Strengthening Health Systems Response to Address Noncommunicable Diseases in the South-East Asia Region

Report of the Regional Consultation
Colombo, Sri Lanka, 7–10 June 2016

World Health Organization
Regional Office for South-East Asia

#beatNCDs

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Annexes

Abbreviations

CVDs	Cardiovascular diseases
DPR Korea	Democratic People's Republic of Korea
EML	Essential medicines list
HLC	Healthy lifestyle centres
ID	Identification
MDG	Millennium Development Goal
NCD	Noncommunicable disease
OOP	Out-of-pocket
PEN	Package of essential noncommunicable disease
PHC	Primary Health Care
SDG	Sustainable Development Goal
SEAR	South-East Asia Region
UHC	Universal health coverage
UN	United Nations
WHO	World Health Organization
WHO HQ	World Health Organization headquarters
WR	World Health Organization Representative

1 Introduction

Noncommunicable diseases (NCDs), which include cardiovascular diseases (CVDs), cancer, diabetes and chronic respiratory disease, are the leading cause of death in the South-East Asia Region (SEAR) accounting for an estimated 8.5 million deaths each year.

Prevention and control of NCDs require a set of actions. Clinical interventions for those at risk of NCDs and for people living with NCDs is an important and critical part of the national NCD response. The clinical interventions required for NCDs are complex, based on management of chronic diseases over time. There is a heavy reliance on a well-functioning health system. Progressive steps are required to address the systemic challenges at the primary health care services. Health care systems in Member States in SEAR are not adequately organized to manage the NCD burden resulting from the demographic and epidemiological transition. The presence of lifelong chronic disease and long-term comorbidities requires not just a rethinking of service delivery but also reorientation of the entire health system building blocks.

Diabetes, cardiovascular disease, stroke, respiratory disease and cancer all require a differentiated response as the system requirements for each differ. An NCD strategy needs to identify what issues are common across the whole health system (such as a focus on equity, social determinants of health, prevention, patient-centred approach, avoiding catastrophic costs and universal health coverage), what issues are common across the spectrum of NCDs (such as chronic disease management, surveillance and prevention) and what issues need a disease-specific focus, particularly in clinical settings.

Member States have agreed to achieve the NCD global goals of 80% coverage of essential NCD medicines and technologies in primary health care (PHC) and to ensure that 50% of people at high risk for CVD are put on drug therapy and counselling along with the overall goal of 25% relative reduction in premature mortality from NCDs by 2025. Furthermore, in 2014, the United Nations (UN) Member States agreed on a time-bound commitment to strengthen and orient health systems to address the prevention and control of NCDs through people-centred primary health care systems by 2016. The first checkpoint is in 2018, when progress will be reviewed. A strong focus on PHC is a key step for NCD response to show results of the commitments.

The World Health Organization (WHO) Regional Office for South-East Asia organized a regional consultation on “Strengthening Health Systems Response

to Address NCDs in the South-East Asia Region" in Colombo, Sri Lanka, on 7–10 June 2016.

The objective of the Regional Consultation was to strengthen health systems responses in integrating NCD management at the PHC level.

The specific objectives of the consultation were as follows:

- Review progress and share lessons for strengthening health systems to deliver NCD services;
- Map the gaps in NCD implementation along various elements of the six health systems building blocks;
- Identify innovative actions for accelerating the integration of NCD prevention and management within the PHC system.

2 Organization of the Regional Consultation

There were 55 participants from all 11 SEAR Member States: from governments, WHO, nongovernmental organizations and academia (Annex 5). The programme (Annex 2) focused on the deliberations around PHC in the context of the six building blocks of the health systems. Sessions were organized through presentations, panel discussions, group activities and development of country priority activities. Guest presentations from the Maldives, Sri Lanka and Tongo were invited during the session recesses. Participants also made field visits at two healthy lifestyle centres (HLCs) to observe the Sri Lanka Model of implementation of NCD services at the PHC level. The Consultation was made interactive and engaging by infusing numerous side activities both during and outside the consultation to advocate healthy lifestyle promotion among delegates (Annex 4). Two special breakfast sessions were organized. The first breakfast session (on the second day) discussed the transformational leadership in NCD prevention and control and managing change. The second breakfast session (on the fourth day) was organized to orient on workplace healthy lifestyle promotion and showcased the Regional Director's initiative of the "Be The Change Programme" at South-East Asis Regional Office.

3 Opening session

The opening session was graced by H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Government of Sri Lanka, and other senior dignitaries from the Ministry of Health.

Dr Jacob Kumaresan, World Health Organization Representative (WR) Sri Lanka, welcomed all participants and conveyed greetings on behalf of Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region. In her message to the Regional Consultation (Annex 4), read by Dr Kumaresan, the Regional Director commended Member States for setting national targets for NCD prevention and control, and emphasized that more actions are required to fulfil the global and regional commitment for NCDs. Dr Singh underscored that strengthening PHC systems to respond to the NCD epidemic is an important step for every Member State. The Regional Director urged participants to take full advantage of the Regional Consultation and provide a collective wisdom to accelerate integration of NCD services at the PHC system. Dr Kumaresan highlighted that partnerships are critical for the prevention and control of

Dr Rajitha Senaratne, Honourable Minister of Health, Nutrition and Indigenous Medicine, Government of Sri Lanka

Dr Jacob Kumaresan, World Health Organization Representative (WR) Sri Lanka

NCDs and the health sector has to learn how to manage collaboration and partnership with other sectors and agencies.

In his opening address, His Excellency Dr Rajitha Senaratne commended WHO for the strides made in the prevention and control of NCDs in Member States. He reiterated the commendable progress made in tackling and controlling NCD prevention and control in Sri Lanka.

Dr Gampo Dorji, Technical Officer, NCD Management, presented an overview of NCD epidemiology, global and regional response to the NCD control and current issues and gaps in NCD response. He highlighted the need for development of a framework of actions for strengthening NCD response at the PHC level and the purpose of the Regional Consultation.

4 Business sessions

Setting the scene, health and systems thinking for health systems

NCD prevention and control – journey ahead

Presenter: Dr Thaksaphon Thamarangsi

Dr Thamarangsi opened the business session of the Regional Consultation. He reiterated the need to identify innovative actions for accelerating NCD prevention and management within the PHC system to achieve Universal Health Coverage (UHC). He explained the benefits of the strategy for each of the six building blocks, the WHO PEN package and addressing NCD risk factors.

He emphasized that a robust health system with a strong focus on PHC was essential in realizing the political commitments made by Member States in expanding UHC and achieving the Sustainable Development Goals (SDGs).

He also pointed out that it was equally important for countries to do a reality check for systems readiness to deal with a situation if health systems become overwhelmed due to improved case finding owing to increased

efforts. He underscored the need for Member States to focus on integrating NCD services with other health programmes, such as communicable diseases, injuries and maternal and child health (MCH) at the PHC level.

Dr Thamarangsi noted that since all Member States have different starting points, strengths, opportunities and challenges differed, which are shaped by varying geographical, financial, cultural and social landscapes. He encouraged participants to bring the collective wisdom to the table and propose practical and pragmatic recommendations to strengthen NCD services at the PHC level.

Health and systems thinking for health systems

Presenter: Professor Don Matheson

Professor Matheson explained that a health system, like any complex system, consists of feedback mechanisms (through information), self-organization (orderly nature) and emerging properties. He informed that systems thinking was an important tool to address dynamic complexities of health systems. He pointed out that countries tended to leave bits out of the health systems during planning cycles and advised to avoid such omissions.

