Hajah Naedawati binti Haji Morsidi,
Research and Development,
Department of Policy and Planning,
Ministry of Health,
Brunei Darussalam.
Email: naeda.morsidi@moh.gov.bn

EMPOWERING HEALTH PROMOTION

A Review on Finance Mechanism and Governance Entity

Acknowledgment

1. *Dr Hazri bin Haji Kifle, Deputy Permanent Secretary (Policy), Ministry of Health;*
2. *Hajah Zahrah binti Dato Paduka Haji Hashim, Head of Policy & Foresight, Ministry of Health;*
3. *Dr Justin Wong Yun Yaw, Medical Superintendent of Public Health, Ministry of Health;*
4. *Dr Hajah Norhayati binti Haji Md Kassim, Head of Health Promotion Centre*

TABLE OF CONTENT

			PAGE
		Executive Summary	3
1		**Introduction**	5
2		**Problem Description**	5
	2.1	*Building a Healthy Nation*	5
	2.2	*The Role of Health Promotion*	10
	2.3	*The Persistence of NCDs Prevalence*	15
	2.4	*Problem Identification*	16
	2.5	*Financing Health Promotion*	19
	2.6	*Health Promotion Governance*	23
3		**Policy Options**	24
	3.1	*Policy Option 1: Changing the governance entity of the Health Promotion Centre to be self-sustainable*	24
	3.2	*Policy Option 2: Review current policy and regulations for revenue collection and use, for alternative financing mechanism for health promotion*	27
	3.3	*Policy Option 3: Strengthen advocacy for tapping on available funding; International Organisations, philanthropists, waqaf, donors, etc*	28
	3.4	*Policy Option 4: Increase financial investment for health promotion within the recommended rate for a specific period of time, then shift allocation from curative to promotive*	30
	3.5	*Policy Option 5: Introduce a new financing scheme through public direct financial contribution*	31
4		**Recommendation and Conclusions**	32
		REFERENCES	33
		BIBLIOGRAPHY	35

ANNEXES 36

LIST OF FIGURES

1.1 *Leading Causes of Deaths in Brunei Darussalam* 7

1.2 *NCD Deaths as a Percentage of Total Deaths in Brunei Darussalam* 7

1.3 *Probability of Premature Deaths from NCDs (Brunei Citizens and Permanent Residents aged 30-69)* 9

1.4 *Health Promotion Emblem* 13

1.5 *Kumar and Preetha's Conceptual Framework for Health Promotion (2012)* 14

1.6 *Broad Conceptual Framework: Challenges in NCDs and Risk Factors Reduction in Brunei Darussalam* 17

1.7 *Detailed Conceptual Framework: Challenges in NCDs and Risk Factors Reduction in Brunei Darussalam* 18

1.8 *MOH Budget vs. Expenditures* 19

1.9 *HPC Recurrent/Operational Budget as a Percentage of MOH Budget* 20

1.10 *Cost-effective Public Health Interventions* 22

LIST OF TABLES

1 *Prevalence of NCDs and Risk Factors among Brunei Adults 1997 and 2011* 8

2.1 *SWOT Analysis of Policy Option 1* 26

2.2 *SWOT Analysis of Policy Option 2* 28

2.3 *SWOT Analysis of Policy Option 3* 29

2.4 *SWOT Analysis of Policy Option 4* 31

2.5 *SWOT Analysis of Policy Option 5* 32

Executive Summary

One of the main aims of Brunei Vision 2035 is to produce a nation with a high quality of life. The Vision relies significantly on healthy generations that are productive and will be able to contribute to the socio-economic development of the country. The Ministry of Health, Brunei Darussalam faces the pressure to bring down the worrying statistics of noncommunicable diseases (NCDs) prevalence that constitute the top killers in Brunei Darussalam since 2-3 decades ago. NCDs are the major cause of deaths in Brunei Darussalam and the main cause of disability in productive population which can hinder the progress of achieving the national target to improve life expectancy at birth.

With the current economic situation, health sector is pressured to provide services under limited budget while maintaining the quality of services provided. There is no doubt that the Ministry of Health is emphasising the notion of "prevention is better than cure", but this is not evident in terms of financial investment for preventive approach. This paper aims to promote the preventive approach in the reduction of noncommunicable diseases (NCDs) as opposed to curative approach in Brunei Darussalam. The paper will analyse the most prominent issue that contributes to the difficulty in meeting the NCDs reduction targets. It seeks into exploring an alternative mechanism for financing health promotion for better investments of limited funding available for the prevention and control of NCDs, with the primary focus on the improvement of population's health through a shift in funding priority. An ideal governance entity for health promotion is also discussed in this paper which complement the new financing option recommended.

Five policy options were considered in this paper as follow:

Policy Option 1: Changing the governance entity of the Health Promotion Centre to be self-sustainable.

Policy Option 2: Review current policy and regulations for revenue collection and use, for alternative financing mechanism for health promotion.

Policy Option 3: Strengthen advocacy for tapping on available funding; International Organisations, philanthropists, waqaf, donors, etc.

Policy Option 4: Increase financial investment for health promotion within the recommended rate for a specific period of time, then shift allocation from curative to promotive.

Policy Option 5: Introduce a new financing scheme through public direct financial contribution.

The paper recommended a combined policy of options 1 and 2 that is to review current policy and regulations for revenue collection and use, and changing the governance entity of the Health Promotion Centre to become a corporate entity. The first is to ensure funding security of the Centre and the latter is to give financial autonomy and freedom for the Centre to manage their own fund by venturing into partnerships in health promotion. This policy will be able to increase the capacity for health promotion in a more cost-effective and sustainable manner.

EMPOWERING HEALTH PROMOTION
A Review on Finance Mechanism and Governance Entity

1. Introduction

This paper aims to promote the preventive approach in the reduction of noncommunicable diseases (NCDs) as opposed to curative approach in Brunei Darussalam. The paper will analyse the most prominent issue that contributes to the difficulty in meeting the NCDs reduction targets. It seeks into exploring an alternative mechanism for financing health promotion for better investments of limited funding available for the prevention and control of NCDs, with the primary focus on the improvement of population's health through a shift in funding priority. An ideal governance entity for health promotion is also discussed in this paper which complement the new financing option recommended.

2. Problem Description

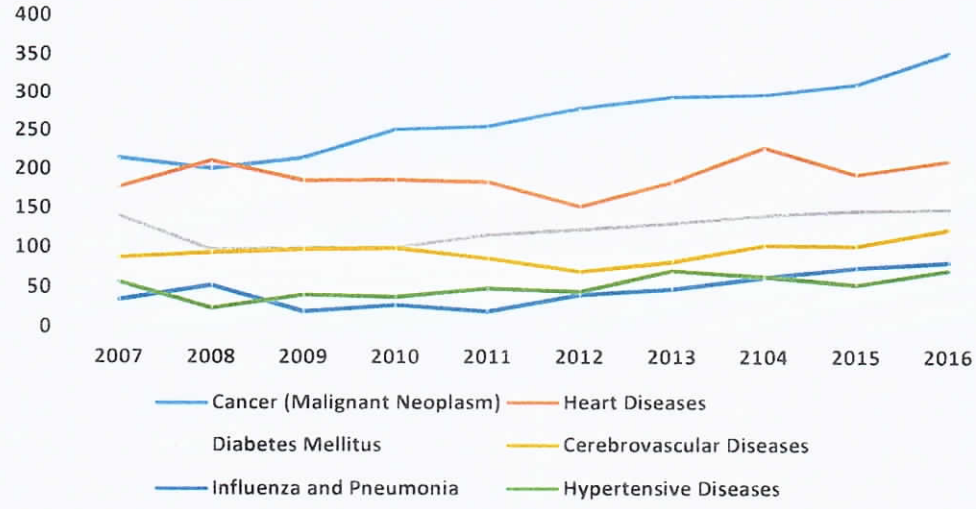
2.1 Building a Healthy Nation

One of the main aims of the Brunei Vision 2035 is to achieve a high quality of life that is among the top 10 countries in the world according to the global human development index. This is aimed to be translated into among others, the building of a healthy nation reflected by an improved life expectancy at birth. The Vision relies significantly on healthy generations that are productive and will be able to contribute to the socio-economic development of the country.

The current economic crisis due to the fall of oil prices, has forced the government of Brunei Darussalam to take strict measures to control government expenditures by cutting down public sectors budget since 2014. The Ministry of Health is not spared from this control measures and similar to other public sectors, pressures are rising in terms of providing public services within the limited budget while maintaining the quality of the services provided. Greater challenges are faced by those sectors which provide public good at minimal revenue in relation to their expenditures such as the health sector.

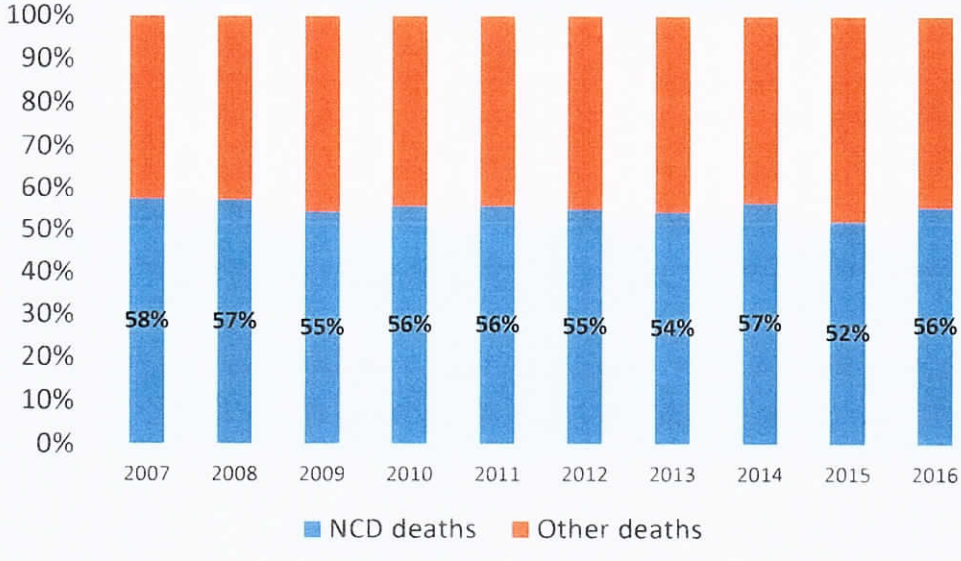
Health sector in Brunei Darussalam is facing the increasing burden of noncommunicable diseases (NCDs) such as cancer, heart diseases, diabetes and cerebrovascular diseases, and the escalating costs of treating them. NCDs have been consistently form a major cause of deaths in Brunei Darussalam since over more than a decade ago where more than 50 per cent of total deaths in Brunei Darussalam have been caused by NCDs. *Figure 1.1* shows the trends of the leading causes of deaths in Brunei Darussalam since 2007 and *Figure 1.2* shows NCDs deaths as a percentage of the total deaths in Brunei Darussalam. The 2011 National Health and Nutritional Status Survey (2nd NHANSS) has shown a huge increase in the prevalence of NCDs and risk factors among Bruneian adults as compared to the 1997 Survey (1st NHANS) (*Table 1*).

