Information session on Reaching Billion 1 and 2 and SDG3.4: NCDs in Primary healthcare and Universal Health Coverage also as a foundation for preparedness

World Health Organization

Dr Bente Mikkelsen, NCDs Department

Tuesday 25 October 2022 from 14:00-15:30 CET

Agenda

1	Welcoming remarks	Dr Minghui Ren, ADG UCN, WHO
2	Strengthening NCD Services through PHC and UHC including Tools and Guidance	Dr Bente Mikkelsen, Director, NCD/HQ, Dr Suraya Dalil, Director, Special Programme on PHC, WHO Dr Rudi Eggers, Director IHS/HQ
3	Country Case Study	Dr Rajesh Pandav, WR Nepal Dr Benido Ipouma, Director NCD AFRO
4	Moderated discussion with Member States	Guy Fones, Head, GCM/NCD, WHO
5	Wrap up and end of session	Dr Bente Mikkelsen, Director, NCD Department, WHO

Welcoming Remarks

Dr Minghui Ren, Assistant Director General UHC/Communicable & Noncommunicable Diseases, WHO, also on behalf of DDG Dr Jakab

Outline

1. NCD Services in PHC and UHC
2. Strengthening NCD services through PHC and UHC also as a foundation for Health Security: Tools and Guidance
3. Strengthening NCD services through PHC : Practice & Case Studies - UHC Partnership, NORAD NCD Flagship Initiative, PENplus, Preparedness
4. Political Engagement and Advocacy : Global Group of Heads of State on NCD, UN High Level Meeting on UHC

Why PHC and UHC for NCDs?

- The magnitude of the problem
- Lack of investment and financial protection for NCDs
- Preparedness and lessons learned from COVID-19
- Mandates to WHO
- Existing tools and ongoing normative and country work
- The need for recommendations
- How to measure the impact

World Health Organization
Invisible numbers
The true extent of noncommunicable diseases and what to do about them
Read the report
https://www.who.int/publications/i/item/9789240057661
Access the NCD Data Portal
https://ncdportal.org/

Data portal on NCDs

Noncommunicable Diseases Data Portal

Noncommunicable diseases (NCDs) – chief among them, cardiovascular diseases (heart disease and stroke), cancer, diabetes and chronic respiratory diseases – cause nearly three-quarters of deaths in the world. Their drivers are social, environmental, commercial and genetic, and their presence is global. Every year 17 million people under the age of 70 die of NCDs, and 86% of them live in low- and middle-income countries.

Users can explore the data below by country, accessing detailed information on noncommunicable diseases and their key risk factors:

Noncommunicable Diseases & Key Risk Factors

Cancer

Cardiovascular diseases (CVDs)

Chronic respiratory diseases (CRDs)

Diabetes

Harmful alcohol use

Obesity / Unhealthy diet

Physical inactivity

Tobacco use

Diseases & Risk Factors | Gender | Indicators

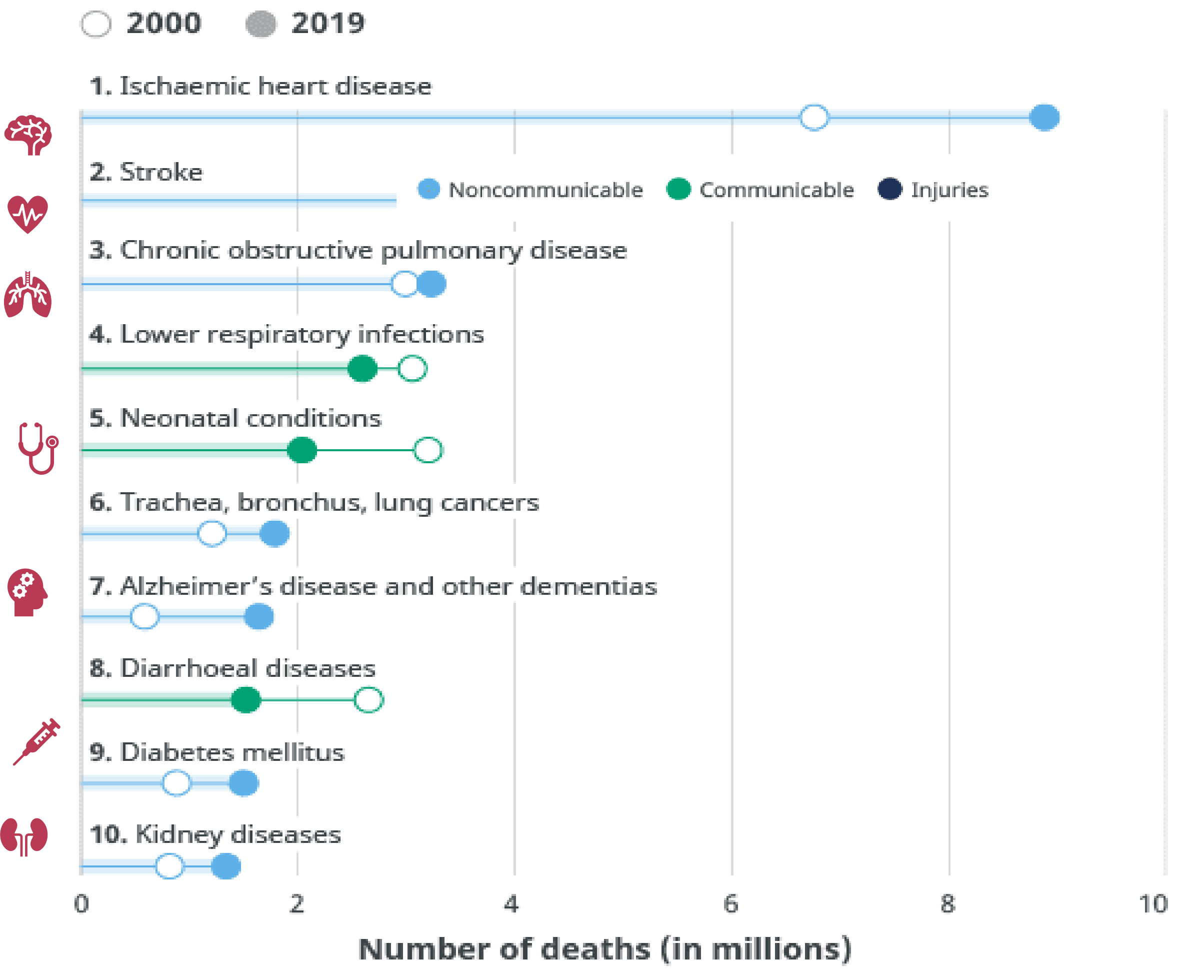
NCDs | Alcohol | Cancer | CRDs | CVDs | Diabetes | Obesity / Diet | Physical Inactivity | Tobacco

Total | Males | Females

Probability of premature mortality ...