As NCDs are a product of a complex system, he stressed that iterative learning, transformational leadership and intersectoral collaboration addressing the six building blocks of a health system at each level are key to operate a complex adaptive system.

Professor Matheson noted that a 5% global funding for NCDs during the past few years is largely contributed by people's spending at the private sector, which has a significant impact on equity and UHC goals. He reiterated that governments, as was done for communicable diseases and maternal and child health, should look into additional funding mechanisms for NCDs. He expressed the need to use local and national knowledge while building health systems, especially the frontline workers.

UHC in the context of NCD services – bringing along those left behind

Presenter/moderator: Dr Palitha Abeykoon

Panel Members: Dr Chinmoyee Das (India), Dr Aries Hamzah (Indonesia), Dr Mohammad Daud (Nepal), Dr Phattarapol Jungsomjatespaisal (Thailand)

Dr Abeykoon made a presentation and moderated the panel discussion. He noted that the key concept of UHCs was that people receive the care that they need without incurring financial hardship. He expressed that the historical transition of global movements in public health, from Health for All and PHC to UHC, shared the same underpinnings, focusing on equity and social determinants of health. He outlined several differences between Millennium Development Goals (MDGs) and SDGs, and summed by saying that MDGs targeted towards poor and low- and middle-income countries while the SDGs relate to all nations, making it truly a global agenda. He expressed that it was important to identify who is being left behind and design health and social interventions to reach them with NCD services in the context of UHC.

Dr Abeykoon highlighted that around 130 million people in SEAR have no access to essential health services, usually the poor being left behind. He suggested that Member States need to review the essential health packages and identify priorities to reach those left behind.

He invited delegates from Indonesia, Thailand, India and Nepal to the panel discussion.

Indonesia: Nearly 20% of PHCs have integrated package of essential NCDs (PEN). Approximately 54% of health facilities reportedly do not have access to cholesterol testing facilities. Scope for improvement both in terms of coverage and quality of NCD services is substantial.

Thailand: NCD services are integrated at various levels of health care (hospital, health facilities and community-based). Disease-specific prevention programmes for cardiovascular diseases, stroke, chronic kidney diseases are implemented at the community level and targeting poor. Cervical cancer screening using VIA, breast and liver cancer screening, and screening of hypertension and stroke for individuals older than 60 years of age are provided at the community level. Thai health systems place strong emphasis on community participation; community health volunteers maintain family folders, conduct brief lifestyle interventions and offer testing of fasting glucose. A 2% sin tax for tobacco is used for health promotion.

India: NCD-related national programmes are hosted within the National Health Mission. NCD screening in communities is being initiated through ASHA workers. Stroke prevention programmes are implemented in one or two States. A referral system exists for cancers. Infrastructure at PHC is limited. Private providers need to be engaged more. With the operationalization of the multisectoral action plan, financing for NCDs is likely to increase and hence provision of a range of NCD services as well. Immediate priorities include expansion of NCD clinics at the block level, training of the health workforce to screen NCDs and development of training module for health workers.

Nepal: Nepal has immediate plans to implement PEN demonstration projects in two districts. PEN protocols for PHC have already been developed. There is no national level opportunistic screening for NCDs; cervical cancer screening occurs in a few districts. UHC is currently being promoted only in a few districts. Rural, hard-to-reach places and poor people have inadequate access to NCD screening and treatment service. Immediate priorities include focus on improving the supply of medicines and initiation of the PEN project.

Groupwork: A creative representation of how to adopt healthy lifestyles

Summary: Member States have initiated the implementation of NCD services at the PHC level. No one is starting from ground zero. Countries have explicit and implicit policies to reach the poor and the marginalized are making conscious efforts to bridge the gaps. Extent of the number of population groups left behind is variable. In general, there is a long way to go to achieve coverage of NCD screening and treatment services in most Member States. It is important to enhance coverage of NCD services through inclusive and equitable NCD programmatic interventions, paying attention to populations left behind.

Core components of NCD management at PHC systems

Presenter/moderator: Professor Rajesh Kumar

Panelists: Dr Choe Sun Hui, Democratic People's Republic of Korea (DPR Korea); Mr Kinga Jamphel (Bhutan; Dr Myint Shwe (Myanmar; Dr T. Sirwadena (Sri Lanka)

Professor Kumar outlined the key concepts of NCD prevention and control at the PHC, core components of chronic care and ways to address the barriers, the principles of opportunistic screening for NCDs and the rationale of package of essential NCDs (PEN). He noted that the implementation of PEN is an important strategy to deliver UHC. He stressed the need to link resources to health outcomes to comprehend the effectiveness of the NCD programmes. He cautioned about the risk of NCD services making into a silo or a vertical programme and advocated for effective integration into PHC and optimizing linkages with other health services, such as communicable diseases and maternal health programmes.

The panelists from Bhutan, Democratic People's Republic of Korea, Myanmar and Sri Lanka discussed the lessons learnt from PEN intervention.

In Bhutan, the PEN package has been integrated as a nationwide programme after the outcome evaluation demonstrated a positive health outcome. Good monitoring tools were not available and urgently needed to support quality enhancement of the national programme.

Democratic People's Republic of Korea has implemented PEN in two provinces. The government has set up a community-based system, where screening is being done for NCD-related risks at the PHC level.

In Sri Lanka, PEN services were provided through HLCs on a special clinic day (once a week). HLCs are distributed nationwide. Service utilization was low, particularly among males.

In Myanmar, PEN services are implemented in two townships and it is planned to expand to 10 additional townships within 2016. Eventually, Myanmar hopes to implement PEN in all the 330 townships. To encourage utilization of services, social mobilization was found to be useful.

Evaluations of PEN in Bhutan and Democratic People's Republic of Korea noted improvement in patient outcomes. Depending on the availability of the health workforce, PEN is being implemented by various categories of health workers. In Bhutan and Myanmar, nonphysician health workers and doctors implement PEN, while in Sri Lanka and Democratic People's Republic of Korea, doctors implement PEN.

PEN services reaching apparently healthy population is low and thus active community mobilization is required to increase the demand for screening services. Common challenges faced by PEN implementing countries were health workers reporting increased workload, poor follow-up of patients, inadequate monitoring for treatment outcomes, low coverage of services and inadequate financial resources to implement nationwide programmes.

Summary: The WHO package of essential NCDs is critical for achieving UHC. Member States not implementing should consider adapting a whole or a part of the components of PEN (without reinventing the wheel) depending on the context and reorient PHC system. Member States implementing PEN demonstration projects should consider rapid scale-up to achieve service coverage targets. Quality monitoring and patient tracking systems should be integrated as a core component of PEN to ensure good-quality services for chronic care.

Governments need to commit to providing finances to ensure training, supply of basic NCD medicines and logistics for integration of PEN at PHC systems.

Overcoming bottlenecks in NCD services at PHC in the context of six building blocks – what and how?

Health service delivery – Presenter/Moderator: Dr Cherian Varghese

Dr Varghese, in his presentation, described the components of patient-centred health services, including patient–provider communication and measures for continuing care. He pointed out that, in most Member States, scope of NCD services were unclear, services were fragmented and not designed to meet the needs of people with NCDs. He suggested that a well-defined service package based on WHO PEN with a model for implementing the services at different levels of health care will help countries to improve coverage. Technological advances can be used to improve monitoring and compliance. The importance of evidence-based approaches and targeted screening was highlighted along with referral care.

Summary of group discussions

While many countries have started some pilot initiatives, the routine services for early detection and management of NCDs and their risk factors are still in early stages of development. Nearly half of the Member States do not have an updated treatment protocols for managing major NCDs.