Figure 1.1: Leading Causes of Deaths in Brunei Darussalam



Source: Health Information Booklet, MOH (2015)

Figure 1.2: NCD Deaths as a Percentage of Total Deaths in Brunei Darussalam



Source: Health Information Booklet, MOH (2015)

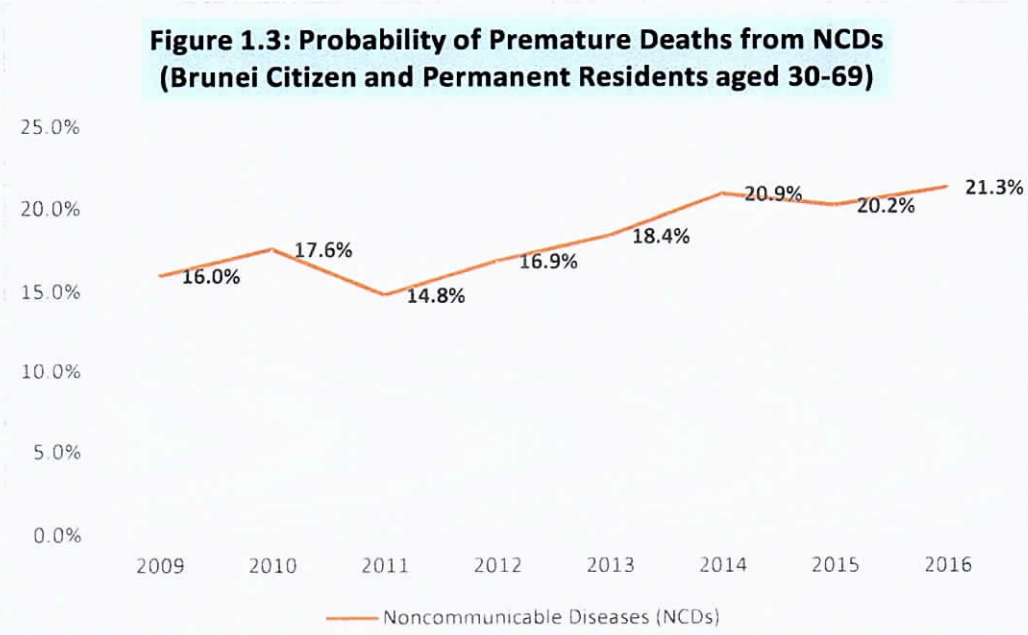
Table 1: Prevalence of NCDs and Risk Factors among Brunei Adults 1997 and 2011

NCDs and Risk Factors	National Nutritional Status Survey (1997)	National Nutritional Status Survey (2011)
Obesity	12%	27%
Overweight and obesity	44%	61%
Diabetes	-	12.5%
Raised blood pressure	28.6%	33.8%

Source: 2nd National Health and Nutritional Status Survey (2011)

NCDs stem from a combination of modifiable and non-modifiable risk factors. However, in Brunei Darussalam, it is well known that the common modifiable risk factors of NCDs are unhealthy diet, physical inactivity and tobacco use. In terms of these common risk factors, Brunei Darussalam has one of the highest rates of obesity in Southeast Asia, with 27% of the adult population being obese. The prevalence of tobacco smoking in Brunei Darussalam is among the highest in high income countries, with nearly one-third (32%) of adult males smoke (*BruMAP-NCD 2013-2018*).

NCDs kill 40 million people each year, equivalent to 70% of all deaths globally, and 17 million people die from a NCD before the age of 70. These "premature" deaths mainly occur in low- and middle-income countries (*WHO, 2017*). In 2009, the probability of people die from NCD-related diseases before the age of 70 (for aged 30-69) in Brunei Darussalam was 16%, and this has shown to be increased to 21.3% in 2016 (*Figure 1.3*).



Source: Health Information Booklet, MOH (2015)

Unless appropriate measures are taken, the NCDs prevalence in Brunei Darussalam and the probability of people dying prematurely from NCDs will continue to rise. NCDs affect quality of life and can reduce productivity among younger population groups. The increase in the probability of premature deaths due to NCDs is alarming in the sense of improving life expectancy which can bring negative impact to the progress of achieving the national targets for Brunei Vision 2035.

2.2 The Role of Health Promotion

There is a growing body of scientific evidence that lifestyle plays a huge part in individual's or population's health. From what they eat and drink, to how much they exercise, and whether they smoke or take drugs, all will affect their health, not only in terms of life expectancy, but how long they can expect to live without experiencing chronic diseases (*Healthy Lifestyles Living, 2011*). Exposure to NCD risk factors starts in early life. Most NCDs have chronic progress and stay silent or asymptomatic for a period of time, with major morbidity and mortality from NCDs occurring in adulthood. Children can also die from treatable NCDs such as cancers, diabetes and asthma. (*BruMAP-NCD 2013-2018*).

NCD related deaths are mostly preventable if interventions for prevention and control are available, NCD risk factors are reduced, and cost-effective disease management is implemented in an effective and balanced manner (*WHO, 2005*). In Brunei Darussalam, the importance of building on a social and cultural understanding of health and illness is highly recognised through the establishment of Health Promotion Centre under the Ministry of Health. The health promotion works include the process of enabling people to increase control over their health through advocacy and inter-sectoral actions which cover mainly the component of health education and community participation. The role and functions of the Health Promotion Centre can be found in ANNEX 1.

There has always been the high level support for health promotion and chronic disease prevention in Brunei Darussalam. His Majesty the Sultan and Yang Di-Pertuan of Brunei Darussalam in one of his Titah on the occasion of the New Year's Day, 1st January 2011said,

"Moving on to the health aspect, we have no choice but to change the focus of treatment services (cure) to prevention so that it can be sustainable in the long term. This can be implemented through increasing public awareness on the importance of a healthy lifestyle inclusively or "Health in All Policies" in all of their daily actions, as a key to effective prevention." (BruMAP-NCD 2013-2018).

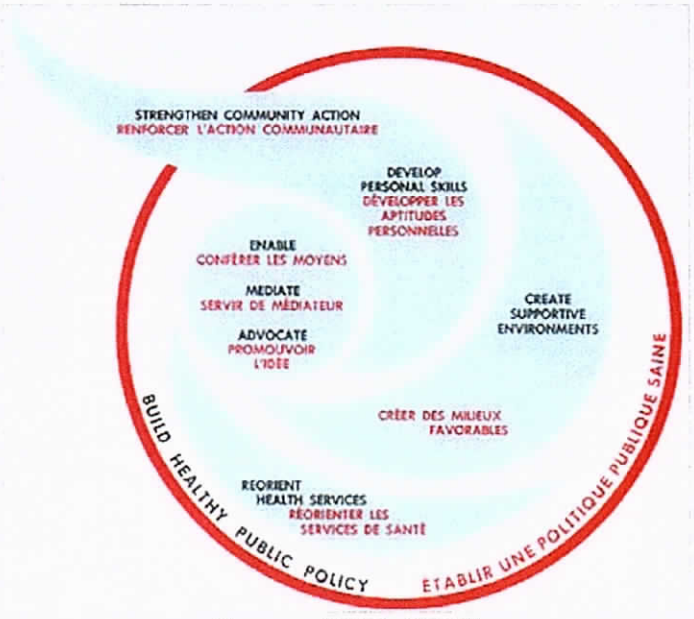
Series of operational and strategic initiatives have been implemented to address NCDs in Brunei Darussalam. The Health Promotion Blueprint 2011-2015 was developed in line with the Ministry of Health's strategic plan to work towards a healthy nation and offers guidance in the initial journey towards curbing the growth of NCDs. This was subsequently followed by the establishment of the National NCD Prevention and Control Strategic Planning Committee in 2012, with the prime objective of strengthening NCD initiatives and responsible for the development of the Brunei Darussalam National Multi-Sectoral Action Plan for the Prevention and Control of Noncommunicable Diseases (BruMAP-NCD) 2013-2018. BruMAP-NCD has been developed with the goal of achieving an 18% relative reduction in premature mortality from NCDs by 2018 ("18 by 18"). It sets up recommended actions for the Ministry of Health and other ministries, leveraging on existing policies and strengthening others, as well as providing detailed guidance to achieve the various goals and targets. It also provides a connection and continuity of actions identified in the Health Promotion Blueprint 2011-2015,

particularly in addressing the first three objectives of reducing tobacco use, promoting balanced and healthy diet, and promoting physical activity (*BruMAP-NCD 2013-2018*). All the initiatives to be implemented by respective ministries were outlined in the BruMAP-NCD document as attached as ANNEX 2.

In February 2016, health promotion has been placed at the highest level of the Ministry of Health's new organisational structure, and NCDs reduction becomes one of the three strategic priorities of the Ministry. The high commitment is reflected with the strengthening of inter-collaborative effort in addressing NCDs through the formation of the National Multi-Sectoral Taskforce for Health to leverage and further strengthen the work of the National NCD Prevention and Control Strategic Planning Committee.

The role of health promotion in the Ministry of Health has been aligned completely with the World Health Organisation's "Ottawa Charter for Health Promotion" produced at the First International Conference on Health Promotion held in Ottawa, Canada in 1986. The Charter defined health promotion action as one (a) which builds up healthy public policy that combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change to build policies which foster equity, (b) create supportive environment, (c) support community action through empowerment of communities – their ownership and control of their own endeavours and destinies, (d) develop personal skills by providing information, education for health services towards health promotion from just providing clinical and curative services (*WHO, 2009*) (*Figure 1.4*)

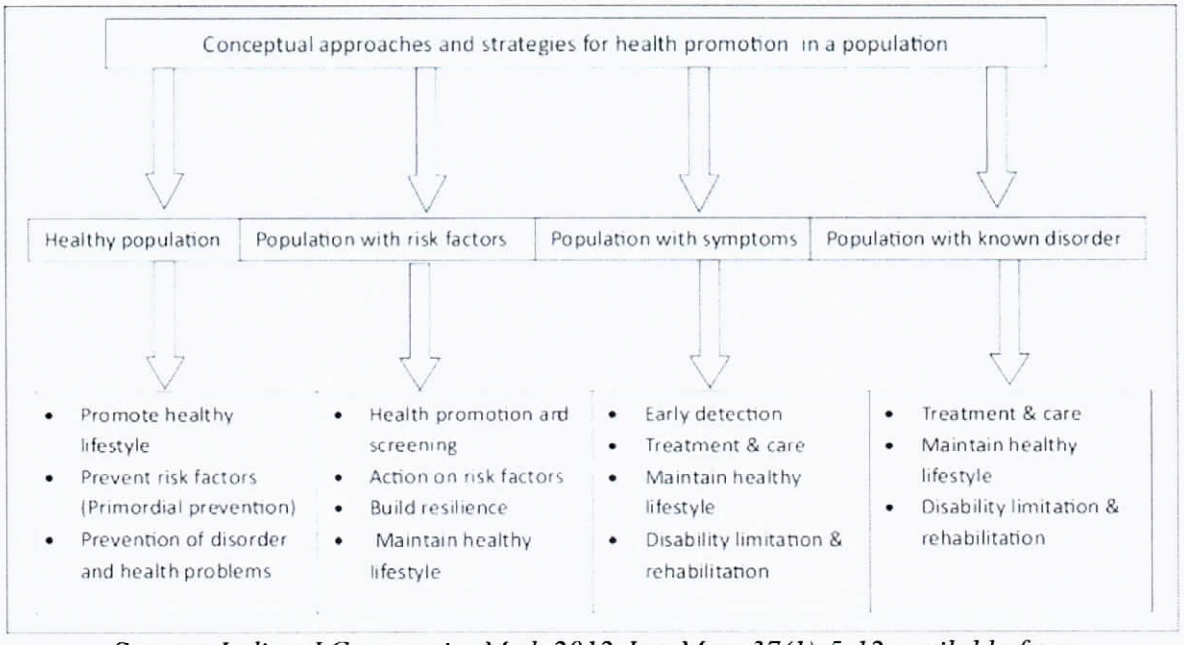
Figure 1.4: Health Promotion Emblem



Source: WHO (2017)

The conceptual framework for health promotion summarised by Kumar & Preetha 2012 (*Figure 1.5*) best described the approaches and strategies for health promotion in population that provides very similar strategies adopted in Brunei Darussalam. In this framework, population is divided into four groups and each population group is targeted with specific interventions to comprehensively address the need of the whole population. In brief, it encompassed primordial prevention for healthy population to curative and rehabilitative care of the population with diseases.