Search country

NCDs are the leading causes of death worldwide



74%

Together, all NCDs accounted for 74% of deaths globally in 2019

NCDs are the leading causes of death worldwide

Almost 3/4 of all deaths in the world are from an NCD

Cardiovascular diseases cause 1 in 3 deaths

Cancers cause 1 in 6 deaths

Chronic respiratory diseases cause 1 in 13 deaths

Diabetes causes 1 in 28 deaths

Source: WHO global health estimates 2019 (2020)

Huge national inequalities remain in the likelihood of dying prematurely from a major NCD

30% likelihood

20% likelihood

10% likelihood

9%: Norway

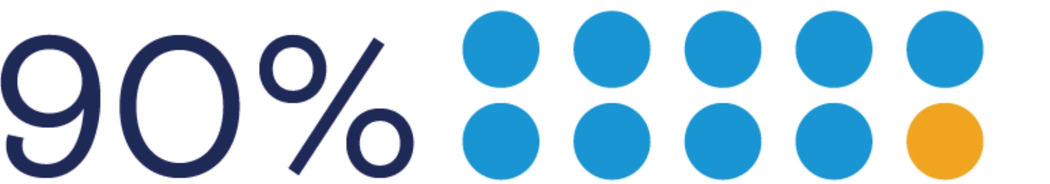
29%: Cote d'Ivoire

Living with breast cancer in Cote d'Ivoire

World Health Organization

Countries are not on track to meet the SDG target on NCDs

- If past trends continue, **only 14 countries will reach the SDG target** to reduce premature NCD mortality by a third.
- Yet with extra spending of 18 billion per year -- equivalent to 0.6% of LMICs' gross national income per capita, **90% of LMICs could meet the target and prevent or delay 39 million deaths.**



With sufficient investment, 90% of LMICs could meet the SDG target to reduce premature deaths from NCDs by a third by 2030

Data Sources: EB 150/7 (2022) and NCD Countdown 2030 collaborators (2022)

Addressing NCDs in UHC will reduce future COVID-19 burden

UNDIAGNOSED

Delays in diagnosis of NCDs resulting in more advanced disease stages

UNPROTECTED

Increases in behavioural risk factors, such as physical inactivity and increased use of harmful substances

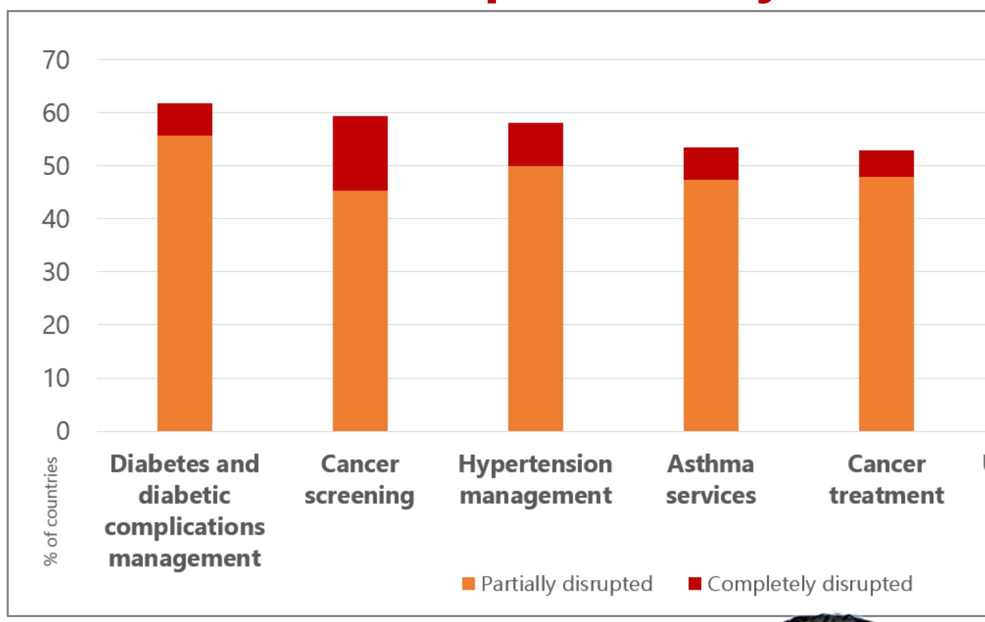
DEADLY INTERPLAY

Higher likelihood of severe outcomes among people with NCDs

UNTREATED

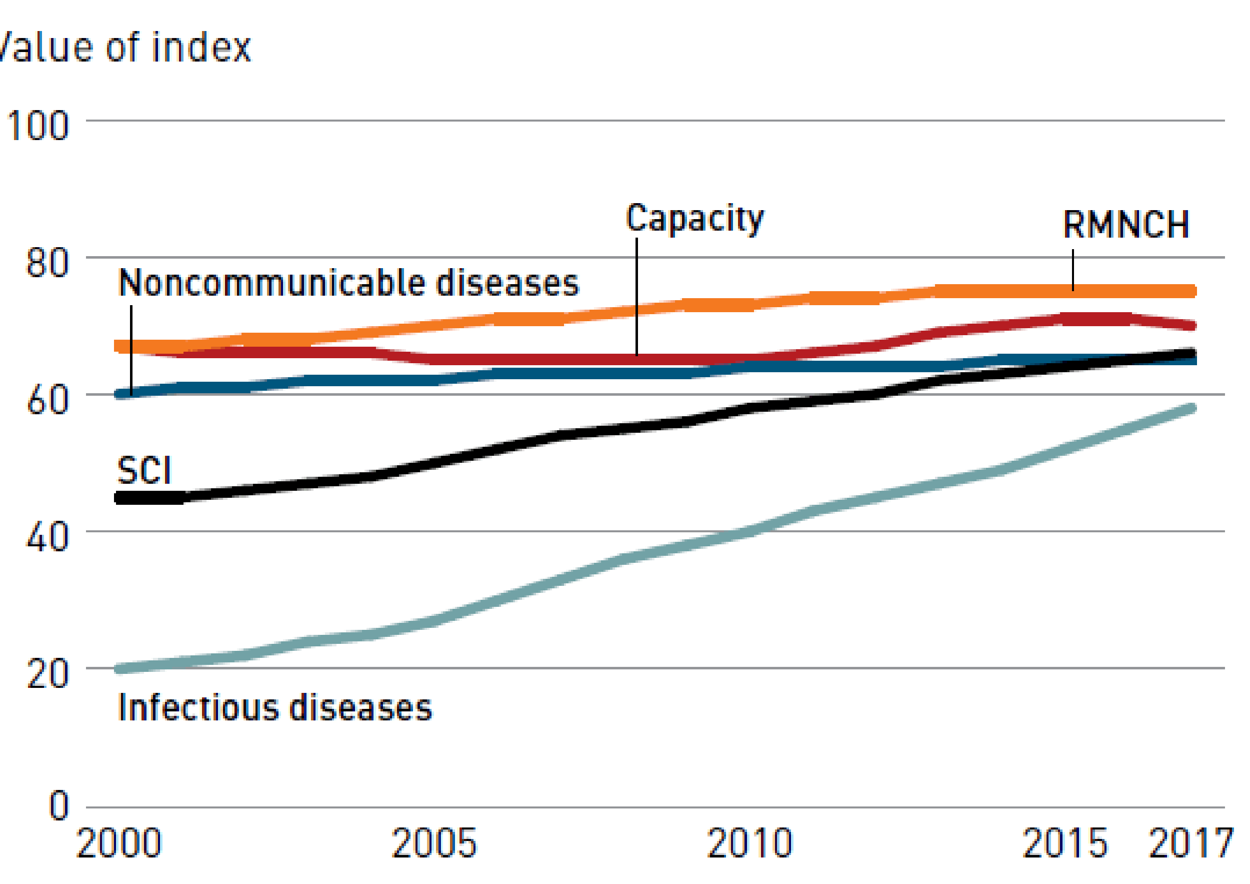
Delayed, incomplete or interrupted therapy (treatment, rehabilitation, palliation) of NCDs

136 countries reported NCD services were disrupted in May 2020



"COVID-19 has **preyed on people with NCDs such as cancer**, cardiovascular disease, diabetes and respiratory disease. Globally, NCDs and their risk factors are increasing vulnerability to COVID-19 infection and the likelihood of worse outcomes, including in younger people. The pandemic has underscored the urgency of addressing NCDs and their risk factors."