Common challenges were weak referral systems, and even when available, formal referral systems are not followed. Transportation and costs were barriers to health service seeking. Communication barriers between referral and referring health facilities, poor provider and patient understanding were noted. Poor patient follow-up and lack of monitoring of quality of clinical services plagued the health service delivery. Despite extensive use of informal health care, monitoring of quality services provided were noted to be extremely challenging.

The themes and recommendations to improve NCD health service delivery that emerged during the group discussions were as follows:

Ensure continued NCD care and treatment, and minimize treatment dropouts. Strengthen patient tracking system through use of unique patient identification (ID) numbers, create case records (individual/family folders), implement appointment system, identify dropouts and make follow-up calls

and incentivize follow-up visits for health workers to minimize interruption of treatment and health behaviour modification services.

Develop lifestyle education and opportunistic screening by linking between and within health facility(ies). Institute multidisciplinary NCD management teams and make NCD services a part and parcel of facility management agenda. Integrate lifestyle education and brief intervention programmes at ANC clinics, MCH, family planning services and other hospital units, and introduce opportunistic screening services for family members, e.g. fathers/ husbands at MCH services.

Improve referral and back referrals for diabetes, hypertension, CVDs and other NCDs between PHC facilities and higher centres. Develop/implement guidelines for referral, back referral, and follow up NCD patients; develop web-based registration to record referral information; review transportation and logistics issues; and improve support for emergency national referral and conduct regular review of NCD services including referrals and use information for 'plan', 'do' and 'act' cycle.

Bring private health providers on board. The private sector is a major provider of services in many SEAR countries, such as Bangladesh and India. Currently there is not much constructive engagement between the public and private sectors; policies and initiatives to improve engagement may help to increase quality and the need for more evidence on what actually works in this area.

Recognize private providers as a key stakeholder in NCD response in certain countries and ensure that they provide high-quality NCD services according to national protocols and report their outcomes. Regulation and oversight of private sector health services can help to improve quality of care and to minimize OOPE ; strengthen contractual process for NCDs and regulate quality of private sector provider.

Enhance community participation for NCD care and self-care. Identify community leaders, faith-based organizations and civil society organizations as relevant, and community volunteers as partners to disease-specific programmes; support self-help groups and family carers; and engage community groups on local health service governing bodies.

Health workforce

Presenter/Moderator: Dr Anita Kotwani

Dr Kotwani made a presentation on the health workforce, medicines and technology building blocks.

She presented the status of health workforce in SEAR. She explained that health workforce in half of the Member States were lower than the WHO threshold of 22.8 doctors, nurses and midwives per 100 000 population. However, she noted concern due to inadequate trained health workforce for NCDs at the primary care level, particularly in rural settings.

Dr Kotwani stated that there is a pressing need to rethink HRH strategies to take into account not only quantity and quality, but also competencies and skill-mix to meet changing health needs for NCD management and task-shifting from physicians to non-physician health workers. She referred to the Global HRH strategy/global code and decade of health workforce strengthening in SEAR 2015–2024 and encouraged delegates to use the information for better planning of health workforce and focus on actions to improve rural retention and transformative education.

Summary of group discussions

Multidisciplinarian chronic disease management teams at the PHC level. This should be promoted by setting standards of regulations (e.g. ministerial decree/regulations), linking provider payments to performance and redefining job descriptions of health workers. Task shifting and task sharing among primary care health workers should be promoted with proper guidelines and job description. Enhance skills of PHC workers for NCD management through PHC accreditation.

Partner with academia in building health workforce in NCD response. Medical and health sciences should be included as a key partner in building competent health workforce. Institutions should be engaged to undertake curricula revisions for all health professionals to prepare graduates' competence to manage NCDs. Regular CME on NCDs should be institutionalized by collaborating with stakeholders and institutions.

Rethink health workforce competencies and initiate policy reforms. Human resources for health needs to rethink HRH strategies, taking into account not only numbers, but also competencies and skill-mix to meet the

changing needs for NCDs. Broader policy reforms ensuring better deployment, observing gender balance in health workforce (e.g. through targeted incentives for female staff and customized student intake), increasing health workforce number and creating a good work environment through provision of non-financial (housing, security, transport, telecommunication, basic equipment and supply, recognition) and performance-based financial incentives should be considered to improve motivation and retention of health workforce, especially for rural postings.

Medicines and technologies

Presenter/Moderator: Dr Anita Kotwani

Dr Kotwani stressed that because of escalating burden of NCDs, there was substantial increase in financial resources spent on management of NCDs by governments and a high out-of-pocket (OOP) spending by patients and their families. She raised concerns about the quality of this expenditure, its impact on equity, catastrophic impact of OOP payments, lack of coordination and lack of focus on prevention and adherence. She stressed that in order to achieve the target of an 80% availability of the affordable basic technologies and essential medicines for NCD in public and private facilities by 2025, much needs to be done.

Dr Kotwani presented data on availability of basic medicines for diabetes, hypertension, asthma and mental illnesses from recently conducted surveys in eight Member States. She highlighted that the availability of some of the medicines was poor in some States and some of the essential medicines for NCDs were not included in the essential medicines list (EML) for primary care. Findings on quality of care for treatment of asthma in an urban setting were also presented as suboptimal. Although there are many challenges to reach our target to provide prevention, detection and quality treatment for NCDs at primary care variety of options, such as revising EMLs for medicines and determine the basic diagnostics and other health technologies, improving procurement and supply chain, developing a pricing policy, finding innovative financing, improving health workforce skills, continuous monitoring and involving academia are recommended for achieving the goals of NCD action plan.

Summary of group discussions

Upgrade essential medicine list (EML). Strengthening NCD response at PHC will require upgrading EML to provide access to generic medicines to treat major NCDs using PEN as a starting point. At the same time, it is necessary to promote good prescribing practices and develop and implement Standard Treatment Guidelines for NCDs at PHC.

Strengthen procurement and supply chain management. Procurement and supply chain management should be made more efficient and reliable by reviewing the current policy, strengthening capacity for procurement, providing adequate budget, reviewing procurement guidelines, and improving procurement and logistic information system.

Build capacity of human resource related to medical technology. Few Member States, such as Indonesia and Thailand, have NCD medicines and technologies at their primary and secondary level health facilities, while others have limited or no service at PHC level. Concurrently, priority should be given to developing human resources, such as those related to medical technologies (pharmacist, doctors, lab technician, home care manager, biomedical engineer, physiotherapist, etc.).

Integrate palliative care at PHC level. Member States acknowledged that there was a gap in palliative care services and agreed to take measures to address inequities in access to controlled opioid analgesics and basic technologies to make palliative care accessible and available for those in need at the PHC level.

Leadership/Governance

Presenter/moderator: Professor Don Matheson

Professor Matheson emphasized that good governance is key to managing NCD prevention and control. The health sector needs leadership skills to manage numerous stakeholders involved in NCD response. At the national level, a high level of political leadership is required for harmonizing the multisectoral action plan with the national development plan. Implementation at the provincial and local levels should be supported by teams.

Summary of group discussions

Make a business case for NCD integrated PHC. Political preference for 'high-tech high-visibility' solutions competes with NCD integrated PHC with the risk of the latter being relegated to a lesser priority. It is necessary to make an investment case for strengthening NCD response at PHC as a cost-effective, social and political programme to secure high-level political .

Activate accountability framework at all levels. Inadequate accountability frameworks, weak health sector stewardship for NCD partnership management, and difficulty in managing private health sector are key challenges. Support and mobilize national committees to drive multisectoral NCD action plan. NCD programme management capacity should be developed and NCD focal points should be instituted at all levels of health services with clear job descriptions.