Figure 1.5: Kumar & Preetha's Conceptual Framework for Health Promotion (2012)



Source: Indian J Community Med. 2012 Jan-Mar; 37(1):5-12 available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3326808/#!po=30.8333. doi: 10.4103/0970-0218.94009

True to the recognition of health being more influenced by factors outside the health sector, health promotion calls for concerted action by multiple sectors in advocacy, financial investment, capacity building, legislations, research, and building partnerships. The multi-sectoral stakeholder approach includes participation from different ministries, public and private sector institutions, civil society, and communities all under the aegis of the Ministry of Health (*WHO, 2008*).

2.3 The Persistence of NCDs Prevalence

From the statistics shown in terms of both mortality and prevalence, it is obvious that the NCDs reduction targets could hardly be achieved within the set timelines. Despite the whole-of-nation approach to health promotion and disease prevention that has been initiated and implemented following the recommendations by the World Health Organisation, a significant impact on the health outcome of the population is hardly seen since the last decades. Although life expectancy at birth is increasing in Brunei Darussalam, this does not mean so the quality of life of the people, as one of the main determining factors for life expectancy apart from health condition, is the level of socio-economic status which is high in Brunei Darussalam. The increasing number of ageing population may increase the burden of treating chronic diseases and accommodating illnesses and disabilities which escalates government expenditures. The level of productivity required to build the nation may also be affected. These lead to questions as to why NCDs are still prevalent among the population in Brunei Darussalam, and what are the gaps in health promotion interventions and disease prevention initiatives in bringing a significant impact on public health outcomes.

It is difficult to establish a direct cause and effect relationship in health promotion as there are many factors influencing the effectiveness of health promotion interventions. Therefore this paper will attempt to identify only the most prominent issue that revolve around the execution of health promotion interventions in Brunei Darussalam, but not neglecting its interdependence with other issues. As there are huge information and established or known facts about health promotion issues available in the literature, and evidence of factors that influence the

effectiveness of health promotion interventions, issues underlying health promotion interventions in Brunei Darussalam will be identified using literature review (narrative) and interview questions to key informants.

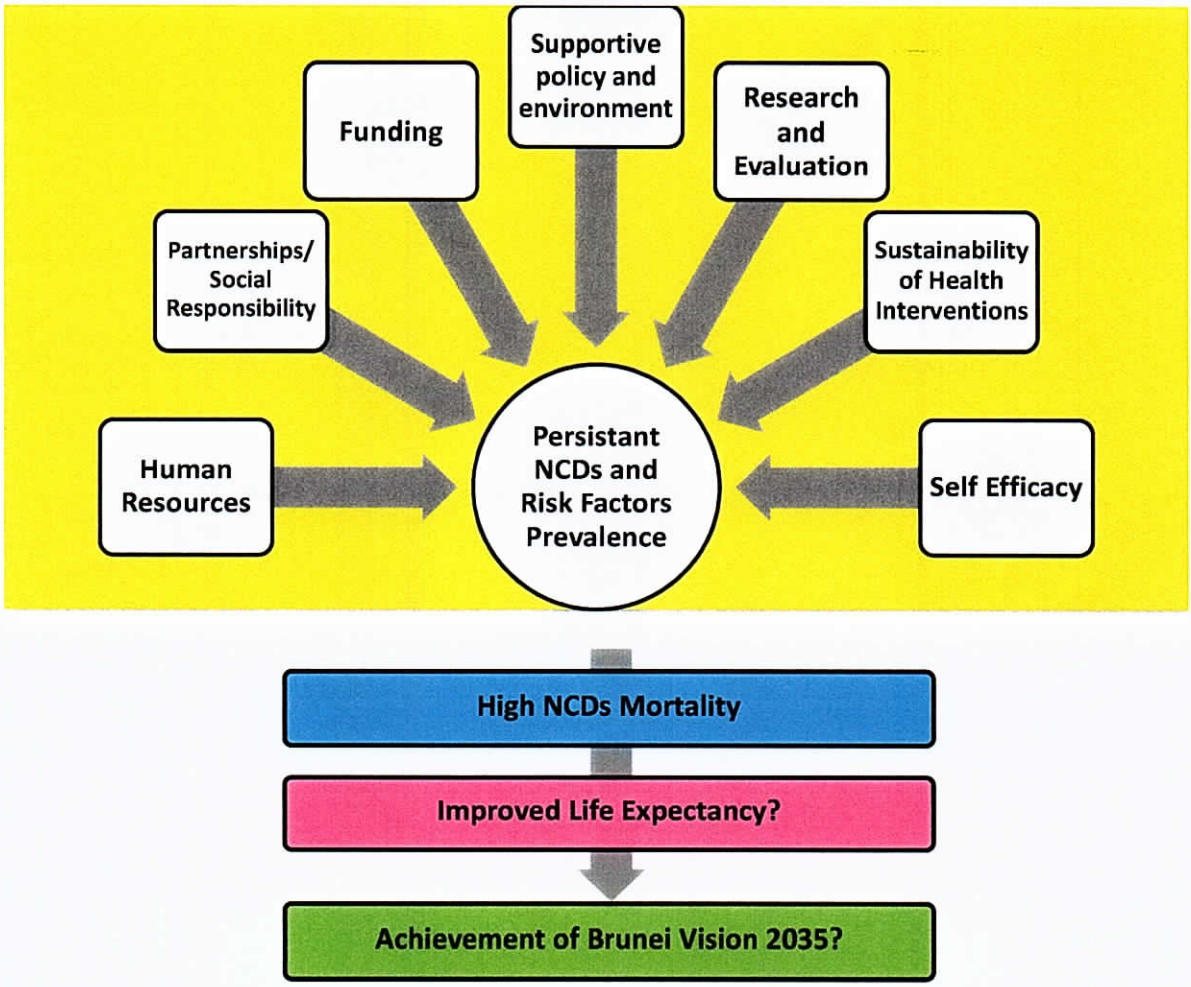
2.4 Problem Identification

Understanding the underlying issues and challenges of health promotion is very context driven hence explains the difficulty in conceptualising them into a comprehensive framework if only based from literature review or even more challenging, systematic review. The difficulty of conducting systematic reviews of public health (health promotion) interventions directly reflects the complexity of the interventions reviewed and the subsequent determination of effectiveness (*Jackson and Waters, 2005*). Users of health promotion and public health reviews have raised a number of criticisms of systematic reviews relating to the methodological criteria for inclusion of studies, insufficient attention to the quality of the interventions reviewed, and a lack of assessment of the theoretical foundation of the intervention and processes of implementation (*Tilford, 2000*). Therefore problem identification for health promotion has to rely mainly on the local setting in which the subject is discussed.

A list of interview questions was sent to 3 key informants who hold medium and high level positions in the Ministry of Health and in the exact positions in deciding the direction and operations of health promotion activities in the organisation. The list of questions is attached as ANNEX 3. The questions are basically to identify the underlying issues and challenges

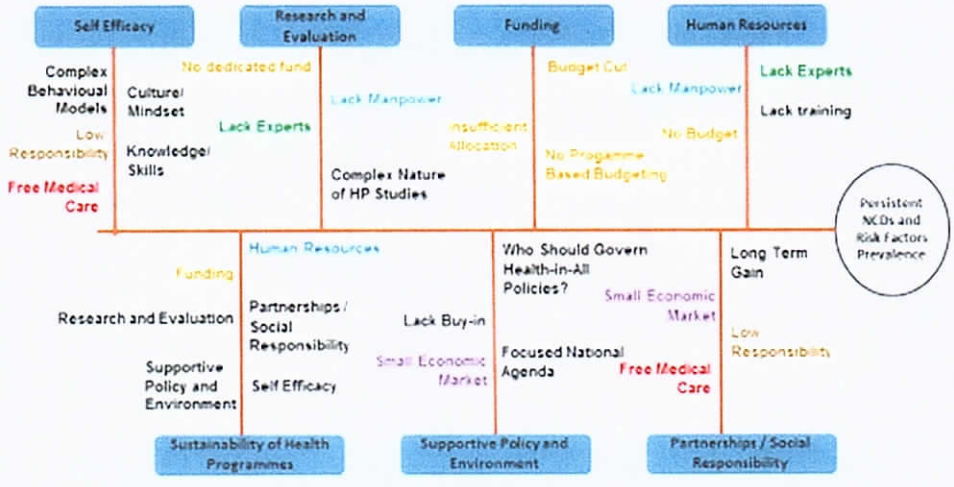
faced by Health Promotion Centre in executing interventions to reduce NCDs. *Figure 1.6* shows the broad conceptual framework of health promotion challenges in Brunei Darussalam.

Figure 1.6: Broad Conceptual Framework: Challenges in NCDs and Risk Factors Reduction in Brunei Darussalam



The identified challenges were further analysed based on the informants input and a detailed conceptual framework is developed as in *Figure 1.7* below. The clearer version of the diagram is attached as slide presentation in ANNEX 4.

Figure 1.7: Detailed Conceptual Framework: NCDs and Risk Factors Reduction in Brunei Darussalam

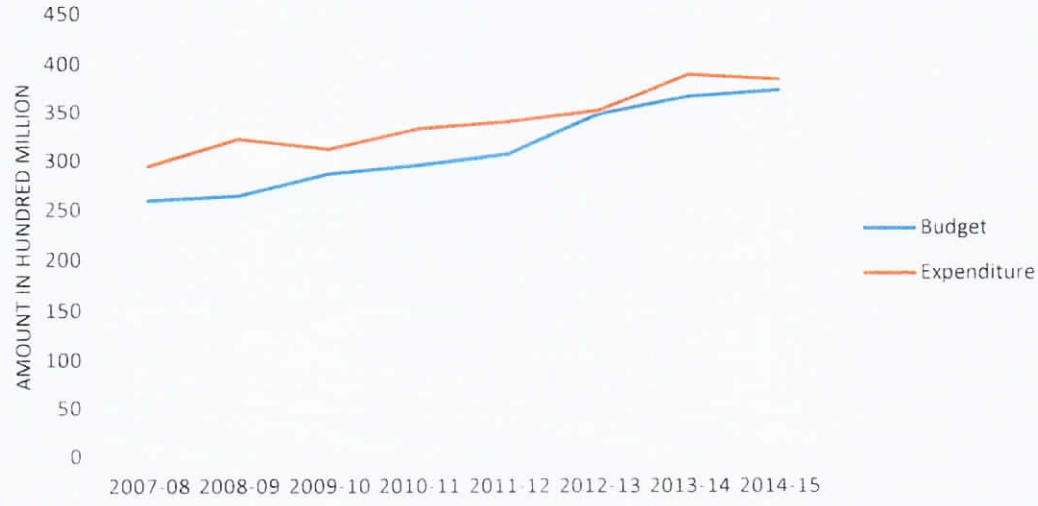


The diagram shows the interdependence of major underlying issues or challenges faced by Health Promotion Centre and among all the factors, issues of lack of budget or funding, and lack of manpower or expertise are the most prominent challenges. It can be seen by their interactions on the other issues that without these two important components of health promotion, it is very difficult to resolve the others. However as mentioned earlier, this paper will only attempt to address the most prominent issue that is financing health promotion.

Since the year 2000, the focus of policies on health promotion has been programme- or intervention-based by producing strategic documents such that of National Dietary Guidelines, National Breastfeeding Policies, School Feeding Schemes and the enactment of law such that of the Tobacco Order 2005. Little attention has been given to the importance of financial investment for preventive as opposed to curative approach. Despite the notion of prevention

is better than cure has become the direction that the Ministry is heading to, the investment for more sustainable and long term health outcome of the population through health promotion and disease prevention is less evident as compared to containing the cost of treating diseases and illnesses that continue to rise. There is no readily available data on how much MOH spent on NCDs, but the overall healthcare expenditures have been rising until the year 2014 where it began to reduce slightly due to the recent prudent spending initiative (*Figure 1.8*).