NCD services are lagging behind

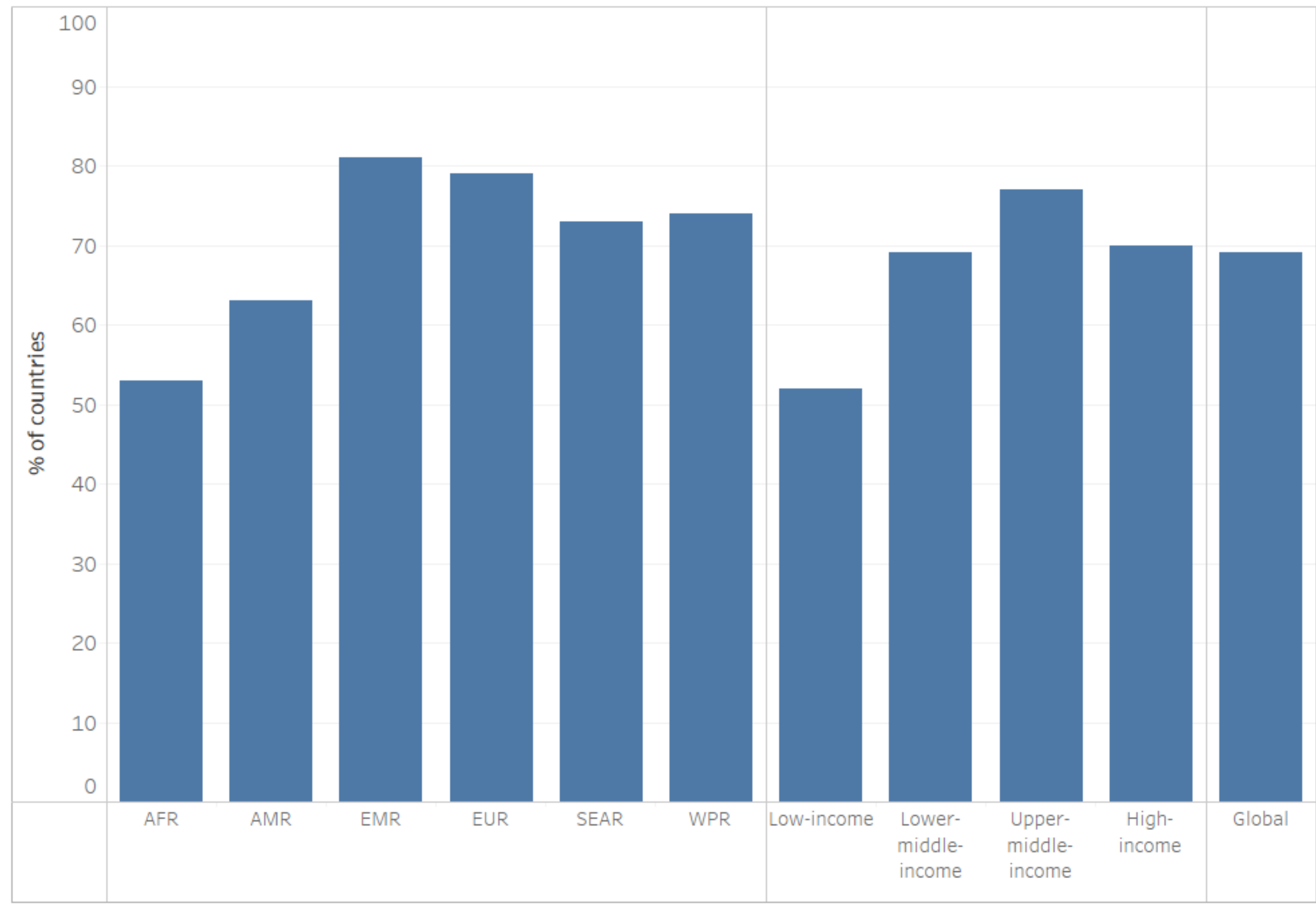


- **Since 2000: rapid improvements in coverage of infectious diseases in UHC vs relatively little change on NCDs**

NCD Country Capacity Survey Data

Are NCD services included in your national essential package of health services or universal health coverage-priority benefits package?

WHO CCS 2021



Do the Health System respond to NCDs? NCD services are key to achieving UHC

EXAMPLE: High systolic blood pressure causes 54% of cardiovascular deaths worldwide

1.3 billion adults 30-79 have hypertension

54% are aware

43% are treated

21%

Only 1 in 5 have controlled their hypertension globally – and it's 1 in 10 in low-income countries

Data Sources: NCD-RisC (2021) and the 2019 Global Burden of Disease Study (2020).

Lack of International investments and OOP expenditure – From MDGs to SDGs?

Only 5% of external aid for health goes to addressing NCDs in LMICs

Catastrophic health expenditure has been found to occur in more than 60% of some patient populations with non-communicable diseases (NCDs; cancer, cardiovascular disease, and stroke); large variations in such outcomes occur by disease and context

Being uninsured increases the risk of catastrophic health expenditure in patients with non-communicable diseases

Programmes to achieve universal health coverage need to adopt **compulsory pre-payment via taxes or national insurance contributions**

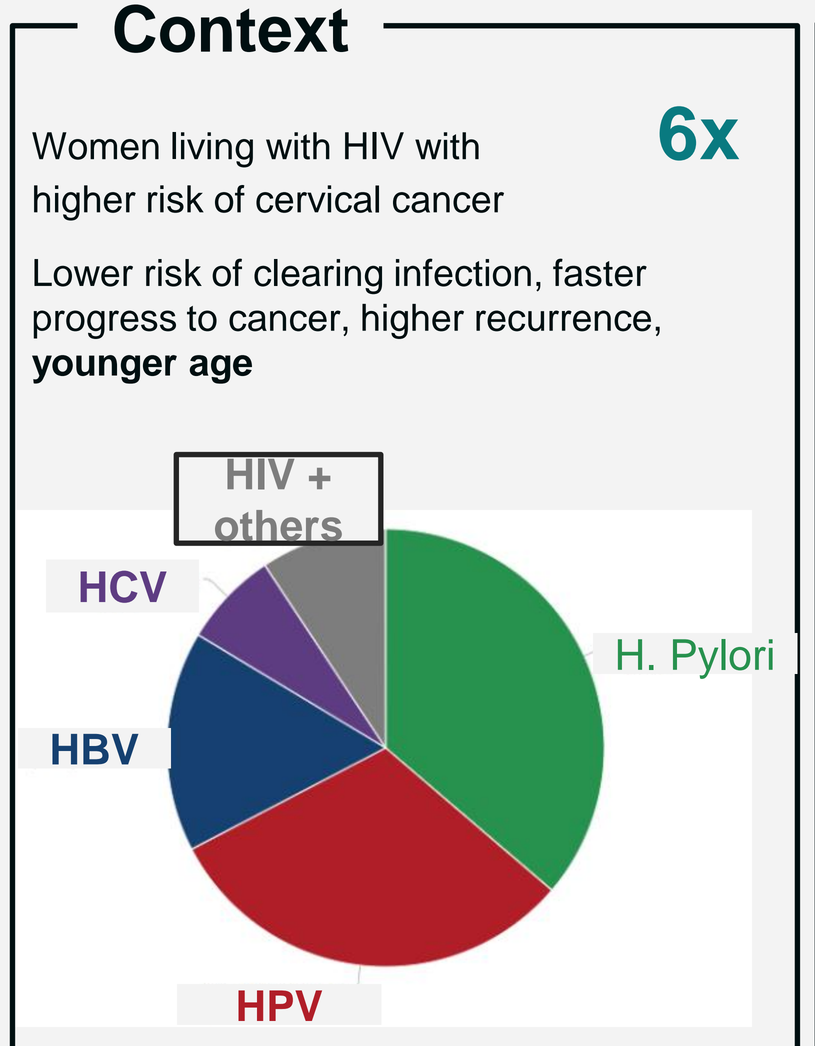
Cost-effectiveness and the targeting of the poorest groups need to be primary considerations in prioritising services that are included in insurance programmes to achieve universal health coverage

Addressing the household economic burden of NCDs is an important step in efforts to alleviate global poverty and achieve the UN's Sustainable Development Goals

Lancet 2018 Action to address the household economic burden of non-communicable diseases,: Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2022 (https://apps.who.int/nha/database, accessed 28 August 2022).