Manage partners effectively. Governance and partnership with private providers should be improved. First, the health sector should have adequate data on private health-care providers and recognize private providers as contributors in NCD services. Licensing system, operational, financial and clinical practice guidelines for private providers should be promoted in monitoring and enforcement of regulations to ensure quality of service for private providers; public-private providers should be implemented.

Improve clinical governance. Overall, clinical governance is poor in most Member States, not only for NCDs but for all other diseases. Regulatory mechanisms should be strengthened through SOP, guidelines and instituting clinical audits of PEN and other NCD services.

Financing

Presenter/moderator: Professor Don Matheson

Professor Matheson presented that the per capita spending for health was low in the majority of Member States due to low fiscal space. He stressed that NCD prevention and control required more financial resources and suggested that evidence-based economic arguments should be put forward to ensure more resources for NCD control as well as making a need-based financing for diseases irrespective of CD or NCDs. He highlighted that there were no clear disaggregated figures on national spending on NCDs to inform policy-makers.

Summary of group discussion

Delegates acknowledged that more financial resources are required to implement NCD prevention, and that the level of financing from domestic funds and benefits and health sector finances for NCDs at national and PHC services were unclear to decision-makers. In order to advocate for increased financing for health and ensure universal health coverage, innovative financing mechanisms, such as the Sin Tax on unhealthy food, sugary products, alcohol and tobacco should be explored to suit the national context.

In order to ensure financial protection and minimize OOP for chronic diseases, Member States should support policy reforms to ensure revenue collection, risk pooling and improve provider payment mechanisms either through taxation or social insurance schemes.

Health information systems on NCDs

Presenter/Moderator: Dr Sunil Senanayake

Dr Senanayake highlighted that a sound health information system is crucial to inform about the disease burden and measure health service performance for evidence-based decision-making. He presented the gaps in the current NCD-related information systems pertaining to measurement of patient outcomes including death and patient tracking, in addition to being paper-based in most Member States.

He emphasized that ascertaining the cause of death was a huge challenge, particularly NCD-related deaths occurring outside of health facilities. He presented a list of SDG indicators (including those for NCDs) against which progress on NCDs will be tracked and measured. He stressed the need to upgrade health information systems to include NCD-related indicators using the IT-enabled systems to provide timely information for decision-making.

Summary of group discussion

Except for Thailand, the major bottlenecks included the following: patient records were paper-based and no optimal use of IT-enabled systems exist; and there is inadequate use of health-facility and patient-level outcome data for decision-making.

Monitoring of patient information and clinical outcomes should be improved by optimizing the use of digital innovations through unique patient identity, utilization of feasible information software, such as Open MRS, and developing a patient tracking system to monitor outcomes of interventions. The importance of introducing a unique patient ID numbering system in all Member States to facilitate and monitor the outcomes and compliance of NCD treatment was emphasized.

Use of health information data at the health facility, district and provincial level should be promoted through periodic (predefined intervals) reviews. Use of facility level information should be encouraged by training health-care managers, health workers and other end-users to analyse and use real time health service data for decision-making.

While these initiatives and interventions have been recommended for several years now, progress has been slow due to multiple challenges at the level of policy, human resources and financing.

Protection of patient information and confidentiality to avoid stigma related to chronic comorbid conditions (e.g. HIV, mental health) should also be strengthened through patient information and data protection policies and orienting data handlers on ethics.

Priority Medical Devices in Cancer Management: A way forward

Presenter: Dr Adriana Velazquez Berumen

Ms Berumen stated that Global Target 9 of the NCD action plan requires availability of 80% medicines and technologies to manage NCDs, by 2025; therefore, WHO headquarters (HQ) has initiated the development of lists of priority medical devices (PMD) for NCD management that can guide Member States in a similar way as the EML.

The first version of this list of technologies for cancer management, required for prevention (vaccination), diagnosis (laboratory, imaging and pathology), treatment (surgery, chemotherapy and radiotherapy) and palliation, was presented in this meeting, to be considered by the participants as a guidance tool for Member States.

It was noted that technologies, in contrast with medicines, are more complex to select, procure and supply manage, because there are more than 10 000 types; without a WHO nomenclature, which needs technical specifications as there are no “generic” medical devices and require an operating cost, users training and infrastructure, are normally overlooked. She stated that access to good-quality affordable medical devices was an important support to empower health-care workers for early detection and management of NCDs for better health outcomes.

Ms Berumen emphasized that the absence of nomenclature of medical devices to facilitate regulation, procurement and access could be raised in the Regional Committee meeting.

5 Field visit and reflections

The participants visited the Healthy Lifestyle Centre-Base hospital Panadura and Healthy Lifestyle Centre-Divisional hospital Thalangama in the outskirts of Colombo city. Participants appreciated PHC services with well-staffed health facilities at these centres. The visit coincided with the NCD clinic day and the centre was found to be busy. NCD screening services were well organized.

Coverage of services was less than 5–20% of the target population. Most of the clients were females. Low coverages and suboptimal use of HLCs appeared to be due to inadequate social mobilization among communities for HLC. No community volunteers were used for promotion of HLC. Community engagement and linkages with other sectors can improve utilization of HLCs. HLCs cater to both well and unwell populations; its promotion should be strategic to capture a population with NCD risk factors.

A register is used for record-keeping for first and follow-up visits. However, patient tracking was poor; digitalization of patient registry and more efficient tracking systems were necessary.

Healthy Lifestyle Centre providing NCD screening services

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6 Expert panel discussion on the innovative ways in NCD management within the health systems

Moderator: Dr Thaksaphon Thamarangsi

Panelists: Dr Chencho Dorji (Bhutan), Dr Rajesh Kumar (India), Professor Hasbullah Thabrany (Indonesia), Professor Ko Ko (Myanmar), Professor Arjun Karki (Nepal), Dr Walaiporm Pacharanaruemol (Thailand)

Experts from Member States were invited to propose key interventions for strengthening NCD services at the PHC level. The following themes emerged from the expert panel discussions:

1. *Strengthen leadership and governance:* high-level political commitment is necessary for appropriate resource allocation for improving PHC services and integration of NCD services. This needs effective advocacy for political support to ensure that primary care approach for NCDs gets the due attention. High-level national committees should be established to coordinate partners involved in NCD management.
2. *Strengthen PHC with patient-centred care; integrate NCDs with primary health and minimize verticalization:* NCDs should be integrated at the PHCs to achieve UHC. NCD services at PHC should be linked to performance, and systems should be instituted to track patients. NCD services should be positioned as a family health programme and avoid verticalization.
3. *A competent health workforce at the PHC level:* PHC workforce should be strengthened. Task shifting among existing health workforce should be promoted in NCD services with clear job descriptions. The hitherto maternal and child health focus should be expanded to include NCDs and lifestyle modification. A lifestyle counselor should be added as a new cadre to meet the demand for lifestyle counseling. Capacity-building of health-care professionals should be given priority, which includes training of village health volunteer workers; also, PHC and the health workforce should be reoriented . Academia should take a lead role and incorporate competency-based curricula for NCD management and programming. Training institutions should be engaged in upgrading and ensuring availability of competent health workforce to manage conditions including NCD response.
4. *Medicines and technology:* with increasing penetration of mobile phones, use of mobile technology for awareness creation, patient care and supply chain management should be widely used.