Figure 1.8: MOH Budget vs. Expenditures

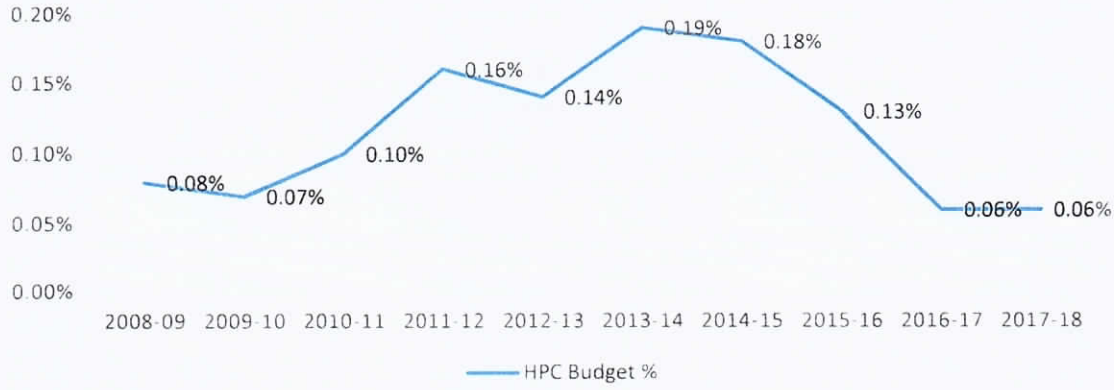


Source: Health Information Booklets (2009, 2012, 2015)

2.5 Financing Health Promotion

The budget for public health including health promotion has been consistently below 1% of the total Ministry of Health's budget. *Figure 1.9* shows the trend of Health Promotion operational budget as a percentage of Ministry of Health's budget since 2008/9 financial year.

Figure 1.9: HPC Recurrent/Operational Budget as a Percentage of MOH Budget



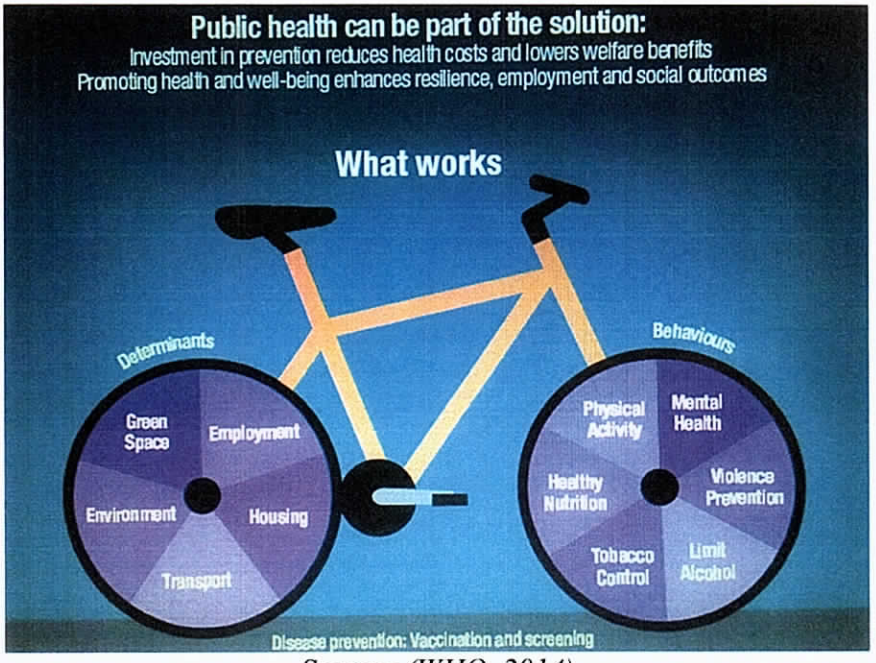
Source: Health Promotion Centre, MOH
Health Information Booklets, 2008; 2015

There is barely cost-effective policies in place for health promotion in Brunei Darussalam. This is due to lack of evaluation on the effectiveness of the programmes that have been implemented in order to come up with evidence-based interventions that is sustainable. But this is not unique to Brunei Darussalam. In fact, the same scenario also applies in many developing countries. Fortunately, some developed countries have had the opportunity to evaluate some public health interventions due to their advances. The findings from those evaluation studies can be regarded as the global reference for other countries taking into considerations the local public health needs and socio-cultural situations of the countries. Although not entirely replicable, the experiences from developed countries in implementing cost-effective and sustainable public health interventions can be learned and used as a cost-saving approach in planning and funding for public health.

There is no specific recommendations on how much a country should spend on health promotion but the World Health Organisation's Regional Office for Europe reported that countries generally spent on average of 3% of their national health sector budget which is considered too low to produce significant impact in offsetting the healthcare expenditures (*WHO, 2014*). But this is considered high if compared to Brunei Darussalam's spending of less than 1% of the total national budget for health. There is still huge gap in the balance of expenditure on preventive versus curative care among developed countries where it varies widely from an estimated less than 1% to over 8% of total health budgets (*WHO, 2014*). This is equivalent from 0.1% to 10% in Brunei Darussalam. Another WHO report on reducing the economic impact of NCDs in low- and middle-income countries estimates that further investment of 1-4% of current health spending is needed to reduce escalating healthcare costs (*WHO, 2011*).

The report also stated that even small investments promise large gains to health, the economy and other sectors, with sustainable outcomes. Investing in health in general has been shown to give economic returns to the health sector, other sectors and the wider economy, with an estimated fourfold return on every dollar invested (*WHO, 2014*). Examples of public health interventions that shown to give short or longer term return of investments are shared in the report. One evidence that was stated was that preventive approaches contribute between approximately 50% and 75% to the reduction of cardiovascular diseases (CVD) mortality in high-income countries, and 78% globally (*WHO, 2014*). *Figure 1.10* below shows the comprehensive framework of what works in terms of developing cost-effective policies for public health in developed countries of the European region.

Figure 1.10: Cost-effective Public Health Interventions



Source: (WHO, 2014)

Like in many countries in the world, financing health promotion in Brunei Darussalam is complicated, among others due to its economic behaviour. Financing of health promotion has been traditionally funded from government general revenue. Therefore, they have always been regarded as free to consumers. This is not surprising as health promotion programmes, like other healthcare services are considered as public goods where the economic market for them is non-existent. It is also difficult to make the market for health promotion (if any) attractive to investors because they are more concerned by the upfront costs of introducing health promotion programmes than its benefits which are only visible over a long term. In a worse case, the impact of the population-based interventions on consumer behaviour is not always clear due to lack of research, monitoring and evaluation of the programmes which makes investment on health promotion a rather risky undertaking.

But this is not what the developed countries has proven. Health promotion is widely recognised as a cost-effective way to reduce the burden of disease and to improve population health. Health promotion programmes has contributed in controlling health problems not just associated with NCDs, but also other problems such as ageing, HIV/AIDS, injuries caused by accidents and violence, infectious diseases, global epidemic influenzas, and others. In a global report on preventing chronic diseases, it confirms that if NCDs risk factors (unhealthy diet, physical inactivity and tobacco use) were eliminated, at least 80% of all heart disease, stroke and type 2 diabetes would be prevented; over 40% of cancers would be prevented. It also confirms that comprehensive and integrated approaches that encompass interventions directed at both the whole population and individuals…, made death rates fall by up to 70% in the last three decades in Australia, Canada, the United Kingdom, the United States, and have also had significant results in middle-income countries, like Poland (*WHO, 2005*).

2.6 Health Promotion Governance

The decision making process for health promotion in Brunei Darussalam has been at the very high level. This is conducive for providing direction and national strategy or policies for health promotion interventions. But as far as financing is concerned, the current finance mechanism has proved to be insufficient to bring significant impact over the years which in this case, the reduction of NCDs and improved health outcomes of the population. While some public health interventions were proved to be effective in Brunei Darussalam such as physical activity (reference), tobacco regulations, and cervical cancer prevention through HPV vaccines, the

question of the sustainability of the programmes over a long course of time will still be very much dependent on the available funding not just to run the programmes, but also to conduct their continuous monitoring and evaluation. The current financing mechanism for health promotion is limiting the potential financial capacity of the Health Promotion Centre due to the rigid nature of the Financial Regulations. Coupled with the current economic crisis, there is no way that Health Promotion Centre will be able to be financially sustainable to run its programmes over the next couple of years. Therefore, whatever policy options available to establish sustainable financial capacity for the Centre, has to depart from the current governance structure.

3. Policy Options

Based on the arguments in the previous sections of the paper, and acknowledging the difficulty faced by the government to secure more funding for health promotion, the following financing policy options are proposed.

*3.1 **Policy Option 1**: Changing the governance entity of the Health Promotion Centre to be self-sustainable*

This policy option seeks towards corporatisation of Health Promotion Centre. There are not many evidence in the literature on successful profitisation of healh promotion programmes, as most corporatisation initiatives have been directed towards hospital services. This could be explained by some articles that examined the marketability of health promotion programmes

as the one by Milio, 1988 which stated that … "not only is the marketplace an ineffective arena for health development, it is currently generating decision-making paths that obscure more effective perspectives and directions to promote Americans' health. … the use of "health promotion" by the proprietor sector, as well as the commercialization of health promotion, is creating decision-making processes that are not accountable to those whom they affect. … These developments require critical examination and work on alternatives if the promotion of health is to result in more health than hype" (*Milio, 1988*). There has also been little elaboration as to how specifically the logic of neoliberalism is deployed in such a way as to contribute to shaping contemporary health promotion policies and facilitating the modern-day health conscious movement (*Ayo, 2011*). The decision to commercialise health promotion programmes is indeed a difficult policy choice. Nevertheless, there are options for better partnerships rather than profit-making incentive in this policy which should be the primary focus of the corporatisation move. Looking from this perspective, there are evidence to support the redefinition of the roles of the state and private providers which has become a central theme of recent healthcare reforms. Preker et al, 2000 developed a framework based on recent developments in institutional economics and organisational theory, that argued for greater private participation in the generation of inputs and the provision of health services, while stressing the importance of a strong stewardship function of governments in securing equity, efficiency and quality objectives through more effective policy-making and financing (*Preker et al, 2000*).

The idea of this policy is to give the financial autonomy to the Health Promotion Centre to freely engage the private sectors to deliver health promotion programmes. Although not all health promotion programmes are marketable, but some are proven to be of high demand such as physical activity and screening programmes for NCDs. There are many studies conducted on the effectiveness of partnerships in health (though many of them were on public-private partnerships) that could be used as guidance and direction towards planning for corporatisation of health promotion. Some of the results that found what kind of partnerships work best and why, include; (1) the stronger the representation of the community and the greater community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gain, (2) sharing of power and control between the public and key protagonists whether they be professionals, business employers, health service providers, organisations or policymakers, (3) engaging local citizens in productive decision-making about health and social welfare and in policy development (*Gillies, 1998*).

Table 2.1: SWOT Analysis of Policy Option 1

Strengths	**Weaknesses**
• Can operate with current budget • Autonomous • Can generate and manage income • Away from government process but retain MOH influence or power	• Intangible targeted outcome • Corporate tax
Opportunities	**Threats**
• Strategic investment of income • Better health programme packages • Promote partnerships • May resolve manpower problem • Private investment opportunities • Increasing demand for effective health programmes	• Sustainability of business model • Market size • Manpower capacity

3.2 ***Policy Option 2:*** *Review current policy and regulations for revenue collection and use, for alternative financing mechanism for health promotion.*

In the previous year, the Ministry of Health collected approximately BND7.3 million revenues from user registration fees and medical treatments. This revenue is minimal compared to the overall healthcare expenditures but consist about 2% of the total spending which is within the recommended rate (1-4%) for increased health promotion investment. The proposed policy is to recoup the revenue back to the Ministry of Health which is currently unfeasible under the Financial Regulations (the regulations require that all revenues collected by the public sector to be consolidated into a central fund under the Ministry of Finance). This means that the existing Financial Regulations need to be reviewed and amended to better suit the current demand for revenue generation within the public sector and to help sectors cope with budget cuts. This option would mean that priority has to be shifted to health promotion but as been argued, it is the most cost-effective way to improve the health of the population which will support the achievement of the Brunei Vision 2035. It will also slowly strike the balance between curative and preventive approach to NCDs reduction in the country, where it is more sustainable to use the revenues from treating diseases for preventing them. The option can also provide more efficient way of managing revenue. In one of the study conducted by the Ministry of Health, the cost of collecting registration fees in all government healthcare facilities is much higher ($3.4 million) than the amount of revenue generated ($800,000). Therefore, instead of wasting resources and money in managing it, the revenue might also be used for obvious return of investment. Further benefit from reviewing the regulations would be the ability to utilise other sources of revenue such as "sin taxes" to fund health promotion

interventions which is very common in developed countries. The recently introduced tax imposed on sweet or sugary products is one example of "sin tax". Others like fat, salt and processed food taxes are yet to be explored. The option may take a long time to be implemented but provides solution at no or low cost, with possible high impact on population's health.