From MDG to SDG? Cancer and HIV as an example

- Addressing infectious causes to reduce cancer burden



Emerging consensus

2015: Member States and stakeholders agree at The Global Fund Board to address the co-morbidities between HIV and cancer

HIV and Cervical cancer
Kaposi sarcoma
Non-Hodgkin lymphoma
Hodgkin lymphoma
Anal cancer
Liver cancer
Colorectal cancer
Prostate cancer
Breast cancer
Lung cancer
Liver disease

Global Fund Area	Universe of co-infections and co-morbidities			
	Co-infections		Co-morbidities	
HIV	*Opportunistic infections*[ii]	Invasive candidiasis Isosporiasis Non-tuberculous mycobacteria Coccidioidomycosis *Pneumocytis jiroveci* pneumonia (PCP) Cryptococcocal disease Tuberculosis Crytosporidiosis Cytomegalovirus Toxoplasmosis Herpes simplex Histoplasmosis	*AIDS-defining cancers*[iii]	Kaposi sarcoma Non-Hodgkin lymphoma Cervical cancer
			Non-AIDS defining cancers[iv]	Hodgkin lymphoma Anal Liver Colorectal Prostate Breast Lung
	Non-opportunistic infections[v,vi]	Hepatitis B Hepatitis C Human papillomavirus Sexually transmitted infections Pneumonia and bacterial infections	*Chronic diseases*[vii,viii]	Cardiovascular Liver Opiate addiction
TB	Pneumonia[ix] and bacterial infections[x]		Autoimmune disease Diabetes Silicosis Tobacco use liver disease	
HIV and TB	Hepatitis Sexually transmitted infections[xi,xii,xiii]		[illegible]iabetes[xiv] [illegible]isease Lun[illegible]	
HIV, TB, and Malaria	Helminths[xv] Leishmaniasis[xvi,xvii] Neglected tropical diseases[xviii]		Malnutrition[xix,xxxxi]	

WHO Member States' Top Demands for technical assistance

#1. To integrate NCDs into PHC and UHC

NCDs in Primary healthcare (PHC) and Universal Health Coverage (UHC)

Some key Mandates

A/RES/73/2. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases 2018
39 Integrate, as appropriate, responses to non-communicable diseases and communicable diseases, such as HIV/AIDS and tuberculosis, especially in countries with the highest prevalence rates, taking into account their linkages;
35 Strengthen health systems and reorient them towards the achievement of universal health coverage and improvement of health outcomes, and high-quality, integrated and people-centered primary and specialized health services for the prevention, screening and control of non-communicable diseases and related mental health disorders and other mental health conditions throughout the life cycle

A/RES/74/2 Political Declaration of the High-level Meeting of the UN General Assembly on UHC 2019
24.“progressively cover all people by 2030 with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies for the prevention, screening, early diagnosis and treatment of NCDs”.
33. Strengthen efforts to address NCDs, including cardiovascular diseases, cancer, chronic respiratory diseases and diabetes, as part of universal health coverage

WHA 74 Implementation Road Map 2023-2030 for the Global Action Plan for the Prevention and Control of NCD 2013-2030

WHA69.24 resolution on “Strengthening integrated people-centered health services”
WHA74.5 resolution on oral health. The resolution recommends that oral health should be firmly embedded within the noncommunicable disease agenda and that oral health-care interventions should be included in universal health coverage programmes.

The power of PHC

- **75% of the projected health gains from the SDGs could be achieved through PHC;**
- **90% of essential UHC interventions can be delivered through PHC;**
- **Investing in PHC could increase life expectancy by up to 6.7 years by 2030**.
- PHC is the **most equitable and cost-effective way** to address comprehensive health needs close to people's communities and everyday environments.
- It includes essential public health functions and contributes to resilience.
- It is an approach (i.e. not just 'primary care' level) that underpins progressive realization of the full continuum of care across health programmes and diseases and levels of care.
- It is integrated, comprehensive, and relevant for countries at all income/development levels.

Primary health care in practice

What it is							
A **whole-of-society approach** to health that aims at ensuring the highest possible level of health & well-being and its equitable distribution in the population	PHC provides better value for money than its alternatives, but still requires **considerable investment.**	Dealing with the **health of everyone** in the community	A **comprehensive response** to people's health needs and expectations, including promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards	A **health system wide approach** to address the health needs and preferences of populations, while maximizing effectiveness, efficiency and equity of health outcomes	Institutionalized participation of **civil society, communities and people** in policy dialogue, accountability, health system management and in decisions about their health care, with improved health literacy	**Integrated and people-centered health services** encompassing all levels and settings of care, focusing on primary care as coordinator	**Teams of health workers with an appropriate skill mix** facilitating access to comprehensive health services and appropriate use of technology and medicines
A basic package of health interventions and essential drugs for the poor	PHC is cheap and requires only a modest investment	Concentration on specific populations (i.e. mother & child health only)	Focus on a small number of selected diseases, primarily infectious and acute (i.e. HIV care alone)	An exclusive focus on primary care services (first-level care) missing out on the opportunities of wider health system alignment, multisectoral action and community engagement and empowerment	People and communities are passive recipients of health services without a voice on health matters	Primary care working in isolation from sub-specialty care, in-patient hospital care, etc., without mechanisms for integration & coordination	Volunteer, non-professional community health workers working in isolation with limited scope of practice, medicines and technologies
What it is not							

Modified from Table 1 'How experience has shifted the focus of the PHC movement', WHR 2008 (WHO, 2008)

Operational Framework for PHC

PHC APPROACH	PHC LEVERS		PHC RESULTS
Integrated health services with an emphasis on primary care and essential public health functions	Strategic Levers	1. Political commitment and leadership 2. Governance and policy frameworks 3. Funding and allocation of resources 4. Engagement of communities and other stakeholders	Improved access, utilization and quality
Empowered people and communities	Operational Levers	5. Models of care 6. Primary health care workforce 7. Physical infrastructure 8. Medicines and other health products 9. Engagement with private sector providers 10. Purchasing and payment systems 11. Digital technologies for health 12. Systems for improving the quality of care 13. Primary health care-oriented research 14. Monitoring and evaluation	Improved participation, health literacy and care seeking
Multisectoral policy and action			Improved determinants of health

Source: Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020. https://www.who.int/publications/i/item/9789240017832 License: CC BY-NC-SA 3.0 IGO.

Meeting the needs of people living with NCDs: Service Package Delivery and Implementation (SPDI) Toolkit

UHCC SPDI tool

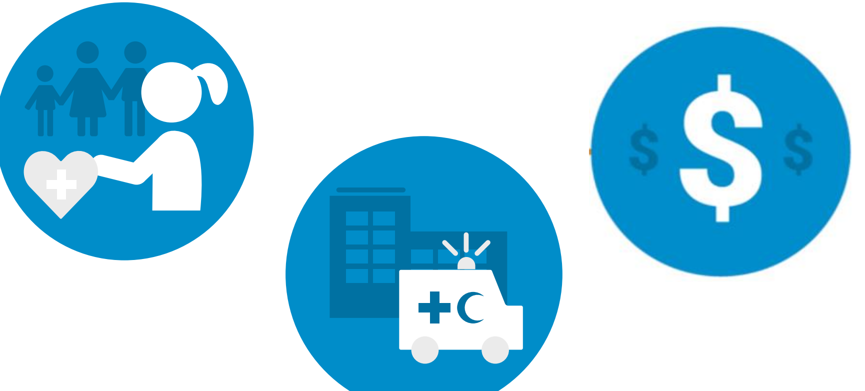
Epidemiologic shift is one of the main drivers for new package development

Package implementation manual

provides guidance on subnational management, community participation & monitoring

