supply of risperidone to patients suffering from schizophrenia and bipolar disorder in northern Ghana and incorporating additional monitoring and evaluation tools that would be able to better demonstrate the impact of the programme on beneficiary facilities by completion of Year 3. In Year 3, a follow-up survey will be conducted at each of the 10 healthcare facilities and further assessment will be carried out to measure and demonstrate the impact of the programme supplying facilities with consistent access to risperidone.

An initial goal of this programme was to have results from the follow-up survey presented to both Johnson & Johnson and government officials in Ghana after completion in 2020. Complications in terms of travel logistics from COVID-19 have made that timing unrealistic, with work on the survey only scheduled to begin in late 2020. The survey instrument includes a selection of questions from WHO-AIMS, which are intended to standardise results at the facility level in terms of resources and capacity for the provision of mental health services across several different dimensions including drug supply, staffing, training, and diagnoses, among others. The survey, which will be conducted in person by a group of Ghanaian researchers, will also focus specifically on utilisation of the drugs that were distributed in the initial round, the change in health status of the patient population that received the drugs, and feedback on process for maintaining a stable supply and dosage rates.

Overall, the distribution of large volumes of an essential mental health drug into rural facilities was made at no additional cost to local partners or the government. The programme also enabled the establishment of a feasible non-profit logistics network via the DR's backbone and the efforts of local partners, expanding services into many remote areas of central and northern Ghana. Direct Relief facilitated the creation of new knowledge about the burden of mental illness and the gaps in the provision of mental health, specific to the local areas and facilities being serviced by the programme. Finally, the initiative alleviated the short-term burden of lack of access to risperidone for patients in the targeted areas in need of anti-psychotic medications.

INSIGHTS

All the partners in this initiative share the common goal of increasing access to this essential mental health drug—a shared-value approach could help to “flesh out” the elements that can be carried forward in a sustainable way, especially as the partners agree that a reform of the country’s mental health care system is needed in parallel. In addition, a people-centred approach could accelerate the deployment of the programme going forward, as it will enable partners to integrate people’s needs in their strategy from the beginning of the process, saving time and money. Overall, the programme demonstrates that adopting a multisectoral approach from the start enabled the programme to scale up quickly and to tackle different aspects of access, namely the affordability and availability of risperidone by building a sustainable non-profit logistics network.



© flowcomm

Market, Ghana

PATH's Coalition for Access to NCD Medicines and Products: Addressing access and affordability of NCD medicines and products through a multi-sectoral approach

The global, multisectoral Coalition for Access to NCD Medicines and Products builds on existing initiatives and innovations to identify and remove barriers to increase access to NCD medicines and products. Keeping the person living with NCDs (PLWNCDs) at the core of all activities, the Coalition provides an inclusive, neutral convening space to come together to achieve objectives shared across sectors, raise the profile of key issues at the global, regional, and national levels, and leverage the range of skills and expertise of members to take action and improve access to life-sustaining NCD medicines and products.

OBJECTIVE

Increase access to medicines and health products for people living with noncommunicable diseases (NCDs)

PARTNERS

Over 25 members including governments (including Senegal, Kenya, Uganda), private-sector entities, NGOs, civil society, philanthropic foundations, and academic institutions (PATH is the Secretariat and founding member)

COUNTRIES

Kenya, Uganda, Tanzania

DATE

Launched in Sept 2017 – ongoing

HIGHLIGHTS

The Coalition works at the **global level**, in partnership with WHO, to influence policy change to establish an enabling environment for NCD supply security and raise the profile of the issue of access to NCD medicines and products. In addition to contributing to the WHO High-Level Commission on NCDs "Time to Deliver Report", the UN HLM on NCDs Outcome Documents, Coalition membership contributed to a briefing note on the impact of COVID-19 on people living with NCDs, to support the inclusion of NCDs in the WHA73 Resolution on the COVID-19 response. The Coalition membership also initiated a blog and webinar series to highlight the impact of COVID-19 on PLWNCDs, the importance of access to person-centered NCD treatment and care during this time, and the need to strengthen resiliency of the health system for the future.