Table 2.2: SWOT Analysis of Policy Option 2

Strengths	**Weaknesses**
• No additional budget required • Sustainability of programmes • Saves cost of collecting revenues	• Intangible targeted oucome
Opportunities	**Threats**
• Strategic investment of government revenue • Promote better financial management • Cost-effective health programmes • Balance between cure and prevention • Utilisation of other sources of revenue	• May take long time to review regulations • Implications on other policies or regulations • Other health priorities

3.3 ***Policy Option 3***: ***Strengthen advocacy for tapping on available funding; International Organisations, philanthropists, waqaf, donors, etc.***

Beside government funding, some minimum in-kind sponsorship from private entities are periodically available to fund specific collaborative programmes and activities within a specific timeframe (eg collaboration with Ghanim on the promotion of healthy food productions). Other source of funding is also available from international organisations such as the World Health Organisation (through biennial progamme budget), Association of South East Asian Nations (ASEAN), Asia Pacific Economic Cooperation (APEC) and others which

are learned to be under-utilised. This provides an opportunity for advocating health promotion initiatives to be the most important national agenda for funding. This policy will also pave the way for the effective adoption of Health-in-All-Policies (HiAP) where public health issue is addressed collectively as one national policy concern such as addressing social determinants of health (eg. poverty) to reduce NCDs that involve the relevant stakeholders such as the Community Development Department (JAPEM) under the Ministry of Culture, Youth and Sports. This would result in the formation of finance review team to manage cross-functional funding of the programme which could be sourced from the sponsorships. This means that specific priority progammes must be identified and prioritised for the eligibility of funding from the source. However, it is difficult to secure a consistent available fund in this option as it relies on voluntary contributions. The process of tapping funding from international organisations which is usually in surplus is complicated and may entail political commitment or dilemma.

Table 2.3: SWOT Analysis of Policy Option 3

Strengths	**Weaknesses**
• Surplus of unused funds	• Unguaranteed funds at any time
Opportunities	**Threats**
• Effective Health-in-All-Policies	• Political dilemma

3.4 ***Policy Option 4:*** *Increase financial investment for health promotion within the recommended rate for a specific period of time, then shift allocation from curative to promotive.*

This policy option requires an initial upfront cost on increased health promotion investment by the amount recommended by the World Health Organisation that is between 1-4% of total healthcare spending. Based on previous year (2015) healthcare spending, this could be amounting between BND$3.9-15 million on top of the annual approved budget. Again public health issues to be addressed have to be identified and planned according to priority and include the monitoring and evaluation process. The length of which the increased funding is invested will take a certain period of time enough for significant impact to be visible which can be determined from the evaluation of the implemented programmes. The RE-AIM framework developed by Russell and Shawn, 1999 is a model for evaluating public health interventions that assesses 5 dimensions of quality; reach, efficacy, adoption, implementation and maintenance which occur at multiple levels (eg. individual, clinic or organisation, community) and interact to determine the public health or population-based impact of a programme or policy (*Russell and Shawn, 1999*). The model recommended that a period of 6 months to 1 year should be allowed for implementation and 2 years for maintenance before it is evaluated. Therefore a health promotion intervention can be evaluated at about 3 years after implementation after which a decision could be made to possibly shift some allocated funding from curative to preventive interventions. The option however, require a significant amount of money at the initial stage which is very unlikely in the current economic situation.

Table 2.4: SWOT Analysis of Policy Option 4

Strengths	Weaknesses
• Sufficient funding to design cost-effective programmes	• High upfront costs • Money not available at the current crisis • Intangible and long term targeted outcomes
Opportunities	**Threats**
• Cost-effective programmes • Improved health outcomes	• Capacity to evaluate programmes • Manpower capacity

3.5 ***Policy Option 5: Introduce a new financing scheme through public direct financial contribution.***

This option has been discussed in great depth within the Ministry of Health. It is a policy where public will be for the first time made responsible for their own health by giving a fixed financial contribution to the government to partially cover their own medical expenses. There are many healthcare financing schemes already introduced and practiced in other countries such as social health insurance, private health insurance, income and sin taxes revenues, outsourcing medical care and many others. Health systems financing has been subdivided into three sub-functions; revenue collection, pooling and purchasing (*WHO, 2000*). The details of each sub-function is available in many WHO reports but the strategic design of each of these functions has an immediate effect on coverage, delivery and access to health services *(WHO, 2007*). Even though the policy seems straightforward, a number of issues exist within the schemes where the implications on the healthcare systems is worth considering. Many countries which have implemented private or social health insurance schemes for example,

faced by issues such as inequity in the access of care due to differences in amount of contributions and the levels of care covered, threatening universal health coverage, reimbursement issues, payment methods, fund management, and in some circumstances has been proven to be detrimental to the population's health especially the socially disadvantaged groups like in the United States. Therefore careful consideration has to be made before venturing into this type of financing policy.

Table 2.5: SWOT Analysis of Policy Option 5

Strengths	**Weaknesses**
• Controls healthcare expenditures • Co-payments in health care	• Unaffordability of paying especially the disadvantaged groups • Unwillingness to pay
Opportunities	**Threats**
• Promote public awareness and responsibility on health • Investing for own health	• Build higher expectations on programmes • Inequity in access to care • Quality of care • Capacity to cope with complicated methods of payment, fund management and services packages

4. Recommendation and Conclusions

Based on the SWOT analyses of the five proposed options, there are more strengths and opportunities discovered in **policy option 1 and 2**, therefore this paper recommends to have combined policy option that is **to review current policy and regulations for revenue collection and use, and changing the governance entity of the Health Promotion Centre to become corporate entity**, where the first is to ensure funding security of the Centre and the latter is to give

financial autonomy and freedom for the Centre to manage their own fund by venturing into partnerships in health promotion. This policy will be able to increase the capacity for health promotion in a more cost-effective and sustainable manner.

The paper argues for the greater investment on health promotion by shifting funding priority from curative to preventive approach towards NCDs reduction. It also explores the possibility of venturing into more innovative ways of funding health sector to cope with the exorbitant costs of medical care that involve review of outdated policies and regulations as well as the restructuring of governance entity and processes. The recommended policy option is vital in the pursuit of reducing the prevalence and mortality from noncommunicable diseases (NCDs) which can be detrimental to the progress of the achievement of the Brunei Vision 2035.

REFERENCES

Ayo, N. (2012). Understanding Health Promotion in a neoliberal climate and the making of health conscious citizens. *Journal of Critical Public Health, Volume 22, 2012 – Issue 1, Pages 99-105.*

Brunei Darussalam National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases (BruMAP-NCD) 2013-2018. *Ministry of Health.*

Gillies, P. (1998). Effectiveness of alliances and partnerships for health promotion. *Health Promotion International © Oxford University Press 1998, Volume 13, No.2.*

Health Information Booklet (2015). *20th edition. Data Management, Office of Policy and Foresight, Ministry of Health.*

Health Information Booklet (2012). *17th edition. Statistics Unit, Department of Policy and Planning, Ministry of Health.*

Health Information Booklet (2009). 14th edition. *Statistics Unit, Department of Policy and Planning, Ministry of Health.*

Healthy Lifestyles Living. What is a Healthy Lifestyle. https://www..healthylifestylesliving.com/health/healthy-lifestyle/what-is-a-healthy-lifestyle/. *Published October 6, 2011. Last accessed on May 5, 2017.*

Jackson, N., & Waters, E. (2005). Criteria for the systematic review of health promotion and public health interventions. *Health Promotion International, Vol.20, No.4 © The Author 2005. Published by Oxford University Press.*

Kumar, S., & Preetha, G.S. (2012). Health Promotion: An Effective Tool for Global Health. *Indian Journal of Community Medicine, Jan-Mar, Vol.37(1), Pg. 5-12. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3326808/#!po=30.8333). doi: 10.4103/0970-0218.94009*

Milio, N. (1988). The Profitization of Health Promotion. *International Journal of Health Services, Vol. 18 – Issue 4, Pages 573-585.*

2nd National Health and Nutritional Status Survey (NHANSS) 2009-2011 (6-75 years). *Community Nutrition, Ministry of Health.*

Preker, A.S., Harding, A., & Travis, P. (2000). "Make or buy" decisions in the production of health care goods and services: new insights from institutional economics and organizational theory. *Bulletin of the World Health Organisation, 2000, 78(6).*

Russell, E., & Shawn, M.Boles. (1999). Evaluating the Public Health Impact of Health Promotion Intervention: The RE-AIM Framework. *American Journal of Public Health, Sept. 1999, Vol.89, No.9.*

Tilford, S. (2000). Evidence-based health promotion. *Health Education Research, Vol.15, Pg.659-663.*

WHO (2000). The World Health Report 2000. Health systems: improving performance. *Geneva, World Health Organisation, Chapter 5: Who pays health systems?*

WHO (2005). Preventing Chronic Diseases. A Vital Investment: WHO Global Report. Geneva: World Health Organization © 2005

WHO (2007). Financing health promotion. Discussion paper number 4, 2007. *World Health Organisation © 2007*

WHO (2008). South East Asia Regional Office. Regional Strategy for Health Promotion for South East Asia. *http://www.searo.who.int/LinkFiles/Reports_and_Publicatios_HE_194.pdf. Last accessed on May 28, 2017.*

WHO (2009). Milestones in Health Promotion – Statements from Global Conferences. *World Health Organisation © 2009.*

WHO (2014). The Case for Investing in Public Health – The strengthening public health services and capacity – A key pillar of the European regional health policy framework Health 2020. *World Health Organisation Regional Office for Europe © 2014.*

WHO (2017). Health Promotion – The Ottawa Charter for Health Promotion – Health Promotion Emblem. *http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index4.html. World Health Organisation © 2017. Last accessed on May 28, 2017.*

WHO (2017). From a burden to "best buy": reducing the economic impact of noncommunicable diseases in low- and middle-income countries. *Genevva: World Economic Forum, 2011. http://apps.who.int/medicinedocs/en/d/Js18804en/. Last accessed on May 31, 2017.*

WHO (2017). Noncommunicable diseases. *http://www.who.int/mediacentre/factsheets/fs355/en/. Last updated April 2017. Last accessed on June 2, 2017*

BIBLIOGRAPHY

Armstrong, R., & Waters, E. (2007). Systematic Reviews of Health Promotion and Public Health Interventions. *The Cochrane Collaboration. Cochrane Health Promotion and Public Health Field. July 2007, Version 2.*

Bury, M., & Taylor, D. (2008). Towards a Theory of Care Transition: From Medical Dominance to Managed Consumerism. *Social Theory & Health, 2008, 6, (201-219) © 2008 Palgrave Macmillan Ltd.*

Hernandez-Aguado, I., & Zaragoza, G. A. (2016). Support of public-private partnerships in health promotion and conflicts of interest. *BMJ Open 2016; 6:e009342. doi: 10.1136/bmjopen-2015-009342.*

McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly, Vol.15(4), 351-377 (Winter 1988). © 1988 by SOPHE. Published by John Wiley & Sons Inc.*