Primary and emergency care toolkits

process protocols & clinical decision support for acute and chronic care for NCDs



Guidance on budgeting, purchasing, payment, and entitlement mechanisms

that support effective integrated service delivery

Models of Care Initiative

promotes integration of health programs and optimizes movement across the health system

UHC Compendium

UHC Compendium Service Package Delivery & Implementation Tool

More about UHCC

Contact us

The Universal Health Coverage (UHC) Compendium of Health Interventions is a powerful database of health services designed to assist countries in making progress toward UHC. The UHCC Selection Interface supports users to develop service and UHC packages that best fit country needs. The Selection Interface provides:

- A systematic approach to creating and revising national and sub-national packages
- A structured architecture that facilitates a stepwise approach to service selection
- Detailed data on resource requirements, WHO guidelines, and country-specific priorities
- Tools to support planning and tracking progress
- A system to map services to delivery platforms, facilitating the integration of services across the health system

My Projects

New

- **Liberia EPHS II** →
- **Copy of EMRO EHS 2022 - Comment** →
- **High-Priority Health Services in Humanitarian Settings (H3)** →
- **Somalia 2020** →

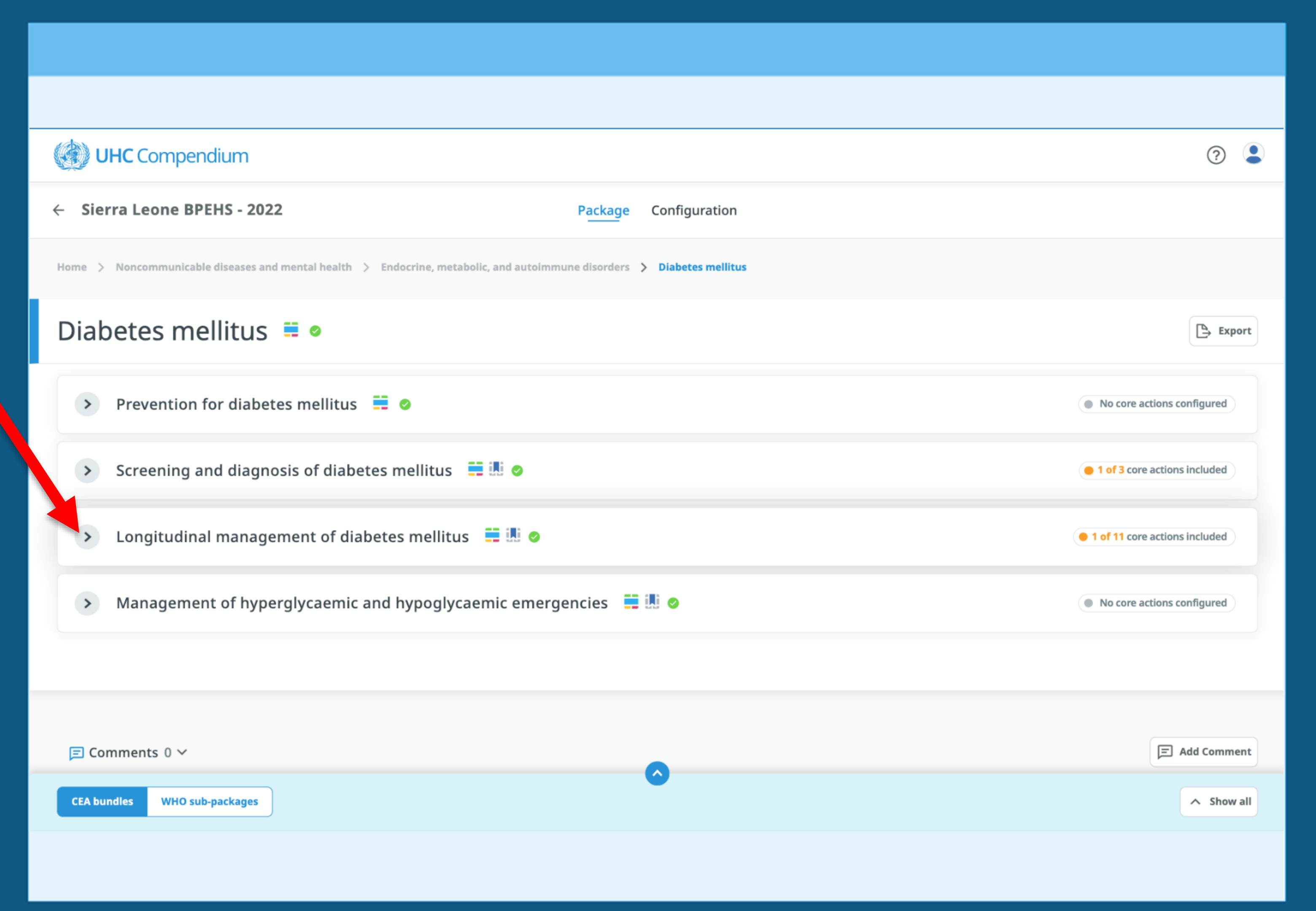
A systematic approach to prioritizing services and resources to meet the needs of people living with NCDs

1 **A structured architecture supports a systematic approach to selection**

2 Each intervention contains a comprehensive list of actions (services)

3 Each action linked to detailed resources

4 Services linked to cost & cost-effectiveness bundles



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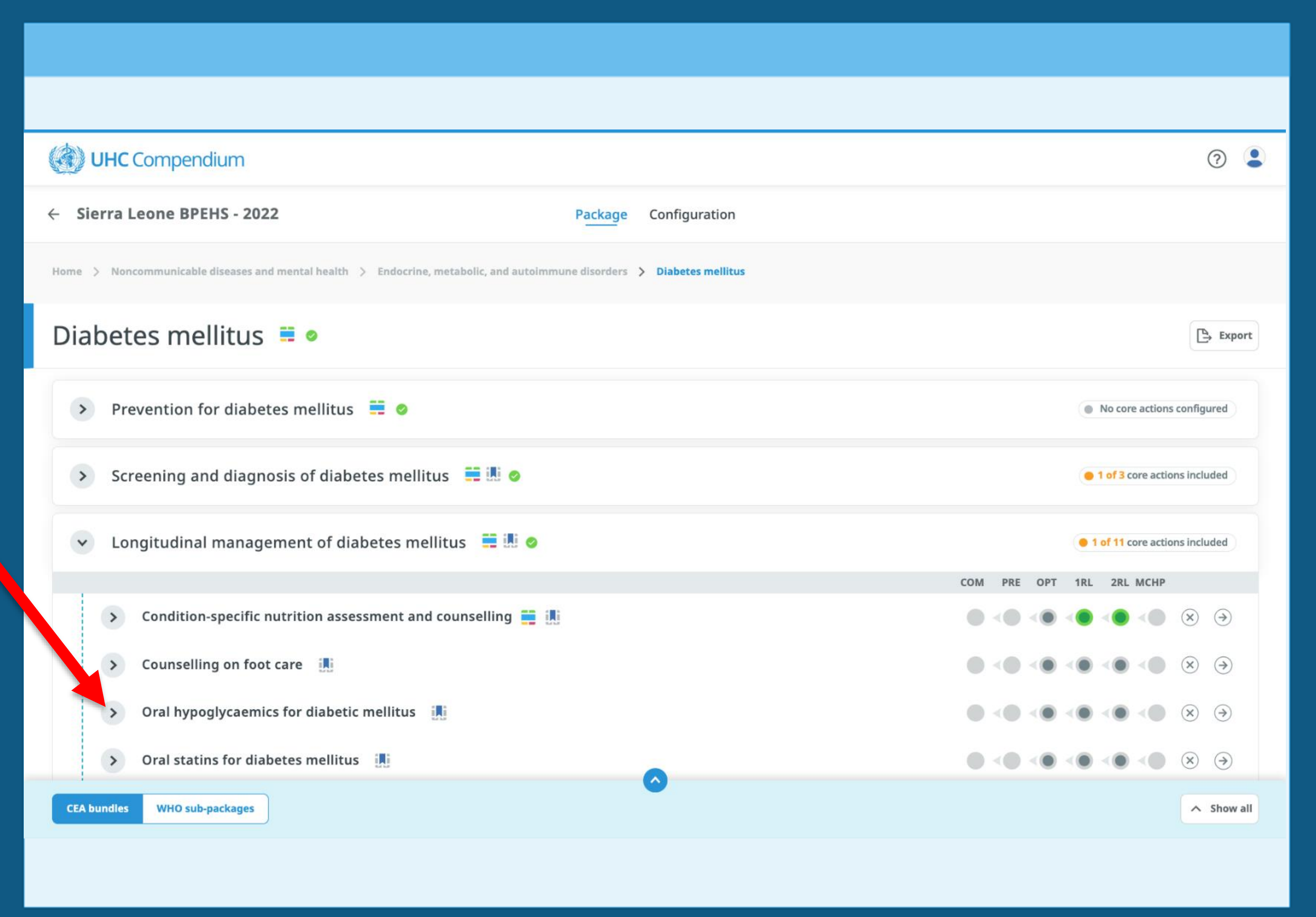