At the **regional level**, through the engagement with the East Africa Community (EAC), the Coalition led the development of the *Issues Paper for the Council of Ministers*, on the NCD burden facing the region and is supporting the EAC in developing a regional framework for NCDs and strengthening supply security. Raising awareness of the need for greater understanding of cost drivers along the supply chain to achieve greater efficiencies and lower out-of-pocket costs for PLWNCDs, the Coalition conducted a literature review highlighting the impact that affordability has on PLWNCDs having access to the medicines and products they need, when and where they need them, to manage their health.



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A health worker readies doses of oral polio vaccine (OPV).

At the **national level**, the Coalition leads implementation efforts in Kenya, Uganda, and Tanzania to address the lack of supply security for NCD medicines and products. In collaboration with ministries of health, stakeholders at the county/district levels, and a multi-sectoral Technical Working Group, the Coalition has developed an innovative demand forecast tool, for NCD medicines, to address this specific supply chain barrier. The testing of this tool will begin in Kenya and Uganda in late 2020, with dissemination of this global good, training, and capacity-building following in 2021. Additionally, with support from Coalition members, the Kenya MOH established an NCD supply chain TWG to address prioritized barriers.

INSIGHTS

Health equity cannot be achieved without access to medicines and products to prevent complications and early death associated with NCDs. And due to the complex nature of supply security, it is not possible to address access barriers by targeting just one component of access. A comprehensive approach, requiring trust, timely action, and resources is critical to ensuring that the barriers faced by PLWNCDs, at each stage of their treatment and care journey, are addressed. Therefore, through a multi-sectoral approach and while keeping a PLWNCD-centered focus, Coalition members are implementing innovative approaches at the global, regional, and national levels to addressing this challenge, making this case a great example of how shared-value can improve access to NCD treatment and care.

Alina Vision, a social enterprise to advance access to eye health supported by the Fred Hollows Foundation^{64,65}

Alina Vision was founded with an ambitious objective: to make world-class eye care available to all, regardless of their ability to pay. Founded in 2017 by global leaders in eye care, Alina Vision develops and manages world-class ophthalmic ambulatory surgery centres in emerging markets.

OBJECTIVE

To advance global eye health equality through a network of more than 60 eye surgery centres in some of the world's most underserved communities.

PARTNERS

The Fred Hollows Foundation, leading social entrepreneurs David Green and Ben Midberry, Japanese pharmaceutical company ROHTO, local NGOs.

COUNTRIES

Vietnam

DATE

2018 – ongoing

HIGHLIGHTS

Globally, there are 43 million people who are blind and 295 million people who have a moderate to severe visual impairment. In many cases, this prevents them from connecting with and supporting their families and communities. 80% of these cases are easily treatable with quick, inexpensive and low-risk procedures that dramatically improve sight, whether it is surgery for cataracts, or simply the right pair of eyeglasses. But millions in need can't access these treatments, due to needlessly high costs, distance from medical providers, lack of knowledge and a shortage of skilled resources.

Alina Vision uses the 'Affordable Eye Care Model', combining high volume, high quality eye care with a strong focus on low cost consumables. It also offers tiered pricing to ensure that the poorest patients receive free or low cost care, cross-subsidised by the fees paid by higher earning patients. By establishing for-profit social purpose hospitals, Alina Vision's key innovation is to bring impact investors to eye care, drawing on best practice and expertise from initiatives applying the 'Affordable Eye Care Model', and blending grants, debt and equity financing to scale more rapidly. This model makes access to eye health more affordable than ever before.