ANNEXES

كمنترين كصيحتن
MINISTRY OF HEALTH
BRUNEI DARUSSALAM

HEALTH PROMOTION CENTRE: ACHIEVEMENTS 2016 & FUTURE PLANS

Dr Hjh Norhasyati Hassim
SMO, Health Promotion Centre, MoH
Monday, 13 March 2017

MINISTRY OF HEALTH client first • together • excellence • dynamic

Strategic Priorities

Health is everyone's business	✓
Prevent and control NCDs	✓
Deliver excellent services through consolidation	✓

MINISTRY OF HEALTH client first • together • excellence • dynamic

Ministry of Health Strategic priorities and initiatives

	to make 'health is everyone's business'	to enhance quality of service delivery	to prevent and control non-communicable diseases
Initiatives	combat communicable diseases	communication & basic courtesy	reduce tobacco use
	health care financing	reduce waiting time	promote balanced and healthy diet
	health in all policies	availability of medicines, health technology and basic services	increase physical activity
		service quality through alignment and consolidation	identify people at risk for NCDs and manage effectively
		International accreditation	
	health securities and emergencies	human resources for health	improve quality of care and outcome of NCDs management

MINISTRY OF HEALTH client first • together • excellence • dynamic

Health Promotion Centre

HPC Mission:
Empowering People Towards Healthy Living

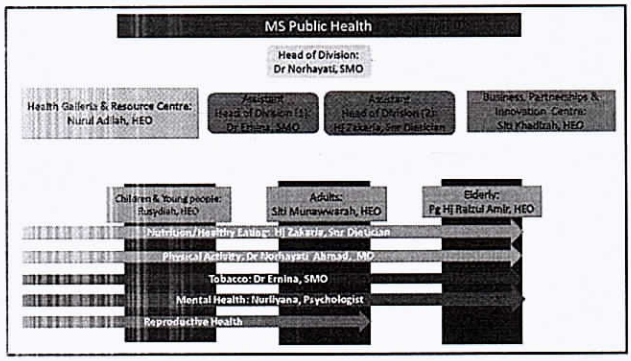
HPC: FUNCTIONS

1. Coordinate & organise health promotion programmes, particularly relating to healthy lifestyle & NCD prevention
2. Conduct surveillance & research on matters relating to healthy lifestyle & NCD prevention
3. Provide consultations, guidance & training on health promotion, healthy lifestyle & the prevention of NCDs
4. Advocate & support health promotion campaigns and activities undertaken by other stakeholders through partnership and collaboration

HPC Manpower (January 2017)

Posts/Designations	Division	Total
Senior Medical Officers	I	4
Medical Officers	II	2
Senior Dietitian	B3	1
Health Education Officer (9)/Dietitian (1)/Research Officer (1)/ Psychologist (1)	II (B2)	12 (1 on PhD)
Senior Translator (1)/ Senior Health Assistant (1)	III	1 1
Nursing – Nursing Officers (3)/ Staff Nurses (6)/Sch Health (12)/Community Health Nurse (1)/ Midwives (1)	II III, IV	23
Health Education Technician	IV	6
Clerk	IV	1
Record Assistant		1
Support Staff – Amah (4)/Pekerja T3 open vote (4)/	V	8
Total		61

- 1 SHA post ?/1 HEO post – seconded/1 HFO post - seconded



HPC Achievements 2016

PROGRAM	STATUS REPORT
Tobacco	• **I2M4 services** – ↑ no. of clients to total 330 in 2015 with ↑quit rate 22%. • **Capacity building** – PEN 2 Workshop attended by 172 community nurses. Evaluation has shown ↑ understanding / knowledge from 67% to 95%. • **Quit2Win Campaign** – for 50 students at Sekolah Menengah Seiyyidina Husin, in which 44% reported to have successfully quit smoking. • **Evaluation STAR apps** – 197 downloads, MARS score 3.31, user rating 3.8. • **Evaluation I2M4 counselors** – All counselors (no=15) used 5 'Rs intervention during their counselling sessions; Rating: ΔAs; 48s, 3Cs (Queensland University's Core Skills Competency Checklist for Counselling Encounter)
Physical Activity	• **Fit4Good** – completed in 4 secondary schools in 2016. Mean ↑ weight 2.10 kg (94 intervention group) vs ↑ weight 3.16 kg (165 control group) • **KBW** – 18 participants completed 15 weeks programme. Highest fat loss is 6.7kg (4.3%) for female & 6.3kg (1.3%) for male. 22% loss more than or equal to 3kg of fat. 44% loss fat weight ranges 0.2% - 4.3%. • **Bandarila Cerla** – facilitated aerobic sessions weekly with mean average of 120 participants per week
Nutrition	• NDG – Draft Revised NDG completed and sent to Dr Katrin Engelhardt (WHO) for review and check • **Healthier Choice Logo** –Guidelines for Nutrition Criteria and Healthier Choice Logo developed • **Healthy Supermarket** - FreshCo, Supasave Seria, Hua Ho Tanjung Bunut and Soon Lee Mentiri • **Healthy Restaurant** – Burger King (Healthier Choice Menu)
Obesity	• **BCHS** - ↓5% of bodyweight:Kohort 1/2016: 52% (14/27 peserta), Kohort 2/2016: 43% (12 /28 peserta). Kohort 3/2116: 55% (17 / 22 peserta), Kohort 4/2016: (still analysing) • **Partners for Weight Loss Program** – 13 fitness groups identified and currently developing guidelines for recognition of partners • **Healthy Weight For Life Program** – Ministry of Defence and Seri Mulia Sarjana School

HPC Achievements 2016

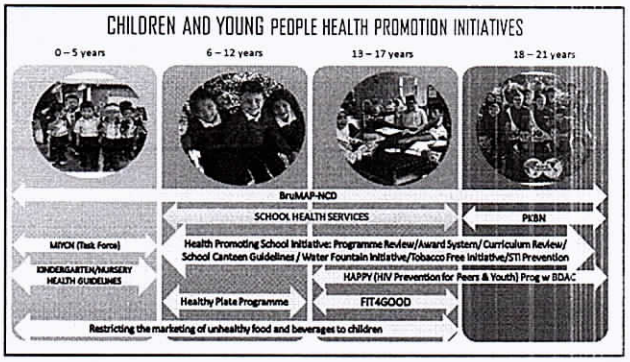
PROGRAM	STATUS REPORT
Workplace Health Promotion Program	• **Development of toolkit**- A Guide and Resource Book on Healthy Workplaces in Brunei Darussalam' was produced • **Training course for WHP facilitators** - 30 participants from 11 Government Ministries, UBD and 5 private organisations attended the course. • **HPC WHP** – May to October 2016: 8 health talks, Fruit Days (Mundoy & Wednesday), Tobacco Poster Competition • **Engagement with workplaces**- MoH, Radisson Hotel, Baiduri Bank, DM, TOTAL, Telbru, JM Rimba, JM Menglait, JPA, Tarsiwan School. • **Workplace Study (WHO budget)** – commissioned to CARe UBD, currently developing sampling frame and awaiting submission for ethics approval.
School based Program	• **PSBN** – 315 participants, ↑ knowledge on healthy diet, food safety, PA, tobacco, stress management and reproductive health • **Revised Science Curriculum (YR 8 Science teachers) Workshop** – Nutrition (120 teachers) and Tobacco (100 teachers) • **Pertandingan Bicara Berirama dan Pidato** - ↑awareness on healthy lifestyle among students • **Healthy Lifestyle Roadshow with IPI**– coverage of 3480 students of Year 4 Ugama Schools and Year 6 for Sekolah Arab • **HAPPY (BDAC)** – 21 schools, 1379 Yr 9 Students, ↑knowledge from 77% to 90% • **Pilot HAPPY plate** – Yr 1 and Yr 3 SMS (1st-22nd Nov2016): Response rates were very poor. ✓ 1st week collection = 15 / 200 Week 1 sheets were collected (12 from Year 1; 13 from Year 3) ✓ 2nd week collection = 3 / 200 Week 2 sheets were collected (1 from Year 1; 2 from Year 3) ✓ 3rd week collection = Only 1 was returned (from Year 3) • **Health Promoting School Evaluation** – Respondent rate: 82% (295 schools). Nearly ¼ (14.5%) of the schools have at least one of the criteria/factors for any of the healthy lifestyle topics/components being implemented as a health promoting school
Nurse-led Program	• **Pre-marital course** – 1017 participants attended and 24 talks were given throughout 2016 • **Health screening** – 1) Tayssir Sultan Hj Hassanal Bolkiah 2) Hua Ho Mangge Mall 3) KUPUSB. Total screened: 274, ↑BP: 8, ↑RBS: 8 (referred). • **Forum Sinar** – Year 7 students in 45 secondary schools • **Women's Health** – Breast Cancer Awareness Talks & BSE Demo: MOD (38 participants) and Biro Wanita Mukim Lumapas (200 participants).

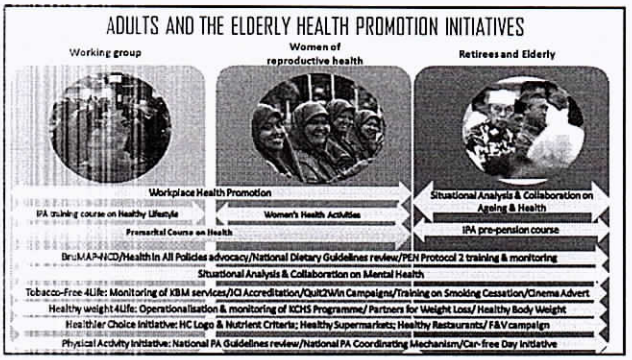
HPC Achievements 2016

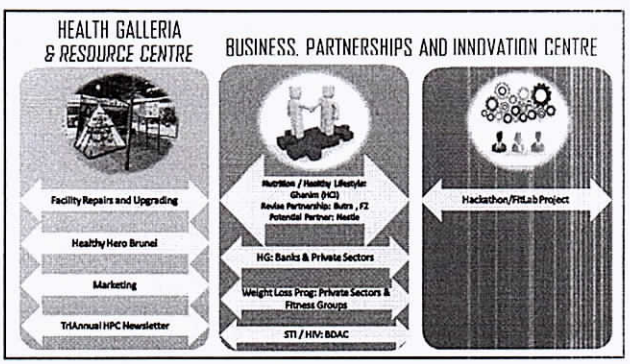
PROGRAM	STATUS REPORT
Health Galleria	• **Lets Grow Towards Health** – A total of 854 of Year 5 students participated between April 2015 and April 2016 • **A total of 2302 Visitors** ✓ 1,987 from schools; ✓ 186 from higher institutions; ✓ 129 public.
Social Marketing	• **Facebook** – 6495 followers (64% female, 36%male) • **Instagram** – 2498 followers (↑102% from 2015) • **Campaigns:** ✓ **#Capai30** - ↑ awareness on 30 mins of PA per day (1016 posts uploaded by public) ✓ **#apalaukraya**- ↑awareness on healthy plate during Ramadhan ✓ **#sugarlessSyawal** - ↑awareness on healthy diet during Syawal
World Health Days	Involvement in coordination of: • World Cancer Day • World Health Day • World Heart Day • Breast Cancer Awareness Week • World AIDs Day