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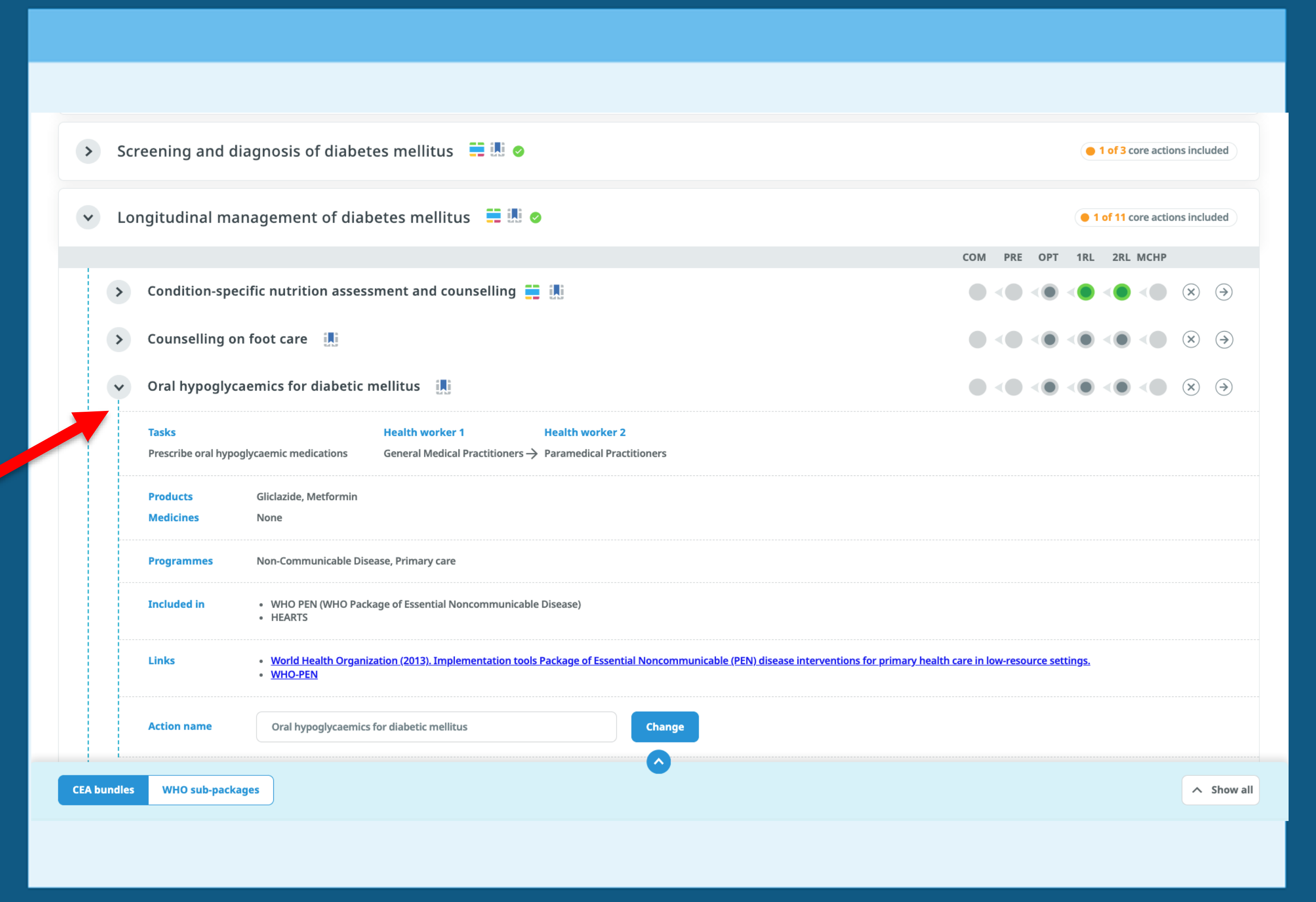