Alina Vision's first surgery centre was opened and licensed in Vietnam in 2019. It is expected to reach break-even in early 2021 despite the disruption of COVID-19, a significant achievement for a new hospital. The centre is already surpassing WHO requirements for surgical outcomes, and maintaining its goal of treating at least 20% of patients with no out-of-pocket costs. The average cost of cataract surgery at the hospital means that even paying patients have less than the typical cost of surgery in Vietnam. With the hospital now eligible to access funding from Vietnam's national health insurance scheme, more patients will be able to receive free or low cost treatment.

⁶⁴ The Fred Hollows Foundation. Alina Vision: taking aim at improving global eye health equality. 2018. Available at: <https://www.hollows.org/au/latest/alina-vision-taking-aim-at-improving-global-eye-health-equality>

⁶⁵ Alina Vision website. Available at: <https://www.alinavision.com/>



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Eye screening at school for students in Ha Nam province, Vietnam.

INSIGHTS

Putting patients at the centre of care is key to the model's success, which relies on a high volume of patients. The surgery centres were built in collaboration with an internationally renowned architect, to ensure a design and ambience that works. Staff were sent abroad for up to a year to work in a similar facility and strengthen not only clinical skills, but also 'soft' skills in engaging with and counselling patients. Feedback from patients to date shows that they are very impressed with the quality of services and care provided through Alina Vision, and expected such a high level of service to cost more. Therefore, it can be understood that acceptance of the programme and feedback is extremely positive.

Alina Vision's first hospital is located in a residential area with a bus stop outside the door, making services more accessible to patients. Outreach has been a key part of the programme, with staff visits to local schools to screen children for eye conditions and organisation of community outreach camps in collaboration with local NGOs. Buses bring patients in need of treatment from the outreach camp to Alina Vision's surgery centre. The clinical team has engaged with local optical shops that also refer patients needing treatment to the surgery centre, and has established its own vision centres in underserved areas to screen patients, offer basic treatments, sell provide glasses and refer patients to the surgery centre— also raising awareness of the programme. These vision centres

will become self-financing, largely through the sale of glasses. Putting surgery centres closer to the community means that travel times and costs can be reduced as well.

The Fred Hollows Foundation' decision to invest in Alina Vision was predicated on the assumption that by bringing impact investors to eye care, it would be possible to build more surgery centres far more quickly than by relying on donations alone. In fact, The Fred Hollows Foundation estimates that with equity and debt financing, their donations can build seven times more facilities, thereby improving availability of services and building local sustainable capacity. Utilising the latest technologies, smart hospital efficiencies, and uncompromising quality standards, Alina Vision's hospitals aim to be financially self-sufficient, and even profitable—a key element of shared value. Planning is now underway for the establishment of a second eye hospital in Nepal.

Alina Vision has brought together a wide range of actors from different sectors to support its success. For example, it has collaborated with international NGOs and private sector investors, other philanthropic donors as well as governments for licensing and accreditation, schools and local NGOs to enable school and community screening, local and international NGOs for funding support, and international hospital networks, ophthalmologists and clinical training institutions for pro bono expertise.

PharmAccess's programme on using mobile technology to break access and awareness barriers in hypertension and diabetes care: Linking Shared Value and Self-Management⁶⁶

PharmAccess has developed a digital service model that combines financial support and physical access to care for people with low-income while stimulating quality of care and generating real-time medical and financial data insights for doctors and healthcare payers. This model runs on the mobile healthcare payment platform M-TIBA, a PharmAccess innovation that connects patients, payers and providers through a health wallet on their mobile phones.

OBJECTIVE

To provide financial support and physical access to care for low-income patients.

PARTNERS

PharmAccess, Sanofi and Boehringer Ingelheim.