5. *Financing and financial protection:* politicians and policy-makers should be convinced by positioning health expenditure as an investment and a way to reduce impoverishment and build social capital. Different options for public financing should be explored to reduce catastrophic health expenditure. Not only should more money for health, more health for the money be sought . Health providers should be encouraged to pay for outcomes by (i) recruitment of champions, (ii) providing financial incentives/disincentives for producers of high-risk products, and (iii) NCD packages should be included in the UHC package.
6. *Information:* the current PHC approach for NCDs lacks follow-up and monitoring.
7. *Partnerships, collaboration and community engagement:* local leaders and communities should be brought aboard and include them in health committees at local levels to solve community health problems; religious organizations, civil society organizations, NGOs and sectors outside the health sector should be included as partners.

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7 Country cluster workshops for strengthening NCD management at the PHC level

Moderator: Dr Gampo Dorji

Delegates outlined key priorities to be completed by 2018. Priority categories listed by the majority of Member States are as follows:

- expansion of targeted screening for CVD risk using common NCDs as entry points (raised blood pressure, raised blood sugar) and management of common NCDs (diabetes, hypertension, COPDs, CVDs) at the PHC;
- initiation/expansion of package of services adapting the WHO Package of Essential NCD Interventions (PEN);
- update national EML and initiate expansion of medical devices, such as nebulizers, glucometer and glucose strip at PHCs starting with PEN;
- strengthen the use of IT and web-based systems and electronic patient tracking as well as patient follow-up.

Promoting physical activity at meetings: Participants' record-sheet for daily steps count

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8 Recommendations

The consultation produced a "Framework of policy options for Member States strengthening NCD response at the primary health care system" (Annex 1) and provided inputs for the Colombo Declaration to be adopted at the Sixty-ninth session of the Regional Committee (strengthening NCD management at PHC level).

Recommendations for Member States

1. Accelerate integration and implementation of NCD services at the PHC services through a defined package adapting WHO PEN.
2. Use the framework of policy options containing key actions within each health system building block to strengthen NCD response at the PHC; (Annex 1).
3. Set up a good accountability framework to monitor delivery of NCD services through a strengthened PHC system.
4. Propose a ministerial declaration at the Sixty-ninth Session of the Regional Committee to improve health systems response to accelerate NCD management at the PHC level.

Recommendations for WHO

1. Develop business case for investment in PHC for NCDs to inform political and policy decisions of values of PHC approaches in NCD services.
2. Support integration of WHO PEN package within the PHC care levels.
3. Conduct regular review and update lists of essential NCD medicines and recommended priority medical devices and equipment, and promote their use in Member States.
4. Support development and use of consistent nomenclature for medical devices.
5. Facilitate active networking of academia to facilitate and review and adaptation of competency-based curricular in medical and health sciences teaching and training institutes for doctors, nurses, pharmacists and other relevant categories.
6. Work with finance-oriented partners (such as development banks) to assist countries to improve chronic disease management and quality in the private health sectors.

7. Support active inter-country learning teams on innovative approaches and best practices for NCD management and prevention.
8. Create a one-stop repository of NCD prevention and control tools, training manuals, standard operating procedures of all countries, best practices and encourage Member States to learn and adapt practices.
9. Report the regional progress of the implementation of the Ministerial Declaration on NCD management to the subsequent RCs.

9 Priorities for Regional Committee for NCD service delivery within the PHC system

The delegates discussed the priority issues for the Sixty-ninth session of the Regional Committee 2016, on delivery of NCD services at the primary health care level.

Governance and financing issues dominated the recommendations from the discussion on the suggested focus of the Regional Committee Meeting.

Delegates suggested that the Health Ministers' Declaration should contain specific steps to support delivery of NCD services at PHC. At the national level, delivery of NCD services at the PHC system should be implemented under the guidance of a high-level national taskforce to promote good governance and policy support for NCDs to follow up on the implementation of the Ministerial Declaration at the country level and support all responses required for accelerating integration of NCDs into the PHC system.

Delegates wished to bring to the attention of Health Ministers the strategic approach that they are recommending for the delivery of NCD health services – integrating the approach with two existing health service agendas – Primary Health Care and Universal Health Coverage. Over time, as a result of the demographic transition with falling birth rates, ageing and urbanization, NCDs will increasingly become the dominant function of PHC services. In most countries in the Region, access to PHC has not been fully achieved, so making NCDs an integral part of primary health care is critical to achieve the UHC. This approach will also reduce duplication that occurs when health programmes take a vertical approach, and will enable the focus to be on strengthening the frontline of health services. It requires countries to ensure that their PHC and UHC policies and programmes have incorporated NCD health services, at the same time as coverage is extended.

Appropriate resourcing to tackle the health system component of the NCD response in terms of finances, workforce, medicines and technology is vital. Delegates reiterated that increase in taxation of health damaging products, such as tobacco, alcohol and unhealthy foods provide an opportunity to raise tax revenue, while at the same time contributing to a reduction in NCDs. Delegates wanted Health Ministers to actively advocate an increase in tax on the health damaging products to increase fiscal space for the health sector.

NCD funding at the subnational level is particularly an urgent necessity. Each facility, district and province needs an actual or nominal NCD budget, so that the necessary drugs and technologies are available. WHO has identified the essential items of service and a risk approach (detecting and treating those

with highest risk) which can be used as the starting point for NCD services at this level. Health sector finances for NCD unclear at national and PHC services . Delegates wanted Health Ministers to increase financial resource allocation for PHC services for implementing NCD services.

Providing a good quality of NCD services with patient-centred care and adequate follow-up is vital. Current gaps, such as inadequate patient for services and outcomes, need to be documented and corrected. The Health Ministers' Declaration should include improving health information systems for quality improvement and monitoring of NCD services. Health facilities should integrate clearly specified NCD service indicators, such as proportion of patients on follow-up for treatment and outcomes at the health-facility level. Investment should be made to upgrade NCD information within the HMIS, using more robust IT-enabled systems at all levels of health facilities.

Delegates also identified addressing shortage as well as competency of the health workforce. Training and orientation of the health workforce, especially the frontline health workers and volunteers that provide a whole of family approach was recommended. Ensuring that the training organizations have updated their curriculum is very important so that tomorrow's health workers see NCDs as integral to the services they provide. Engage community health volunteers to be responsibility of whole of family care.

10 Closing session

The closing session of the regional consultation was graced by Dr Lakshmi Somathunga, Deputy Director-General, Medical Services I and Dr Amal Harsha De Silva, Deputy Director-General, Medical Services II from the Ministry of Health, Nutrition and Indigenous Medicine, Government of Sri Lanka, and Dr Jacob Kumaresan, WR, Sri Lanka. Mr Kinga Jamphel, on behalf of the participants, shared the process and outcomes of the meeting. The three dignitaries expressed their appreciation for the successful completion and fruitful outcomes of the consultation. Dr Gampo Dorji, on behalf of SEARO, thanked the participants, Government of Sri Lanka, Sri Lanka WHO Country Office team, expert invitees, other WHO staff and the organizing team for their contribution in the regional consultation.