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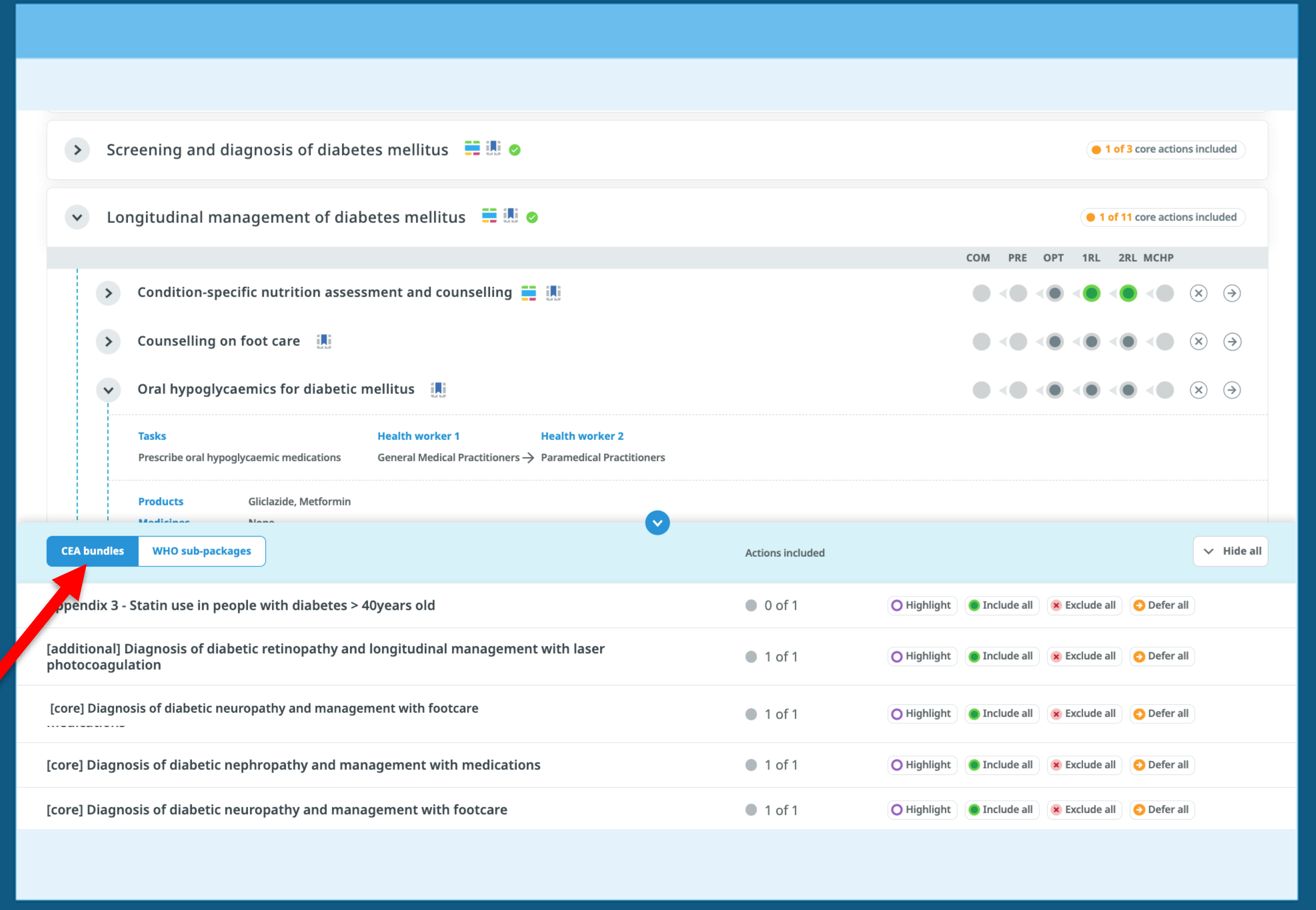
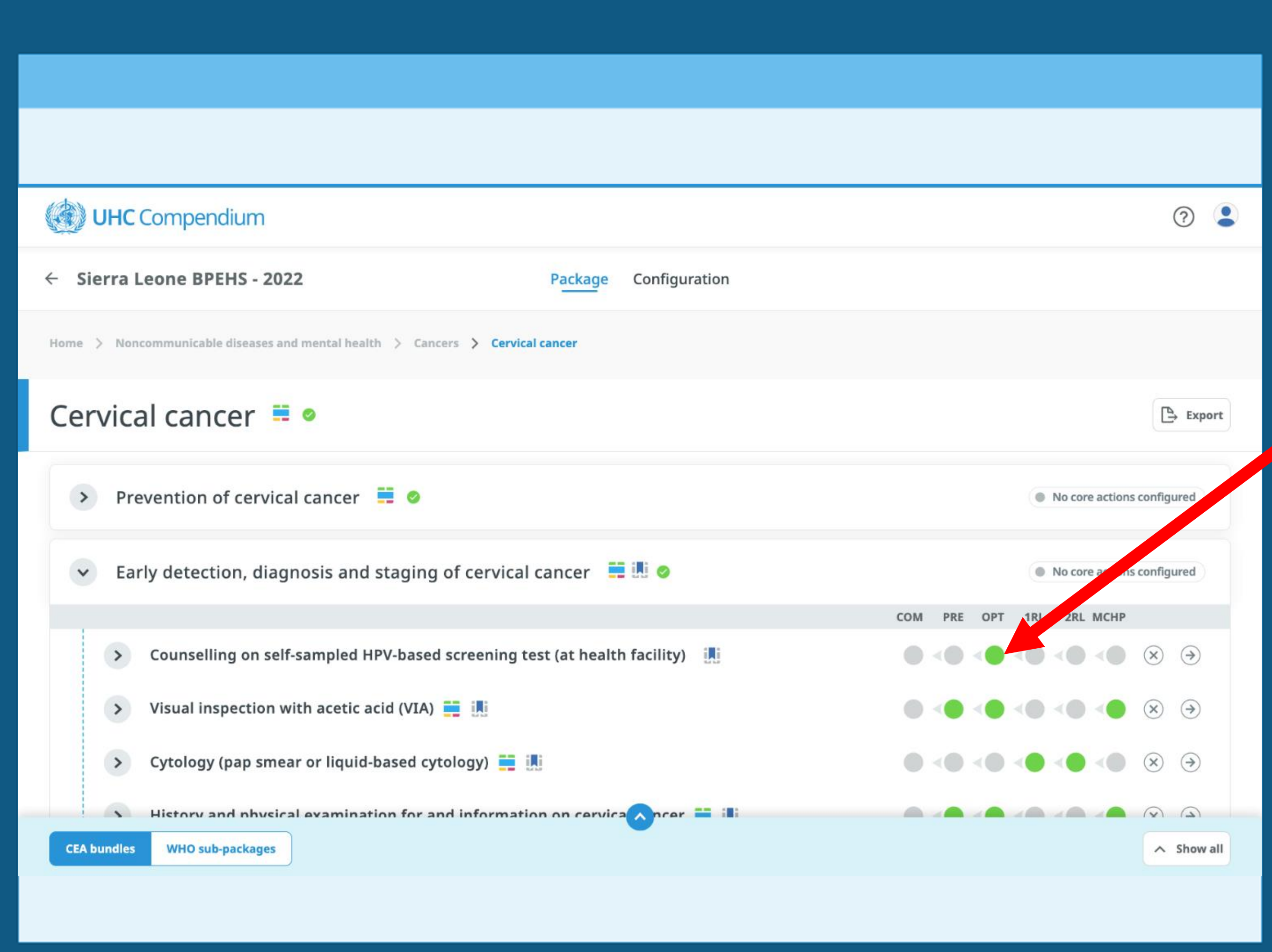


Optimizing models of care to deliver for people living with NCDs



1. Assign actions to context specific delivery platforms
2. Defer actions if needed for when resources are more available
3. Easily visualize actions found in reference packages to support decision making

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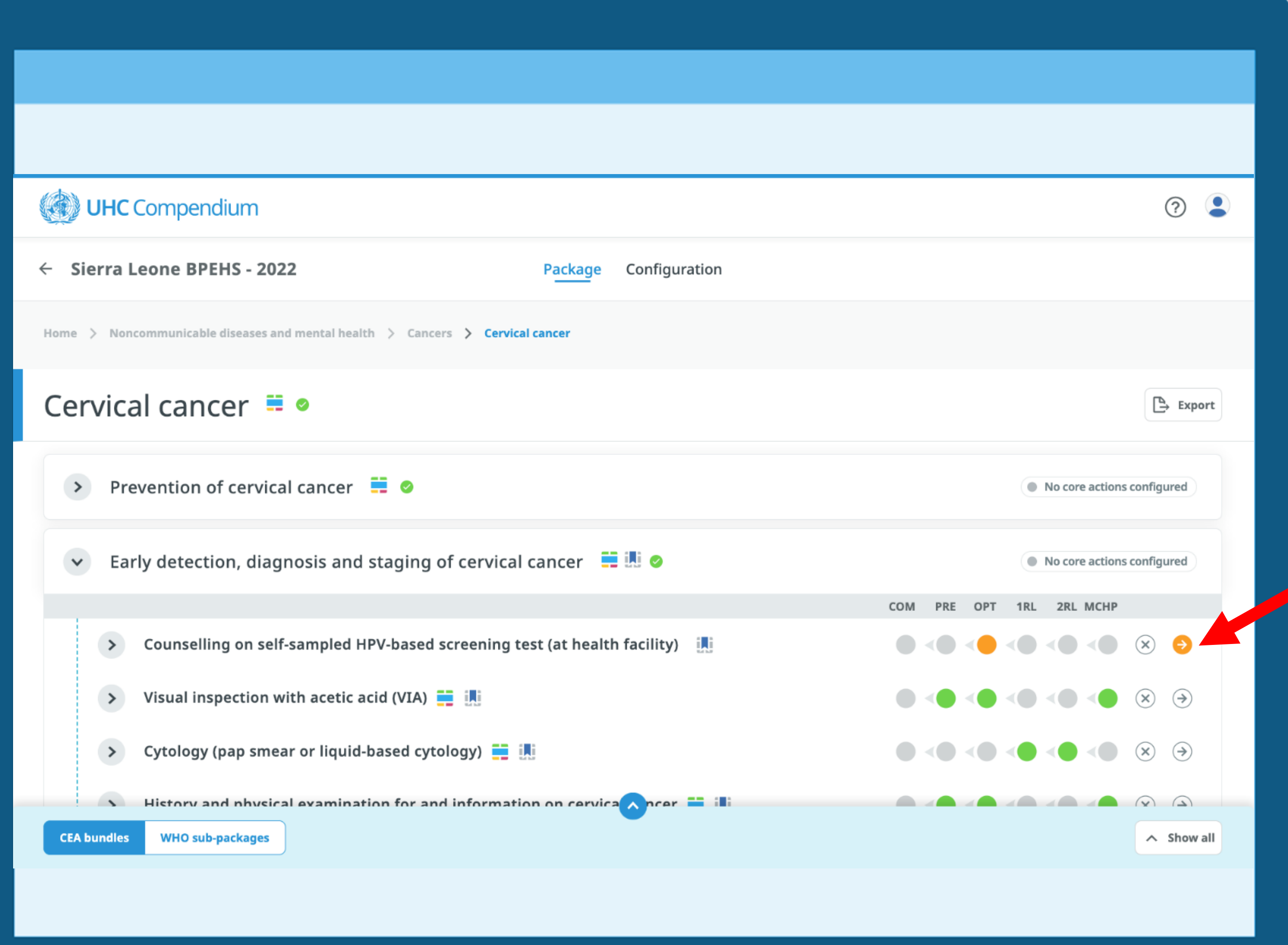