COUNTRIES

Kenya

DATE

2010 – ongoing

HIGHLIGHTS

The model strengthens the key players in the healthcare system, beginning with patients. When diagnosed with hypertension and diabetes, patients enrolled in the programme through M-TIBA receive mobile entitlements to (co)pay for healthcare directly with their mobile health wallets at connected M-TIBA clinics. In addition, patients are encouraged to self-manage their disease via their telephones (smartphone or analogue). Combined with blood pressure and glucose meters, the app allows patients to upload blood pressure and glucose readings and share them with their healthcare provider. They also receive support in leading a healthier lifestyle and adhering to treatment (Figure 6).

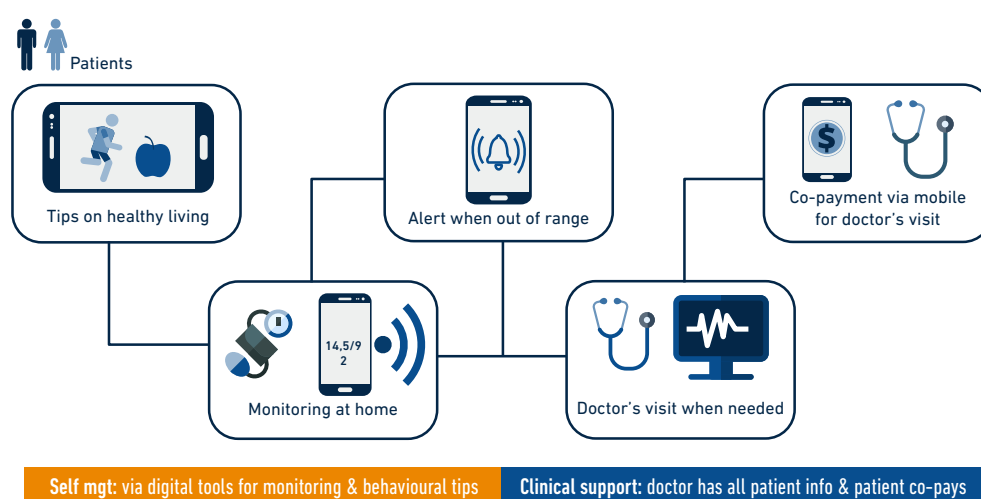


Figure 6. The patient is supported throughout the patient journey with self-management tools

⁶⁶ Pharm Access Foundation. Breaking access and awareness barriers in hypertension and diabetes care through mobile technology. 2019. Available at: <https://www.pharmaccess.org/update/breaking-access-and-awareness-barriers-in-hypertension-and-diabetes-care-through-mobile-technology/>

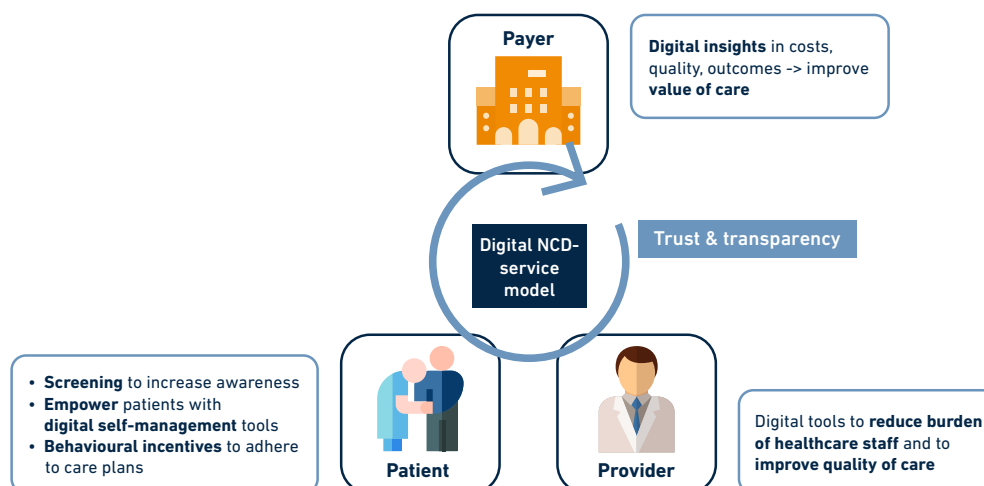


Figure 7. The digital service model and the benefits for patients, the provider, and the payer

For doctors, the model helps them remotely monitor the health status of their patients and provide feedback on guideline adherence. The digital platform collects medical and financial data from each healthcare visit in real-time, offering doctors immediate insights on blood pressure and glucose trends, as well as healthcare utilisation and costs, at both the individual and patient population level. Payers get realtime information on costs and outcomes of care (Figure 7), helping them make informed decisions on financing NCD care more efficiently.

