

NCD Burden in Urban Poor: Silent and Persistent Improving Screening and Treatment for Hypertension and Diabetes

INTRODUCTION

The Primary Healthcare – Doorstep Delivery Project (PHC-DSDP) implemented by RADS with funding support Gates Foundation looked at diabetes and hypertension prevalence and screening barriers (new cases) in 5,010 urban poor households in Orangi, Karachi and Dhoke Hassu Rawalpindi. The objective was to generate evidence for improving risk stratification, screening and referrals. The evidence shows that in poor urban communities the prevalence of undetected hypertension and diabetes is high while routine screening, diagnosis, treatment, and follow-up remain weak. Without outreach or some targeted screening mechanisms, hypertension and diabetes will remain undetected, and households will seek care only when complications occur.

KEY FINDINGS

Hypertension and diabetes are widespread: Among adults aged **49 years and above**, **55% report hypertension** and **46% report diabetes**. This shows a large NCD burden among older adults in urban poor communities

Figure 1: Prevalence of Hypertension and Diabetes Among Adults Aged 49+



Routine Screening is Missed: One in three adults (30 years and above) has never had their blood pressure measured, and **two in three** have never had their blood sugar tested. This means that early detection of high-risk adults remains undiagnosed until later stage complications appear.

Post Diagnosis Treatment Gaps: Among those diagnosed, **32% people with hypertension** and **15% people with diabetes** are not on treatment. Reasons are no follow-up, treatment discontinuation or lack of understanding. Our data shows that referral and follow up is a necessity for treatment compliance.

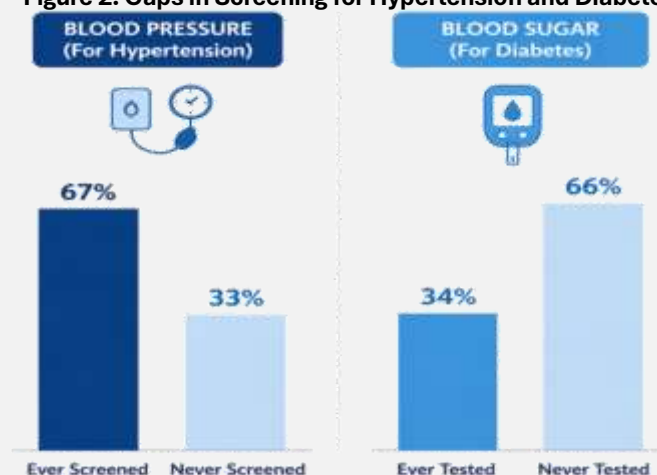
POLICY RECOMMENDATIONS

Outreach Mechanism for Routine Screening: community outreach has to integrate routine screening and risk identification both before diagnosis and post diagnosis follow up

Use Technology Tools to Complete Referral Loops: outreach has to maintain **digital** registers for hypertension and diabetes referral tracking and treatment follow up.

Targeted Missed Patients: In low-income communities small area estimates can help in identifying missed pockets of potential patients at risk of diabetes and hypertension.

Figure 2: Gaps in Screening for Hypertension and Diabetes



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