Annex 1

Framework of policy options for Member States for strengthening delivery of noncommunicable disease services at the primary health care system

Issue/themes	Policy options
Leadership and Governance	
Inadequate resource allocation for NCDs and PHC	• Present NCD prevention and control to decision-makers as an investment in health and development • Advocacy at the political level, including the political, social and economic benefits of NCD integrated PHC
Political preference is for high visibility and tech solutions	• Support decision-making on resource allocation, based on equity and evidence-based policy and across the health sector, such as focussing on poor and socioeconomically marginalized populations (those left behind) • Build evidence-based economic argument for NCD and PHC investment
Resistance to change in the mindset among health service providers from original concepts of MCH focused PHCs to integrate NCD services in PHC services	• Develop PHC policies and programmes to incorporate NCDs, and implement principles of people-centred, whole of family care and chronic care management
Weak stewardship over the private sector in NCD services impedes PHC and UHC goals resulting in OOP and poor quality of services	• Develop and strengthen regulatory mechanisms for reporting of activity and quality of private health sector, including PPPs (Noting that they are highly but ineffectively regulated now) • Support third sector providers (NGOs) as an additional provider option to public and private services

Issue/themes	Policy options
Engagement of both the private and public sector in delivery of NCD services	• Institute strong contractual mechanism for private services • Regulation and certification of private services (Noting that they are highly but ineffectively regulated now). Ensure enforcement of regulations • Develop third sector (NGOs) as an additional provider option to public and private services • Consider public-private partnership with well-defined guidelines and oversight, appropriately regulated
NCD weak visibility at senior level of the health system	• Institutionalize NCD health service management within MoH and establish NCD health service coordination mechanisms at subnational levels of health systems
Community participation	• Engage civil society, community leaders in health service committees at local levels • Assist and incentivize the community health volunteers to incorporate NCD focus in their "Whole of Family" health programme
Inequity in health services as poor, rural and urban slums are left behind without NCD services	• Expand coverage of universal health programmes to reach communities and people left behind • Include equity indicators within the progress measurement of NCD services
Finances	
Inadequate level of financing from domestic funds and benefits that are not clear to decision-makers	• Develop investment case (economic benefits) of addressing NCDS within PHC, demonstrating health expenditure as investment in health and development • Enlarge the envelope for health through PHC approach and including NCDs
Alternative financing to increase fiscal space for health	• Engage relevant agencies of the government to set an agenda to increase tax for alcohol, tobacco and sugary drinks

Issue/themes	Policy options
Health sector finances for NCD unclear at national and PHC services	• Include NCD resourcing and spending in national health accounts • Develop country specific costing of the NCD package within PHC at facilities and districts and make funds available to lower level of health facilities in a transparent manner
Medicines, Supplies and Equipment	
Regular updating of EMLs aligned with evidence-based treatment guidelines for management of NCDs	• Review and update National EML with NCD medicines based on evidence and national service package and levels of service • Revise national treatment guidelines/protocols with new medicines
Inappropriate prescribing	• Regulate irrational prescribing across the health sector
Priority Technology List needs developing	• Prioritize technologies for NCDs by level of service with reference to PEN as a starting point
Priority Technology unregulated, untried, and inefficiently purchased	• Support between-country learning of experience with purchasing priority technologies of good quality and encourage a national regulatory approval process
Uninterrupted regular supply of all essential medicines and health technology/equipment	• Supply chain management – consider pooled procurement, quantification, real time evaluation, use of technology and computerized systems • Include NCD medicines and devices in the quantification in overall procurement of medical supplies
Palliative care, including management of severe pain	• Develop policies to increase access to severe pain control drugs and management of palliative care at PHC
Services	
Hard-to-reach areas and remote areas left behind	• Develop/expand NCD services through PHC and other outreach projects for populations left behind
Unclear scope and access of services. No treatment protocol for PHC	• Define a set of services – NCD package for different levels of health care using PEN as the starting point • Adapt the standardize protocols, such as PEN (without reinventing the wheel)

Issue/themes	Policy options
NCD initiatives operating but not yet to be rolled-out nationally	• Evaluate initiatives, and focus on scaling-up those that are successful and scale up PEN at PHC
Weak referral systems	• Strengthen guidelines for referral, encourage compliance with the referral systems • Address communication barriers between primary/secondary – include reporting back of care provided • Support clinical governance, encompassing both hospital and community care (DM)
Lack of population health focus	• Define catchment area of the health facility, implement NCD programmes and assess coverage of interventions
Weak monitoring and supervision at PHC level. Weak clinical governance	• Refine/integrate supervision and monitoring systems of NCD inclusive PHC, use of checklists, supported by IT innovations • Develop and promote clinical audits for PEN
Inadequate linkages of NCD services with other health units	• Develop working groups and include lifestyle education through other programmes, (MCH, HIV,) poly clinics
Lack of patient focus	• Develop patient–centred care and support self-managed care programmes • Introduce case records • Promote patient and family as primary carers in people with diabetes and other chronic diseases
Information	
Policy Gaps arising from ICT and patient information management	• Strengthen national policies on protection of patient information and privacy. • Train health workforce on management of patient privacy and bioethics.
Opportunities of ICT innovation for patient management, monitoring for services and outcome	• Improve use of ICT and use of mHealth for case management, and record-keeping with unique identifier • Build patient record system for Chronic care management • Promote use of Open source MRS, and share experience of ICT innovations across the region that has been evaluated for outcomes

Issue/themes	Policy options
Information use weak at health facilities	• Population-level reports for each facility and catchment • Motivate optimization use of data through visual and informatics and link health facility data to decision-making
Innovative and effective programmes not developed/ shared	• Create mechanisms for sharing local best practices among and within Member States
Health Workforce	
Workforce untrained to meet NCD challenge	• Redefine scope of work and responsibilities for health workforce, including new cadres, to meet NCD needs along with other areas for pre-training, post-training, post-graduates and on the job training • Accreditation of new skill building programmes by training institutions
Integrate teaching on NCDs	• Adapt curricula of various training programmes and appropriate changes for pre and in service curriculum • Conduct training in relation to effective use of information and implementation research • Develop accredited skill-based NCD courses linked to continuation medical education credits • Develop linkage with teaching institutions and universities
Inadequate workforce and NCD increases health worker workload	• Optimal use of available workforce and volunteers through training, incentives and task sharing • Workers trained in approaches, such as health promotion, case management, counselling, bio engineering, IT, logistics, purchasing, informatics and quality systems • Build NCD capable workforces as part of overall health human resource strategy

Issue/themes	Policy options
Skill gaps in health promotion and basic epidemiological approaches	• Develop/upgrade medical, nursing and allied health workers with competency in health promotion, prevention and management of basic NCDs • Strengthen continuing medical education accreditation systems to include NCD-related competencies
Weak incentives	• Offer incentives, non-financial based on the national context
Fragmented care	• Develop and train health workers in team approach, multidisciplinary teams with defined outputs and performance • Integrate PHC planning across programmes
Difficulty in retaining health workers	• Promote recruitments and training with the support of local communities • Implement bonding schemes, such as national services and training services • Introduce financial incentives and nonfinancial rewards, such as improved work environment, basic equipment and recognition programmes • Generate local evidence on retention and motivation for health workforce and implement to inform retention strategies • Consider new positions within health service delivery, such as case manages, counsellors

Annex 2

Programme

Day 1 – 7 June, 2016 (Tuesday)	
08:30–09:00	**Registration**
09:00–10:00	**Session 1.1: Opening** • Lamp lighting ceremony and national anthem • Welcome Remarks and address by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, to be delivered by Dr Jacob Anantharayan Kumaresan, WHO Representative to Sri Lanka • Objectives of the Regional Consultation and an update on the NCD epidemiology and regional progress in NCD responses in SEAR, Dr Gampo Dorji, NCD Management, NDE, SEARO • Address by H.E. Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Government of Sri Lanka
10:30–11:45	**Session 1.2: Setting the Scene** • **NCDs prevention and control –A Journey Ahead** Dr Thaksaphon Thamarangsi, Director, Department of Noncommunicable Diseases and Environmental Health, SEARO • **Health Systems and Systems Thinking for Health Systems,** Professor Don Matheson – Interactive discussion
	Session 1.3: Expanding NCD services in the context of Universal Health Coverage – Bringing along those left behind – Dr Palitha Abeykoon • **Panel discussion:** NCD services in the context of Universal Health Coverage in Indonesia, India, Nepal and Thailand
14:00–15:30	**Session 1.4: Core components of NCD management at primary health care system –** Dr Rajesh Kumar • **Panel discussion:** Experiences on Healthy Lifestyle Centres in Sri Lanka, PEN in Democratic People's Republic of Korea, Bhutan and Myanmar
16:00–17:15	**Session 1.5: Overcoming bottlenecks in NCD services at the primary health care in the context of six building blocks – what and how?** Dr Cherian Varghese • Health Service Delivery Group Work