Average costs of care are US\$6.80 per month for patients with hypertension, US\$8.40 for patients with diabetes and US\$13 for patients with both conditions. Drugs comprise 63% of monthly costs. To date, adherence⁶⁷ is 46%, almost twice the benchmark (25%).⁶⁸ The main reasons for drop out are the opportunity costs of travelling to the clinic, the option of buying cheaper drugs in pharmacies outside the clinic, and relocation.

INSIGHTS

Although adherence is almost twice as high as the benchmark, there is still room for improvement. As most patients drop out for financial reasons (opportunity costs of clinic visits and costs of drugs), PharmAccess is experimenting with teleconsultations to reduce the need for clinic visits. Together with behavioural scientists from Duke University, PharmAccess is testing behavioural interventions such as reminders, positive feedback from the app, and the use of social norms and peer-pressure from patient groups.

Patients report that the self-management programme empowers them to take control of their disease, and the feedback on blood pressure and glucose levels helps them to understand the relation between adherence to therapy and disease outcomes. PharmAccess partnered with the Kenya Defeat Diabetes Association to organise patient group meetings, where peer educators discuss topics such as lifestyle issues or how to use the digital tools. This model is both low-cost and self-sustaining—two key elements of shared value. Moreover, it addresses multiple aspects of access, including affordability, awareness and appropriateness.

PharmAccess technology is by definition people-centred, as its core objective is to empower patients to self-manage their conditions. Going forward, the programme will address adherence issues by adopting a shared value approach throughout the NCD treatment journey and by involving people living with NCDs earlier on in the programme design.

⁶⁷ Adherence defined as measuring at home or visiting the clinic.

⁶⁸ Oti et al. Outcomes and costs of implementing a community-based intervention for hypertension in an urban slum in Kenya. Bull World Health Organ. 2016;94(7):501-9

SECTION 5

FRAMEWORK

A framework to capture the access challenges and needs of PLWNCDs and achieve shared value in NCD initiatives

Informed by the case studies and consultations with PLWNCDs, a framework has been developed as a conceptual tool, whereby a people-centred lens is applied to social impact in order to guide the implementation and scaling of access initiatives and programmes on NCDs.

The framework builds on the Strategic Approaches provided in the WHO Framework on Integrated People-Centred Health Services to consider various dimensions of Access (6As) (Acceptability; Awareness; Availability; Affordability; Appropriateness; Actors) from the perspective of those with lived experiences. For each dimension of access, the framework presents complementary perspectives regarding indicators that should be factored into NCD programming to more adequately address the needs of PLWNCDs, resulting in access initiatives that truly have social impact.



WHO Framework on Integrated People-Centred Health Services' Strategies and Strategic Approaches

Dimensions of access



Acceptability (ability to seek)

Relates to cultural and social factors determining the possibility for people to accept the aspects of the service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the perceived appropriateness of people seeking care. The extent to which PLWNCDs are comfortable with the characteristics of their providers (and vice-versa) and their health options.

STRATEGY 1

Engaging and empowering people & communities

Strategic Approach

1. Engaging and empowering individuals and families
2. Engaging and empowering communities
3. Engaging and empowering informal carers
4. Reaching the underserved and marginalised

STRATEGY 2

Strengthening governance & accountability

Strategic Approach

1. Bolstering participatory governance
2. Enhancing mutual accountability

The programme seeks to understand and address the cultural beliefs and social perceptions of PLWNCDs regarding their condition(s) and their subsequent needs to inform education and awareness raising, screening and prevention, treatment and follow-up.