HPC Achievements 2016

PROGRAM	STATUS REPORT
Research Monitoring Evaluation	• **STEPSNCD survey** – Data collection done August 2015 to April 2016. Data already analysed with preliminary results. Report in progress. Budgets Approved: $260,262.79, BudgetsUsed: $190, 370, Pending: $30,750 • **Student Projects:** ✓ Restricting marketing on unhealthy foods and beverages to children (Hj Zakaria), ✓ School canteen and fruit and vegetable marketing project (Ak Raizul) and; ✓ Healthier Choice Initiative (Hj Zakaria) ✓ Study on commercial weight management programmes (Dr Norhayati Ahmad and Hj Zakaria) ✓ Evaluation of STAR apps (Dr Yati / Ernina) ✓ Integrated Smoking Cessation Services in Brunei Darussalam (Dr Yati / Ernina) ✓ Literature Review and Proposal for mass media campaign on fruits and vegetables (Siti Munawwarah) ✓ Secondary analysis on tobacco from KAPs-NCD raw data (Siti Khadijah) ✓ Food and beverages marketing in and around schools and the availability of potable water in schools (Hj Zakaria) ✓ The consumption of sugar-sweetened beverages in Brunei Darussalam (Hj Zakaria) ✓ Healthier Choice Initiative; Identifying products with the potential to meet the Nutrient Criteria for the Healthier Choice Logo (Hj Zakaria) ✓ Evaluation of Health Promoting School Initiatives (Dr Norol)
Management & Strategic Partnerships	• **HP Blueprint 2011-2015 Report** – completed for printing • **IHSHP 2007-2011 Survey Report** – completed for printing • **Partnership** – Ghanim for Healthier Choice Initiatives • **Student attachments** – Total of 77 students

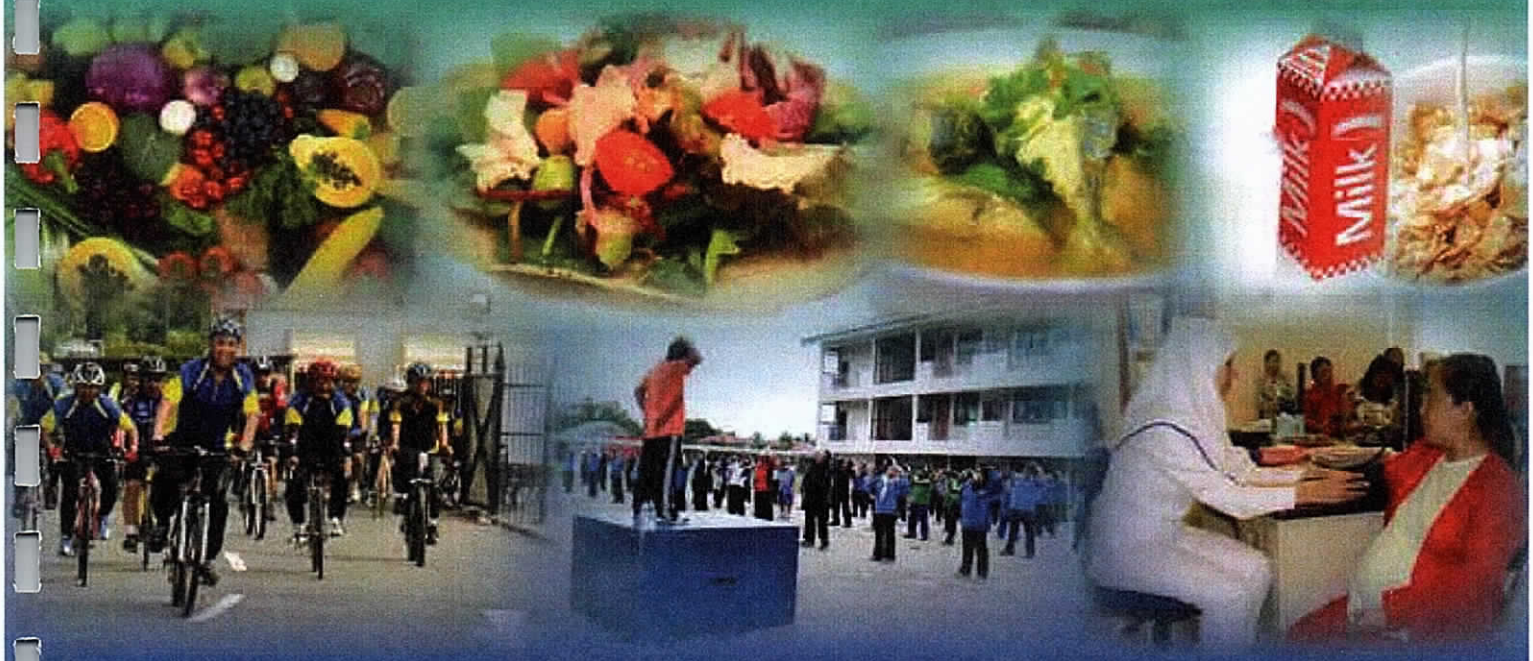

CHILDREN AND YOUNG PEOPLE HEALTH PROMOTION INITIATIVES
0 – 5 years
6 – 12 years
13 – 17 years
18 – 21 years
BruMAP-NCD
SCHOOL HEALTH SERVICES
PKBN
MIYCN (Task Force)
KINDERGARTEN/NURSERY HEALTH GUIDELINES
Health Promoting School Initiative: Programme Review/Award System/ Curriculum Review/ School Canteen Guidelines / Water Fountain Initiative/Tobacco Free Initiative/STI Prevention
HAPPY (HIV Prevention for Peers & Youth) Prog w BDAC
Healthy Plate Programme
FIT4GOOD
Restricting the marketing of unhealthy food and beverages to children


ADULTS AND THE ELDERLY HEALTH PROMOTION INITIATIVES
Working group
Women of reproductive health
Retirees and Elderly
Workplace Health Promotion
IPA training course on Healthy Lifestyle
Women's Health Activities
Premarital Course on Health
Situational Analysis & Collaboration on Ageing & Health
IPA pre-pension course
BruMAP-NCD/Health in All Policies advocacy/National Dietary Guidelines review/PEN Protocol 2 training & monitoring
Situational Analysis & Collaboration on Mental Health
Tobacco-Free 4Life: Monitoring of KBM services/ICI Accreditation/Quit2Win Campaigns/Training on Smoking Cessation/Cinema Advert
Healthy weight 4Life: Operationalisation & monitoring of KCHS Programme/ Partners for Weight Loss/ Healthy Body Weight
Healthier Choice Initiative: HC Logo & Nutrient Criteria; Healthy Supermarkets; Healthy Restaurants/ F&V campaign
Physical Activity Initiative: National PA Guidelines review/National PA Coordinating Mechanism/Car-free Day Initiative


HEALTH GALLERIA & RESOURCE CENTRE
BUSINESS, PARTNERSHIPS AND INNOVATION CENTRE
Facility Repairs and Upgrading
Healthy Hero Brunei
Marketing
TriAnnual HPC Newsletter
Nutrition / Healthy Lifestyle: Ghanim (HCI)
Revise Partnership: Butra , F2
Potential Partner: Nestle
HG: Banks & Private Sectors
Weight Loss Prog: Private Sectors & Fitness Groups
STI / HIV: BDAC
Hackathon/FitLab Project

Brunei Darussalam National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases (BruMAP-NCD)

2013-2018



Feedback Sample

QUESTIONS OF KEY INFORMANTS FOR POLICY PAPER OF 25TH EXECUTIVE DEVELOPMENT PROGRAMME FOR MIDDLE MANAGERS (EDPMMO)

Possible topic areas

- Identify factors that influence the impact of current health promotion interventions on NCDs on public health in Brunei Darussalam
- Assessing the effectiveness of funding mechanism in Brunei to support health promotion interventions to control NCDs
- Assessing the human capacity of services in MOH involved in health promotion interventions towards achieving NCDs targets 2018
- Assessing different partnership models in health promotion for NCDs prevention and control.

Background

One of the main aims of Brunei Vision 2035 is to produce a nation with a high quality of life. The Vision relies significantly on healthy generations that are productive and will be able to contribute to the socio-economic development of the country. There is no doubt that the Ministry of Health is now focusing more on prevention than cure. With the current health situations in Brunei Darussalam, the Ministry of Health faces the pressure to bring down the worrying statistics of NCDs prevalence that constitute the top killers in Brunei Darussalam since 2-3 decades ago. NCDs are the major cause of deaths in Brunei Darussalam and the main cause of disability in productive population which can bring negative impact to the socio-economic development of the country. Despite its big role in promoting the health of the population, the Ministry has to run health promotion initiatives with limited resource in terms of human capacity, financial, service facilities, and the soft infrastructure such as enabling policy to promote venture into alternative source of funding for health promotion programmes such as national economic policies on PPP, FDI or GLC among others for health. The Ministry of Health is still the core sector which is functionally recognized in implementing health promoting initiatives for the nation. In Brunei, investing for sustainable and long term health outcome is less evident as compared to containing the cost of treating diseases and illnesses that continue rise. The approach and direction of the policy paper is to be decided depending on your feedback to the following questions.

Questions

1. What is the goal, process, role and interpersonal relationship (GRPI) of Health Promotion Centre in Ministry of Health?

   Goal:

   'Empowering people towards healthy living' (mission statement). Focus is mostly on (various aspects of) NCD prevention & promotion of healthy lifestyle.

   Process:

   Advocate - provide facts, guidance & advisories for MoH & other stakeholders on issues pertaining to the promotion of healthy lifestyle & prevention of diseases, in order to help plan related strategies to achieve MoH's and Brunei's Vision 2035 strategic priorities.

   Enable – ensure all stakeholders have access to pertinent information, provide training on & for healthy lifestyle skills and competencies; help create opportunities for making healthy choices

   Mediate – work in partnership & collaboration with relevant stakeholders, at all levels, to make the healthier choice an easy choice

Role:
Guided by MoH's strategic priorities, BruMAP-NCD 2013-2018 & evidence from national NCD surveillance, HPC's roles include, but are not limited to:
Resource provision – expertise for advice, guidance, training; materials for advocacy, education & training; facilities for education & training
Programme planning & management – execution of pre-planned actions for NCD prevention, using different approaches & settings, guided by national & WHO mandates
Programme evaluation – provide evidence for effectiveness, programme improvement & policy changes, if needed
Policy/guidelines development – preventive actions for NCDs implies working upstream & across sectors to influence policies & the environment in which we live, study, work & play (eg BruMAP-NCD); also in providing evidence-based guidelines on actions that can result in positive health outcomes (National Dietary Guidelines, National Physical Activity Guidelines, Healthier Choice Logo, etc)
Facilitation of actions – through intersectoral platforms, partnerships & collaboration with other stakeholders; ideally monitored through a structured governance mechanism & guided by standardized processes (eg, partnership guidelines)

Interpersonal relationship:
The nature of health promotion work requires a lot of interdisciplinary involvement. In HPC itself, teams are basically divided into 2 teams – Team 1: Children & Young People and Team 2: Adults & Elderly. Each team comprises of doctors, nurses, allied health professionals & support staff. Depending on the work, programme or project, each team may work in collaboration with other services in MoH eg, Health Regulations, Community Health, Allied Health Professionals; as well as from other (government & non-government) sectors eg, relevant departments under Ministry of Education, Ministry of Culture, Youth & Sports, Ministry of Home Affairs, Ghanim, Brunei Darussalam AIDS Council etc. Collaboration with other sectors are usually through working committees; also through Memorandum of Agreements with selected private sectors.

2. Describe the current capacity of the Ministry of Health to control and prevent NCDs in Brunei Darussalam. Please state your opinion whether the current capacity is enough to give impact on public health.
   - For HPC per se, there is currently insufficient capacity for NCD prevention, particularly, from human resources & expertise perspective. Current NCD preventive actions cover a wide scope from policy reviews and development to programme planning, interventions and evaluation and these mostly focus on tobacco control, healthy eating, physical activity, obesity across the life course (from children to adults & elderly). See attached organization structure & manpower. Doctors and officers working in HPC or in the area of NCD prevention are expected to have backgrounds or working knowledge and competencies in public health and health promotion generally as well as the various approaches used in interventions; they need to know about NCDs & risk factors, associated psychological and behaviourial theories underpinning various interventions; policies of other government agencies in the country that can facilitate or be barrier to actions needed; managing teams, time frame and budget programme; developing the communication & marketing messages required; etc
   - Equally important is NCD monitoring and surveillance, where data needs to be collected routinely and periodically through national survey instruments eg, NHANSS/STEPS, GATS, GSHS/GYTS etc. This requires comprehensive planning of resources for implementation and

analysis, preparation of reports, information for dissemination and recommendations for improving current policies and programmes. Reporting of indicators are required for actions identified in BruMAP-NCD, Wawasan Initiatives as well as for WHO to fulfill the global monitoring framework for NCDs as agreed by members states. For NCD surveillance & epidemiology, currently there is only 1 full time public health specialist aided by a public health trainee and 3 support staff. This team is responsible for also responsible for our National Cancer Registry, which forms the bulk of daily routine work.