Day 2 – 8 June, 2016 (Wednesday)	
*08:30–10:30	**Session 2.1: Overcoming the bottlenecks in NCD services at the primary health care in the context of six building blocks – what and how?** Dr Anita Kotwani • Health workforce • Medicines and technology Group Work
11:00–13:00	**Session 2.2: Overcoming the bottlenecks in NCD services at the primary health care in the context of six building blocks – what and how?** Professor Don Matheson • Governance and leadership • Health financing Group Work
14:00–15:30	**Session 2.3: Overcoming the bottlenecks in NCD services at the primary health care in the context of six building blocks – what and how?** Dr Sunil Senanayake • Health information system on NCDs Group Work
16:00–17:15	**Session 2.4: Priority Medical Devices in Cancer Management – A way forward.** Adriana Velazquez Berumen
Day 3 – 9 June, 2016 (Thursday)	
08:15–13:00	**Session 3.1: Field visit**
14:00–15:30	**Session 3.2: Reflections on the field observations** Moderator**:** Dr DSV Mallawarachchi
16:00–17:00	**Session 3.3: Expert panel discussion on the innovative ways in NCD management within the primary health care systems** (Each expert delivers a five minute speech). Dr Thaksaphon Thamarangsi
Day 4 – 10 June, 2016 (Friday)	
**08:30–10:30	**Session 4.1a: Country cluster workshops for strengthening management at primary health care level**. Dr Gampo Dorji
	Session 4.1b: Recommendation drafting committee meeting – Prof. Don Matheson

11:00–12:00	**Session 4.2: Presentation on Country works on strengthening the NCD** Moderator: Dr Chinmoyee Das
12:00–13:00	**Session 4.3: Discussion on recommendations on Strengthening Health Systems Response to Address NCDs in the South-East Asia Region (in the context of primary health care services)** Moderator: Dr T. Siriwardena
14:00–15:00	**Session 4.4: Discussion on the potential recommendations on Strengthening Health Systems Response to address NCDs in the South-East Asia Region (in the context of primary health care services) for the Sixty-ninth Regional Committee** Moderator: Dr T. Siriwardena
15:15–16:00	**Session 4.5: Closing Session** Closing Remarks, Dignitaries from the Ministry of Health, Sri Lanka Closing Remarks, Dr Jacob Anantharayan Kumaresan, WR, Sri Lanka Vote of Thanks, Dr Gampo Dorji, WHO SEARO

*Special breakfast session: Transformational leadership seminar, Prof. Don Matheson

**Special breakfast session: Be the change session, Ms Anika Singh

Annex 3

Inaugural address by Dr Poonam Khetrapal Singh Regional Director, WHO South-East Asia Region

(Delivered by Dr Jacob Kumaresan, WHO Representative to Sri Lanka)

Distinguished delegates, NCD experts and colleagues,

On behalf of Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, I am pleased to welcome all participants to the Regional Consultation on Strengthening Health Systems Response to Address NCDs in the South-East Asia Region. At the outset, the Regional Director would like to express her gratitude to the Government of Sri Lanka for kindly consenting to host this consultation in Colombo. She is also happy to note the presence of representatives from Member States of the Region, as well as experts, and to all of them, she extends a warm welcome. Although Dr Singh would have liked to attend this important event, she is unable to do so due to urgent prior commitments. Therefore, I take great pleasure in delivering her address on her behalf.

Noncommunicable diseases, as we all know, have emerged as the number one public health problem worldwide. NCDs are the leading cause of death in the South-East Asia Region accounting for an estimated 8.5 million deaths each year.

Tackling NCDs is a major health and development challenge. Recognizing the potential devastation to human progress, Member States made an unequivocal UN High-Level Political Declaration on prevention and control of Noncommunicable Diseases at the UN General Assembly in September 2011.

This Political Declaration reaffirmed WHO's leadership role as a specialized health agency and tasked it with developing an updated Global NCD Action Plan and a comprehensive global monitoring framework including indicators and voluntary targets.

The Sixty-sixth World Health Assembly in 2013 passed a resolution endorsing the WHO Global Action Plan For The Prevention and Control of Noncommunicable Diseases 2013–2020, including the global monitoring framework and a set of 25 indicators and nine voluntary targets for monitoring progress in prevention and control of NCDs. The Health Assembly agreed to pursue a goal of 25% reduction in NCD mortality by 2025. This goal is further

linked to the 2030 SDG targets of a one third reduction in premature mortality due to NCDs.

In the same year, Member States of the South-East Asia further adapted the Regional NCD Action Plan by adding a target on indoor air pollution.

Commendable progress has been made with NCD prevention and control globally and in the Region since the UN High-Level Political Declaration.

Partnerships are an important tool for improving public health outcomes, particularly in NCD control since most determinants of NCDs fall outside of the health sector. In this regard, I am very happy to note that all Member States have set national targets on NCD prevention and control that align with the global commitment, and the majority of Member States are in the final phase of adoption of their multisectoral NCD action plans.

The multisectoral plans provide an opportunity to address NCDs in a comprehensive manner by tackling the major modifiable risk factors - alcohol, tobacco, physical inactivity, unhealthy diet and poor indoor air - through sound public policies as well as strengthening health systems to respond effectively to NCDs.

One thing appears to be common in Member States of the Region. All can benefit from a comprehensive response including prevention and treatment and in particular by strengthening health systems at the primary health-care level. The stewardship of the health sector is key to the success of NCD control. Other sectors will largely rely on the health sector's ability to lead NCD prevention and control.

Recognizing health systems as critical factors, Member States at the UN General Assembly in 2014 adopted the UN Outcome Document on NCDs with four time-bound commitments. These included strengthening and orienting health services to address the prevention and control of NCDs through people-centred primary health care health systems by 2016.

The 2030 SDGs include six NCD-related targets, three of which are directly related to the strengthening of health systems. These are:

- Achieve universal health coverage (target 3.8)
- Provide access to affordable essential medicine and vaccines for NCDs (target 3.b)

- Support research and development of vaccines for NCDs that primarily affect developing countries (target 3.b).

Common health systems challenges related to NCDs include poor governance and lack of coordination, shortage of health workforce, weak data and information systems on NCDs, low access to essential and life-saving NCD medicines and technologies, weak supply chain management and irrational use of drugs, and catastrophic health spending. Member States need to take progressive steps to accelerate the provision of NCD services to achieve the 2025 targets.

This regional consultation is an opportunity to have in-depth discussions, take stock of the situation, share experiences and innovative ideas and suggest practical ways to respond to NCD management that best suits each country situation.