The programme has a governance system that embeds context-specific perspectives to ensure interventions are appropriate, feasible, and meet the needs of local communities, with services that are culturally appropriate and welcoming.

STRATEGY 3 Reorienting the model of care	STRATEGY 4 Coordinating services within and across sectors	STRATEGY 5 Creating an enabling environment
<p><i>Strategic Approach</i></p> <ol style="list-style-type: none"> 1. Defining service priorities based on life-course needs, respecting social preferences 2. Revaluating promotion, prevention, prevention and public health 3. Building strong primary care-based systems 4. Shifting towards more outpatient and ambulatory care 5. Innovating and incorporating new technologies 	<p><i>Strategic Approach</i></p> <ol style="list-style-type: none"> 1. Coordinating care for individuals 2. Coordinating health programmes and providers 3. Coordinating across sectors 	<p><i>Strategic Approach</i></p> <ol style="list-style-type: none"> 1. Strengthening leadership and management for change 2. Strengthening information systems and knowledge 3. Striving for quality improvement and safety 4. Reorienting the health workforce 5. Aligning regulatory frameworks 6. Improving funding and reforming payment systems
<p>The programme takes a holistic approach to the needs of PLWNCDs, by conducting prevention, screening, treatment, care and support and follow-up activities. This makes the services that the programme provides easier for PLWNCDs to seek, in particular to overcome the stigma that might be associated with NCDs in their communities.</p> <hr/> <p>The programme is designed, implemented and monitored in terms of how it fits the needs of PLWNCDs and their cultural and social context.</p>	<p>The programme facilitates integration across health platforms such as health platforms for communicable diseases (especially HIV/AIDS) and helps address stigma that may be associated with NCDs and other conditions, including infectious conditions. NCDs provide an opportunity to incentivise bi-directional screening as part of a package of services.</p> <hr/> <p>The programme includes psychosocial support services and peer-support activities are integrated.</p>	<p>The programme seeks to ensure cultural beliefs and social perceptions are taken into consideration across sectors to drive social and policy change.</p>



Awareness / approachability (ability to perceive)

Relates to the ability of people with health needs to identify that some form of service exists, can be reached, and can have a positive impact on their health. Various elements contribute to making the services more or less approachable, such as health literacy, knowledge about health and sickness, transparency, trust and expectations.

STRATEGY 1

Engaging and empowering people & communities

The programme engages with people in their communities, including PLWNCDs, their carers and families to evaluate levels of health literacy.

These engagements become the basis for educating people on NCDs. The programme seeks to provide PLWNCDs with health education and support to improve NCD self-management and prevent secondary complications of NCDs. Health education is conducted in the local language to ensure that information reaches and is understood by the greatest number of people.

PLWNCDs are informed on their condition(s), and they and their communities can be substantially involved in designing the programme in its early stages and remain involved in subsequent phases when the programme is (re)adapted.

STRATEGY 2

Strengthening governance & accountability

The programme clearly communicates on opportunities for PLWNCDs and members of their communities to get involved in the programme design, monitoring and evaluation.



Availability (ability to reach)

Constitutes the physical existence of health resources with sufficient capacity to provide services. It results from characteristics of facilities, individuals (e.g. duration and flexibility of working hours), providers (e.g. presence of HCPs, qualification) and modes of service provision.

The programme evaluates existing health infrastructures, presence and qualification of healthcare providers, and modes of service provision.

The programme addresses barriers in PLWNCDs' ability to reach health infrastructures and qualified healthcare providers.

The programme organises transportation to healthcare facilities, sets up facilities as needed, or repurposes existing infrastructure as appropriate.