- Useful data related to NCDs is also recorded in BruHIMS, however, currently, the system is unable to provide meaningful aggregated data for population health monitoring (need to pay extra for additional functions).
- Control of NCDs also depends on screening activities and the extent of patient compliance to treatment and follow up. These functions are undertaken at the primary, secondary & tertiary levels and very much depends on the capacity in the related services as well. PHC serves as the entry point into the health system for detection of risk factors and treatment of early disease; therefore, has a role in gatekeeping & limiting complications. A number of protocols and clinical guidelines eg, WHO's Package of Essential NCD management protocols (PEN protocols) are available as guidance. PEN protocol 1 is largely adhered to; PEN protocol 2 (health education & counselling on healthy behavior for all patients) has been taught to nurses in PHC through a workshop in 2016 & has yet to be audited.
- Specific services for risk factors and behaviours are available at the PHC level eg, smoking cessation, dietary advice & monitoring; however, there are only 3 known structured multidisciplinary programmes for weight management – Obesity Clinic in RIPAS Hospital, KCHS at Berakas Health Centre (4 cohorts a year) & KCHS in PIHM Hospital (1 cohort/year). Paediatric Dept at RIPAS Hospital runs an obesity clinic for children under 12 years but is not multidisciplinary in nature. No services exist for adolescents. MoH does not have any exercise physiologists currently & only a few physiotherapists available to give counselling at the PHC level. Obesity rates among adults and children are approximately 30% & 20% respectively.
- There is a need to consider mental health & healthy ageing in the overall strategy for NCD prevention as well as ensuring Bruneian's quality of life; preventive actions for these have not been addressed fully as yet.
- In terms of funding, a large proportion of MoH's budget for NCDs is allocated for diagnostics and treatment of NCDs, including cancer, with very minimal allocation for health promotion & disease prevention. Last financial year and again this year, HPC's recurrent budget (most of which is spent on NCD preventive actions) has been severely slashed from $700 000 previously to just over $200 000 recently.
- Based on the above, it will be difficult to achieve targets identified within the specified time frame, ie, huge impact will not be seen in the next 3-5 years; bearing in mind that there are also a lot of other processes involved during planning and implementation (eg, training, etc) as well as other responsibilities undertaken by officers for their personal and professional development & in supporting HPC's daily & periodic administrative duties.

3. How do you describe the effectiveness of the health promotion interventions to reduce NCDs in Brunei? What are the limiting factors (Human capacity? Funding? Culture? Multi-sectoral support?)

   Effectiveness of interventions to reduce NCDs at the population level is monitored through population health studies such as, NHANSS 2009-2011, STEPS-NCD 2015-2016, mini GATS 2015 for adults & GSHS 2014 & GYTS 2013 for adolescents. For adults, positive changes has been seen

in physical activity levels (on track); however, no changes or slight worsening in tobacco use; poor fruit and vegetable intake; very minimal changes in obesity, hypertension & diabetes prevalence; 1 in 2 have high levels of cholesterol. Amongst adolescents, approximately 20% are obese; there are high rates of physical inactivity, poor fruit and vegetable intake & 1 in 2 consume at least 1 can of carbonated soft drinks daily. Levels of general knowledge on healthy lifestyle are high amongst the population, however, this does not translate into relevant actions due to other personal, socio-economic and environmental factors.

Limiting factors: All those mentioned are applicable. Depends on the issue as well. Eg, tobacco control – currently, tobacco use is sustained by tobacco products that are supplied or available in the community 'illegally'; in which case, actions to curb such activities lies with enforcement agencies. There are only 2 (almost) full time staff dealing with tobacco – 1 doctor and 1 nurse; others are 'part-time', ie , have other duties For healthy eating, many factors need to be considered, from education & information dissemination for various population groups to influencing the eating environment through various policy actions. Currently there are only 2 dietitians working full time in HPC (1 is also focal point for workplace health promotion programmes), supported by 2 health education officers, who also cover other programmes and activities. Support from other AHPs is minimal; focus on clinical work and commitments have been given priority. It would help tremendously if operational budget can be used for engaging with (trained) project assistants on a temporary basis for some of the programmes. High level multisectoral committees for NCDs exist; however, membership is different from previous committees; sometimes resulting in a repeat of previous actions being undertaken in the present & constraints in moving forward (previously, National Committeee on Health Promotion; National Tobacco Control Committee; etc; now Peneraju Kesihatan; Health Task Force). Of utmost importance is an optimal number of trained human resources to undertake the various actions needed in NCD prevention and control. Within the last 2 years, 3 B2 officers have been either promoted or transferred with no replacement, but NCD interventions are expected to be undertaken as usual or more.

4. What are the sources of funding for health promotion interventions on NCDs by the Ministry of Health?

   Funding for health promotion interventions on NCDs is mostly through allocation of a recurrent operational budget by MoH. Some minimum in-kind sponsorship by private entities are periodically available but only for specific collaborative programmes & activities & time frame (eg, Ghanim). Potential for additional sources of funding are being explored (setting up a private account for donations by philanthropists, private entities etc) & partnership guidelines are being drawn up for guidance on which entities HPC can work with and under what conditions (eg, partnership with Nestle for workplace health promotion programmes, healthy supermarket programmes). Some funding from WHO programme budget allocated since last 3 years (subject to approval by WHO).

5. Does Ministry of Health conduct evaluation of health promotion interventions so far? If yes, what model is used (eg. RE-AIM model)? Has this evaluation been used in the application of funding?

   No specific evaluation model is used; usually process and summative evaluation undertaken for short term programmes (3-12 months). As mentioned, national population surveys are used to monitor trends in the long term; these can also indicate the success & effectiveness of current policies & programmes to a certain extent.

   Funding application based on evaluation is difficult when recurrent budget is given on annual basis & NCD interventions may take a long time for positive outcomes to be seen. Current PPB type of

budgeting that is being practiced by all ministries generally requires short term outcomes & indicators & may not be suitable for reporting of population-level monitoring & evaluation; this may be suitable for clinic-based activities eg, KBM – quit rates, KCHS – weight loss rates & actions to change awareness and knowledge as well as some behavior (albeit self-reported). A better way may be that funding should be tied with national development planning ie, on a 5-year term for reporting with identified mid-term indicators.
In many other countries, evaluation is usually outsourced and conducted by academia or research organisations since this can take a long time. Currently, HPC does some process & summative evaluation; these are usually done with the help of students on attachment in HPC (& therefore, very much depends on the number of students available or if any at all). Otherwise, this will depend on HPC staff availability. Alternatively & ideally, evaluation work can be outsourced, thereby, leaving HPC to help plan the work & budget required.

6. Please state the current short, medium or long term population-based strategies or initiatives or interventions directed towards the reduction of NCDs apart from institutional interventions such as BruMap NCDs and the National Multi-sectorial Health Task Force.

Policies:

- National Dietary Guidelines review (& dissemination of messages) – draft to be completed 2017
- National Physical Activity Guidelines review – to be completed by 2018
- Healthier Choice Logo – ongoing marketing, roadshows & recruitment; copyright application
- Evaluation of SSB tax impact on consumption
- Regulating the marketing of unhealthy food & beverages to children (including voluntary pledge by food industries)
- Monitoring of school canteen guidelines implementation (including training of canteen vendors)
- Amendments to Tobacco Order

Programmes & activities:

- Workplace Health Promotion programmes (for promotion of healthy lifestyle & weight management) – provision of guidance, support & training
- Healthier Choice Initiative – Healthy Supermarkets; Healthy Restaurants
- Klinik Cara Hidup Sihat – counselling, activities & monitoring
- Klinik Berhenti Merokok – training, counselling & monitoring
- Quit2Win & other smoking cessation campaigns
- PEN protocol 2 implementation in Health Centres – training & monitoring
- School Health Services – screening & health education; HPV vaccination
- Health Promoting Schools Initiative – provision of guidance, support & training
- Curriculum review to update topics on healthy lifestyle at different levels
- School Canteen Guidelines – training of school canteen operators
- Fit4Good programme (weight management amongst adolescents in secondary schools)
- Breast cancer awareness roadshow & campaigns
- PKBN health module (once a year)
- IPA healthy lifestyle modules (2-3 times a year)
- Kursus Pra-Nikah – once a month
- Evaluation of Bandarku Ceria

- Evaluation of community-based weight management programmes (partners for weight loss prog)
- Health Galleria visits & talks

Many of these are also included in the reporting of BruMAP-NCD & the Health KPI for Wawasan 2035 (under Healt is Everyone's Business & NCD Prevention & Control).

7. Please provide a list of projects directed towards the reduction of NCDs that involved partnerships with (1) government and semi-government sectors; (2) private; (3) NGO; (4) international organisations from 2010 to 2017.
   Please refer to the list attached. Examples:
   - Partnerships with govt sector – mostly with MoE on school canteen guidelines review & monitoring; curriculum review; etc
   - Partnership with GLC – Ghanim/BruneiHalal on healthy eating campaign
   - Partnership with private sector – Butra Heidelburg Cement on diabetes prevention
   - Partnership with NGO – BDAC on HIV/STI prevention (indirectly prevention of cervical & liver cancers, too)
   - Partnership with international organisations – not really partnership but more on the provision of funding ie, WHO programme budget allows specific actions on NCD prevention to be carried out. Eg, Training on social marketing; training & pilot project on exercise prescription; PARK (Program Aktif & Riadah Untuk Kesihatan) project; fruit & vegetable campaign; Workplace Healthy Lifestyle Programme Study.

8. Is there any increase in the funding allocation and capacity for NCDs control and prevention since the last 10 years? Please provide statistics.
   There was an increase between 2010-2015 (from $200K to $700K); however, this has since then been reduced drastically over the last 2 years. Am not sure of actual allocation for 2016-2017 as this was subject to reduction due to 'contingency measures'; amount allocated in 2017-2018 was $160K for 'mass media campaigns' (which is traditionally assigned to HPC) and the rest cumulated under Public Health's operational budget. There is no specific allocation for 'NCD prevention' anymore.

9. In your opinion, is it possible to establish public-private partnerships in health promotion or in this context NCDs control and prevention in Brunei? Are there PPP projects so far? How successful are the projects?
   Yes, it is possible but requires dedicated officer/team to oversee; strict and transparent governance mechanism as well as clear TORs & deliverables agreed to by both (or more) parties involved. Previous PPPs have been short-termed in terms of activities & outcomes eg, diabetes prevention programme with BHC & BFit programme (reality weight loss) with B-Mobile & Fitness Zone.

10. Which of the main risk factors of NCDs that Ministry of Health has most difficulty dealing with? (Physical inactivity / smoking / unhealthy diet?)
    Addressing unhealthy diet (and subsequently, obesity) is probably the most complex issue currently faced.

Feedback Sample

11. Which strategy will give the highest impact on public health?
    a) Boosting financial and human resources and empowerment for health promotion interventions
    b) Create built environment for healthy lifestyle
    c) Changing culture and mindset of the public

    All of these need to be addressed simultaneously – for health promotion interventions to succeed, actions need to be done at all levels (population to individuals), using different approaches and settings that are evidence-based.

12. Is there any consideration to shift available funding for investment of long term population health outcome such as health promotion to reduce NCDs as opposed to containing costs of treating NCDs which continue to rise?
    I think this question should be addressed to the SMT in MoH; based on the last 2 years' allocation of budget, it seemed that there has been a reversal in the priorities accorded to NCD preventive actions.

Figure 1.7: Detailed Conceptual Framework: Challenges in NCDs and Risk Factors Reduction in Brunei Darussalam