In the conclusion, the Regional Director wishes to state her three expectations from this consultation. **First,** she hopes the discussions of this meeting will yield feasible and specific guidance to Member countries on strengthening their health systems responses to address NCDs. **Secondly,** an outcome from the meeting will be tabled at the Ministerial Roundtable during the Sixty-ninth session of the Regional Committee meeting in September 2016. She expects the consultation to come up with a practical, realistic and feasible proposition to be considered for the Ministerial Roundtable discussion. **Lastly,** any consultation and meeting is an avenue for learning and sharing. She is certain that you will get to hear ways of better responding to NCDs from each other. She urges you to please share these lessons and take them home to strengthen health systems response to NCDs.

The Regional Director also wishes you all success in your deliberations and hopes that you have a pleasant stay in Colombo. I wish you the same.

Thank you, ladies and gentlemen on my behalf and on behalf of the Regional Director.

Annex 4

Be the Change Programme

Be the Change activity summary

Below is an overview of the side-events and activities that were done at the 'Regional consultation on strengthening health systems response to address NCDs in the South-East Asia Region':

S.No.	Activity	Activity Outcomes
Morning physical activities (6:00 - 6:45 hours) **Objective:** To promote physical activity amongst participants and encourage staying active even during duty travel.		
1.	Day 1. Beach run and exercises	25 participants attended this session, i.e. 50% of the total number of participants. Participants learnt stretching exercises that they could practice at home and got approx. 4000 steps during this morning activity.
2.	Day 2. Dance your way to fitness: Zumba	10 participants attended this session. They were introduced the idea of how fun can be added to fitness to add steps and loose calories. A total of 5000 steps were gained during this activity.
3.	Day 3. Beach run and aerobic exercises	15 people attended this session. The session focused on fun aerobic exercises and some strengthening activities. A total of 4000 steps were gained through this activity.
Team activities: 5 Teams **Objective:** To encourage individual and collective goal-setting for fitness through team-building activities. These sessions also focused on learning through creativity and fun. Participants were divided in 5 teams on Day 1 and all the below activities were done during the course of 4 days.		
4.	All days: Step up! 10 000 steps every day – the team that gets maximum step-count, wins	Individuals were given pedometers and they had record their individual step-count for all the 4 days. At the end of 4 days, total steps were counted for individuals, for the teams and an average for each team was worked out. Forty-three people actively participated. The total number of steps done as a larger group were 1 196 000, which came to an average of 7000 steps every day by participants. The participants reported saying that this has been the most active meeting they have ever been to.

S.No.	Activity	Activity Outcomes
5.	Day 2 and 3. 'Storyboard'- the team that uses the resources (cut-outs) in the most creative way to demonstrate how they can be the change and inspire the same in their communities, wins (teams prepared charts and pasted cut-outs to present a story)	Participants summarized their learning of health promotion through creative medium of the storyboard. The groups focused on the following aspects: • Group 1 presented on the life course approach to alter lifestyle and adapt healthy behaviours from a young age. Healthy people = Healthy communities = Healthy environment. • Group 2 presented on how advocacy for policymakers is most important in bringing about a sustainable change. • Group 3 presented on how NCD is in a mess and needs urgent action with individuals in the centre of the change cycle. • Group 4 presented on practicing the ABCDEFGH of holistic health focusing on staying active, eating healthy, keeping mental fitness, and staying stress-free. • Group 5 focused on being a healthy productive workforce by being aware and taking action for healthy living.
6.	Day 4. Treasure hunt – clues were given to teams to look for items related with a healthy lifestyle. With the finding of each clue, there was a health promotion message. The game was educative and fun.	Participants learnt team-building through this activity. The focus was on giving out the health promotion messages in a fun-way through this game. Some of the important messages given through this activity includes: start your day with a healthy breakfast, choose water over sugary sweetened drinks, watch your plate for a healthy weight, do at least 30 minutes of exercise every day.
Activities in mid-breaks (these activities were done all days) **Objective:** To make the breaks more active for participants. To encourage participants to have a more healthy lifestyles by moving away from sedentary lifestyle with conscious changes in behaviours.		
7.	Follow the leader: dance steps and cross-cultural music for a refreshing 2-minutes break	Participants reported back saying that the active breaks helped them to be more productive during the meeting.

S.No.	Activity	Activity Outcomes
8.	Stretching exercises	Participants felt charged and had better concentration after the stretches.
9.	Musical chairs – with one group of participants singing and the rest playing musical chairs on different tables (all playing at the same time)	Participants enjoyed this activity saying that it energized them and helped them in focusing better.
10.	ABCDE song for staying healthy (our version of NCD Anthem)	The song was composed on the advocacy poster produced by WHO SEARO- ABCD of health. The lyrics of the song were as follow: Say no to alcohol, Cut down on sugar (and) salt, Be wise enough to throw that cigarette, Regular exercise, Lots of fruits and veggies nice, Being healthy is as easy as can be… So don't break your heart, That precious little heart, Being healthy is as easy as ABCDE The participants enjoyed singing what they called the NCD-anthem.
11.	Standing group-work sessions	The standing sessions for group-work ensured movement and better discussions. Participants reported that they felt more active and energized with this new style of standing and brainstorming.
Healthy breakfast session **Objective:** To have 2 side sessions on leadership and Be the Change, both important in being a role-model both as an organization and as individuals.		
12.	Day 2: Transformational Leadership on change management – focusing on the leadership role needed in management of NCDs. Healthy breakfast was served.	The participants had a better understanding of what were the qualities of a leader and how it is important to imbibe these for better NCD management. While the session was run by an expert, there was lot of peer learning as well. Participants were also served healthy breakfast.

S.No.	Activity	Activity Outcomes
13.	Day 4. Be the Change – the session focused on how 'healthy norms' are or can be institutionalized in different organizations/ countries. Healthy breakfast was served.	The participants were oriented to the "Be the Change" programme and its 6 WATCH components launched by WHO SEARO on the World Health Day 2016. The participants felt ready to institutionalize the health promotion activities in their respective workplaces. There was a lot of peer-learning in this session, such as: WCO Sri Lanka's adaptation of Eats at Meets and Canteen guidelines issues in MOH, WHO HQ's guidelines on healthy meetings, Government of Myanmar has combined health and youth ministry to focus on health programmes through schools; etc.
Tools shared **Objective:** To share some tools for health both for fun in fitness and for monitoring of targets set for health.		
14.	**Fun tools –** skipping ropes, stretch bands, pedometers – add fun to fitness	The participants enjoyed the demonstration of each of the fun tools and learnt that portable skipping rope, stretch bands and pedometers can be the best accompaniment during duty travels to stay active.
15.	**Measuring tools –** measuring tape, BMI charts	The participants felt encouraged to use the BMI charts and have targets to come in the healthy category. Also, the target for women to have waist circumference under 80 cms and for men to have under 90 cms to reduce the risks related to NCDs was highlighted in this session.

Annex 5

List of participants

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Regional consultation on strengthening health systems response to address noncommunicable diseases
Colombo, Sri Lanka, 7–10 June 2016

Noncommunicable diseases, which include cardiovascular diseases, cancer, diabetes and chronic respiratory disease, are the leading cause of death in the South-East Asia Region accounting for an estimated 8.5 million deaths each year.

Prevention and control of NCDs require a set of actions. Clinical interventions for those at risk of NCDs and for people living with NCDs is an important and critical part of the national NCD response. Health-care systems in Member States in SEAR are not adequately organized to manage the NCD burden resulting from the demographic and epidemiological transition. The presence of lifelong chronic disease and long-term comorbidities requires not just a rethinking of service delivery but also reorientation of the entire health system building blocks.

The World Health Organization Regional Office for South-East Asia organized a regional consultation on "Strengthening Health Systems Response to Address NCDs in the South-East Asia Region, Colombo, Sri Lanka, 7–10 June 2016.

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