The programme assesses how the health workforce and delivery platforms are deployed and optimised to address the needs of PLWNCDs.

STRATEGY 3 Reorienting the model of care	STRATEGY 4 Coordinating services within and across sectors	STRATEGY 5 Creating an enabling environment
<p>The programme evaluates the promotion and prevention measures that might be in place for NCDs.</p> <hr/> <p>The programme addresses NCD prevention and/or includes relevant organisations as partners to ensure that any prevention activities are coordinated to have a maximum reach.</p>	<p>The programme communicates on the different services, including those outside the health sector and community-based resources available to PLWNCDs, in a way that is adapted to levels of health literacy, social norms and with technology that most people can be expected to reach.</p> <hr/> <p>The programme takes a life course approach to assess populations' needs, including at-risk and marginalised populations such as women or older people.</p>	<p>PLWNCDs receive training and achieve predefined goals, including better adoption of preventive health behaviours, increased knowledge of symptoms, better health-seeking behaviour, and better adherence to treatment.</p>
<p>The programme provides outpatient care that does not require PLWNCDs travelling long distances to access care services.</p> <hr/> <p>The programme supports the strengthening of primary-care based systems.</p> <hr/> <p>Digital health services are leveraged in a way that is adapted to the digital literacy of populations, taking into account the particular challenges of those who are less familiar with technology or do not have access to any internet signal, and perhaps do not have access to water or electricity services.</p>	<p>The programme adopts an integrated-care approach, which enables PLWNCDs to access the services they need, even for multiple NCDs, in one place. For example, PLWNCDs can visit both a GP and specialists without having to travel to different places. Therefore, the programme should support health workers' training on multi- and comorbidities.</p> <hr/> <p>The programme leverages eHealth and mHealth interventions to improve access to information and coordination of care through the establishment of integrated medical record systems that facilitate the tracking of medical histories.</p>	<p>Health workers receive comprehensive and people-centred NCDs training, developed to address the needs of PLWNCDs.</p>



Affordability

(ability to pay)

The measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). It is influenced by the wider health financing system and by household income.



Appropriateness

(ability to engage)

The extent to which the provider's operation is able to meet people's preferences (hours of operation, scheduling practices, communication options). It relates to the fit between services and need, timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided.



Actors

To best address the above dimensions, successful models will need to support the development of a sustainable ecosystem of actors and partners, as part of a whole of society approach to NCDs that calls on all sectors to step up and highlight the central role that civil society and PLWNCDs play within health governance, planning, accountability and multisectoral partnerships.

STRATEGY 1

Engaging and empowering people & communities

The programme evaluates the financial situation of PLWNCDs and their communities and focuses on adapted solutions.

The programme is rooted in a charter on how to facilitate dialogue between healthcare professionals and PLWNCDs.

The programme places the meaningful involvement of communities and PLWNCDs at the very core of its strategy. It seeks to keep involving PLWNCDs and their communities on a regular basis at every stage of the programme.

The multistakeholder programme increases community awareness of NCD risk factors, co-morbidities, and opportunities for prevention.

STRATEGY 2

Strengthening governance & accountability

The programme has a means-based assessment tool to determine a personalised financial support plan for each patient.

The programme provides services for free, or has a co-financing mechanism in place where PLWNCDs share in the cost of treatment according to their means, with programme partners stepping in to cover the rest.

The programme results in a lower average end user price per course of treatment for products.

The programme evaluates the quality of care provided to PLWNCDs.

Communities and PLWNCDs are represented through a governance body and are involved in every step of programme design and take part in the monitoring and evaluation of it.

The programme sets up a board, or another form of governance body, where PLWNCDs and members of their communities can sit and engage with the other stakeholders.

