EMPHNET's Research Digest

Implementing and Evaluating Integrated Care Models for Noncommunicable Diseases in Fragile and Humanitarian Settings

The Growing Need for Non-Communicable Diseases (NCDs) Care in Humanitarian Settings

Nearly 80% of global NCDs-related deaths occur in low-and-middle-income countries, with about half of these fatalities occurring prematurely in individuals under the age of 70. This highlights an urgent need for effective management of NCDs, particularly in humanitarian settings where health systems are often disrupted and inadequate.

This research digest delves into a commentary titled "Implementing and Evaluating Integrated Care Models for Non-Communicable Diseases in Fragile and Humanitarian Settings." Published in Migration and Health, the commentary advocates for an integrated approach to NCD care in humanitarian environments, which aligns medical treatment with preventive and rehabilitative services to address the complex needs of people living with NCDs (PLWNCDs). It details the ongoing evaluation of the CAJA integrated model in North Lebanon, a case study designed to enrich the limited literature on integrated NCD care in humanitarian settings and improve health system responses in these areas.

Existing Barriers to Effective and Sustainable NCD Care

Humanitarian settings face significant obstacles to effective NCD care, with care often being sporadic and historically overlooked. Despite recent attention, NCD care remains fragmented with poor coordination during crises. At the health system level, primary healthcare for NCDs is underdeveloped, supported minimally by government initiatives, and plagued by inadequate funding.

Challenges such as insufficient staffing, high turnover, and limited availability of essential medicines and diagnostic equipment exacerbate the situation, limiting access to comprehensive care and complicating sustainable care delivery due to short term humanitarian funding and inadequate health information systems.

The Potential Value of Integrated Care

In the challenging environment of humanitarian settings, integrated care offers a promising solution to enhance NCD management. Advocated by the World Health Organization, integrated care aims to improve the coordination and delivery of health services at a primary healthcare level. This approach utilizes existing health platforms, extending services to include a comprehensive care range, thus fostering a coordinated, people-centered approach.

In-tegrated care also aligns work processes and communication across different health areas, breaking down traditional silos. This enhances resource efficiency and

contributes to higher care quality, accessibility, and system resilience during crises. For service users, integrated care can reduce costs and improve life quality, particularly for those with chronic conditions and multi-morbidities. Studies from high-income countries show that integrated care increases patient satisfaction and accessibility to services, highlighting its potential in humanitarian contexts.

Feasibility and Cost Effectiveness of Integrated Care

The commentary sheds light on a knowledge gap regarding the feasibility, effectiveness, and sustainability of integrated NCD care across various humanitarian settings. Evaluations by Médecins Sans Frontières (MSF) have demonstrated that integrating NCD care within existing health programs can be feasible and effective.

In Kenya, MSF successfully incorporated NCD care into their HIV program, with evaluations showing positive health outcomes over three years. In Jordan, MSF integrated additional services like mental health and psychosocial support, and physiotherapy into a primary-level NCD program and found it to be feasible and accepted by stakeholders, though it became costlier as services expanded. They suggested simplifying service delivery and adapting procurement practices could enhance future cost-effectiveness. There are also examples of NCD care integration into maternal and reproductive health programs in low-resource settings which point toward the overall feasibility of such a model.

Implementation Lessons to Support Integrated Care

Evidence on implementing integrated care for NCDs in humanitarian settings is limited, making lessons from other contexts essential for effective program design. Critical factors influencing implementation success include human resources, management and strong leadership, established relationships, regular team interactions, adequate resources including human resource remuneration, available replacements during holidays, and sustainable and long-term budgets.

Barriers such as traditional practices, role confusion, and greater dependence on informality or organically formed communication systems also play a significant role in reducing like-lihood of success.

Research Gaps, Needs, and Recommendations

Research on integrated NCD care in humanitarian settings highlights the need for stronger evidence, especially tailored to local contexts. Utilizing frameworks like the UK's Medical Research Council's and National Institute for Health and Care Research guidelines could refine the evaluation of care strategies. Implementation research also provides a useful approach to studying what factors affect how a complex intervention (i.e. integrated care for PLWNCDs) can be implemented in complex humanitarian settings.

Future re-search should focus on evidence that supports adapting and scaling care models, with early-phase studies alongside implementation for real-time adaptations. It is crucial to involve patients in co-creation, employ mixed research methods suitable for these contexts, and conduct economic evaluations to guide funding decisions. This will enhance the effectiveness and sus-tainability of integrated NCD care.

The CAJA Model: Integrating NCD Care in Lebanon

An ongoing academic and humanitarian partnership aiming to improve NCD care in Lebanon, especially among refugees from Syria implemented the CAJA model. In the first phase, they assessed existing NCD care models and found gaps in continuous, standardized care. This led to the development of an integrated care model named after the CAJA (Chabab Al Ataa Al Jazeel Association) clinic in Akkar, where it was piloted. The Akkar Governorate, hosting a significant Syrian refugee population, was chosen due to its high NCD burden. The model integrates various health services already present in the clinic, aiming to improve coordination and patient-centered care. The second phase was guided by a participatory theory of change and involves implementing and evaluating this model, focusing on a comprehensive suite of interventions that centered around the alignment of human resource processes and capacity, the use of a joint data management system integration, and patient empowerment. A concurrent mixed-methods study is documenting the implementation process and assessing progress toward program goals to inform future adaptations and maintenance.

Conclusion

The challenges of providing effective and sustainable NCD care in humanitarian settings are significant, yet the potential of integrated care models to transform this landscape is substantial. However, realizing the full potential of integrated care requires overcoming substantial barriers, including logistical, financial, and systemic challenges. As humanitarian settings continue to evolve, robust research and strategic implementation are crucial to inform the development of scalable and effective health interventions.

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