STRATEGY 3 Reorienting the model of care	STRATEGY 4 Coordinating services within and across sectors	STRATEGY 5 Creating an enabling environment
<p>The programme builds the necessary infrastructure and donates the necessary equipment to run.</p> <p>The programme results in more facilities having NCD products in stock.</p> <p>The programme develops new / leverages existing financing mechanisms to cover needed services for PLWNCDs, that are adapted to individuals' financial and social situations, providing the care that is most appropriate.</p> <p>The programme uses integrated supply chains to deliver on its activities in the most efficient way.</p>		<p>Part of the programme's expenditure goes to building stronger people-centred health systems in a way that advances achievement of universal health coverage (UHC) and eliminates financial barriers to the uptake of and adherence to NCD interventions that are cost-effective.</p> <p>The programme is financially sustainable.</p>
<p>The programme takes into account the social preferences of the communities it operates in, to design a model of care that allows PLWNCDs to engage.</p> <p>The programme has referral and counter referral systems in place.</p> <p>The programme has shared clinical decision making in place.</p>	<p>The programme uses multidisciplinary care teams where PLWNCDs can seek different healthcare providers based on their needs.</p> <p>Health workers receive training on how to communicate and engage with PLWNCDs. In particular, health workers know what questions to ask to evaluate a person's health and educate them on self-management of NCDs.</p> <p>Health workers know if and when PLWNCDs need to be referred to another service—in particular, a primary care provider knows when to refer an individual to a specialist, and specialists know when the individual needs to be referred to another specialist.</p>	
<p>The programme supports and funds local social enterprises, and community/PLWNCDs-led organisations are supported to ensure the sustainability of delivery platforms at community level in the long run.</p>	<p>The programme seeks to collect and share data across stakeholders and sectors, including patient-reported experiences and outcomes. Evaluations by a multidisciplinary team can ensure real-time adjustments are made across the spectrum of interventions.</p>	<p>Impact of the programme on PLWNCDs, including lower prevalence of NCDs among the population, increased QALYs (Quality Adjusted Life Years) / decreased DALYs (Disability Adjusted Life Years), PLWNCDs-reported experiences and outcomes, and lower out-of-pocket costs for PLWNCDs and their families. Such indicators make the case for people-centredness as a mechanism to mobilise long-term change, improve efficiency and achieve social impact for PLWNCDs.</p>

Social Impacts & Outcomes for Actors/Stakeholders

Impacts & Outcomes on PLWNCDs	Impacts & Outcomes on SOCIETY	Impacts & Outcomes on BUSINESSES
<ul style="list-style-type: none"> • Prevalence of NCDs • QALYs (Quality Adjusted Life Years) / DALYs (Disability Adjusted Life Years) • Mortality avoided / lives saved • PLWNCDs-reported experiences and outcomes 	<ul style="list-style-type: none"> • Greater community awareness of NCD risk factors, co-morbidities, and opportunities for prevention • Facility-level availability: % of facilities with NCD products in stock • Average end-user price per course of treatment for products • % of health workers receiving NCDs training that achieve predefined training goals (increased knowledge of symptoms or treatment protocols, application of that knowledge, improved quality of care) • % of PLWNCDs receiving training that achieve predefined training goals (better adoption of preventive health behaviours, increased knowledge of symptoms, better health-seeking behaviours, better adherence to treatment) 	<ul style="list-style-type: none"> • Sales and profits generated • The programme is financially sustainable for the companies and organisations involved

In exploring the notion of social impact in the context of NCDs, we have recognised the long-standing barriers to access faced by people living with NCDs and the urgent need to respond to these challenges with meaningful and appropriate action. The framework proposed in this publication is the result of collaborative work involving people living with NCDs, NGOs, academia and private sector, who contributed their views and expertise to implement effective NCD action, as described in the case studies. As the world seeks to build back better from the COVID-19 pandemic and with ever stronger commitments to NCDs rooted within the robust framework of the Sustainable Development Goals, it is our hope that this discussion paper will help inform novel approaches and practices to deliver social impact in a manner that improves access for everyone, everywhere and truly puts people first.



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