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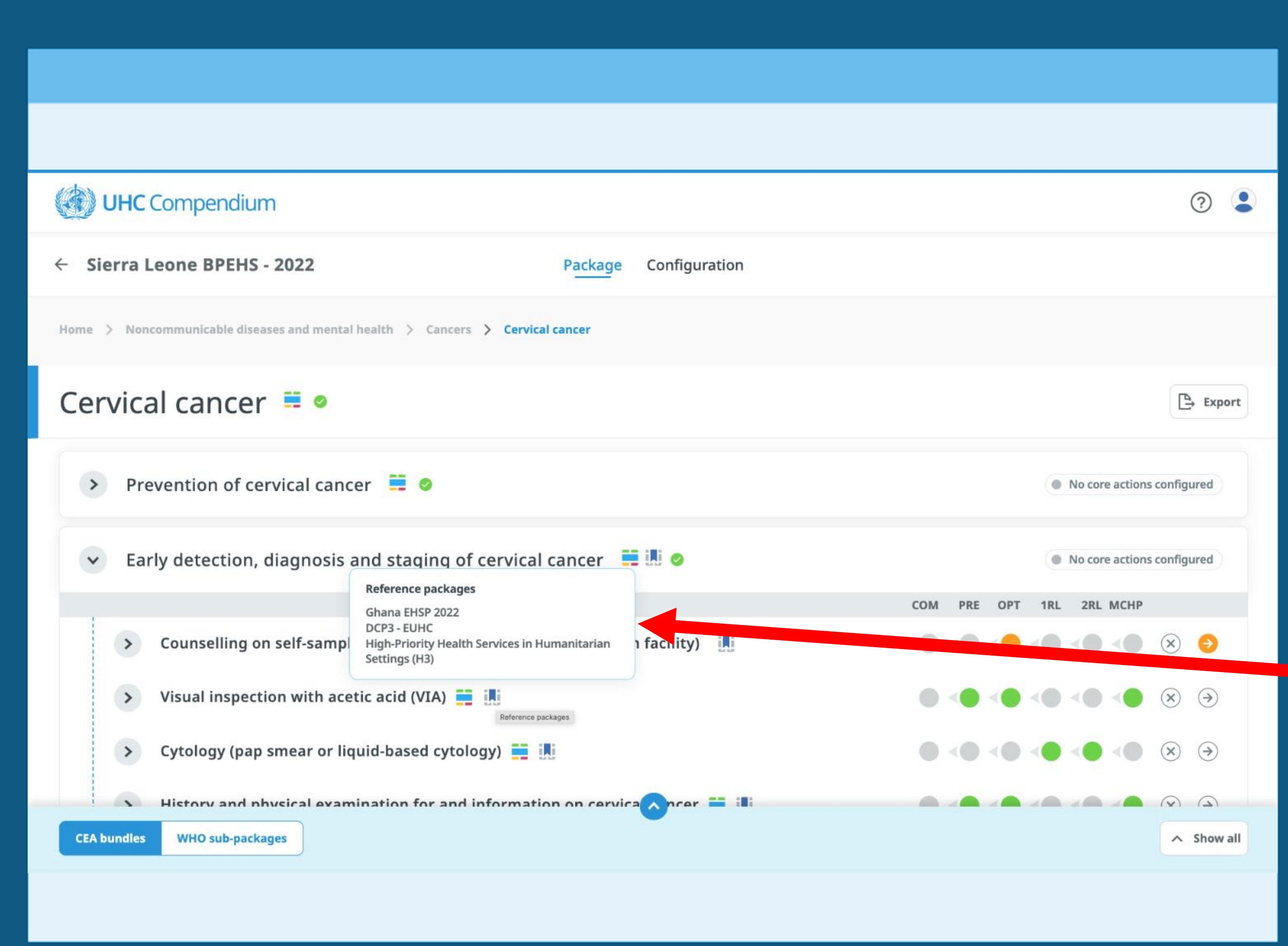

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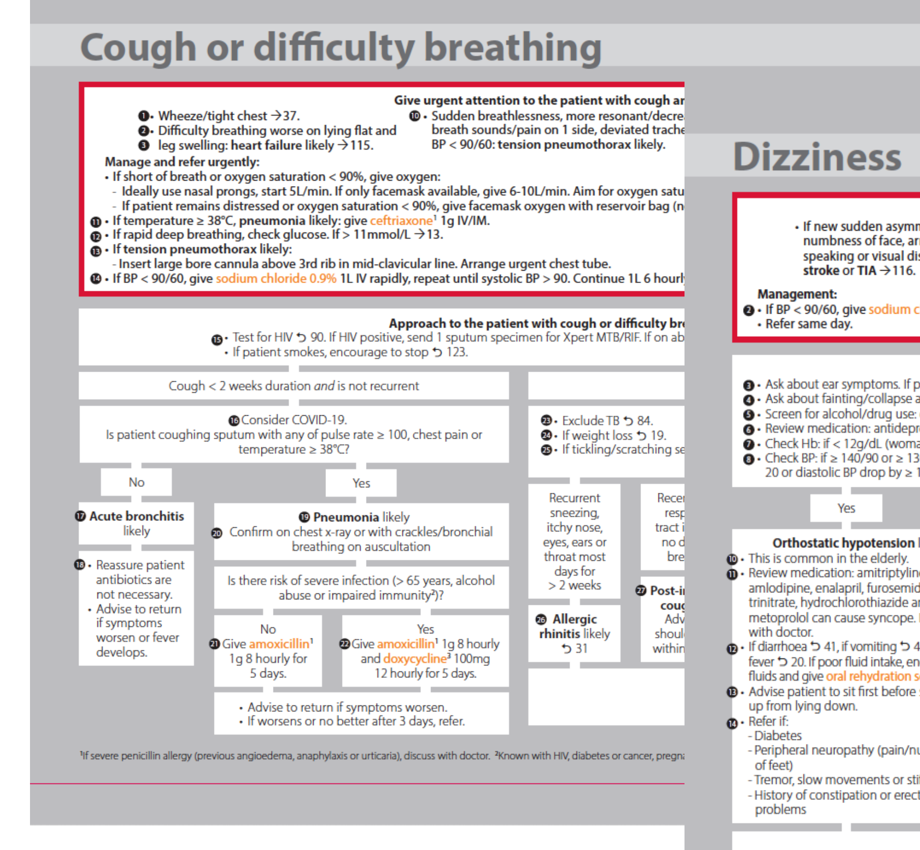
Symptom-based algorithms with referral criteria

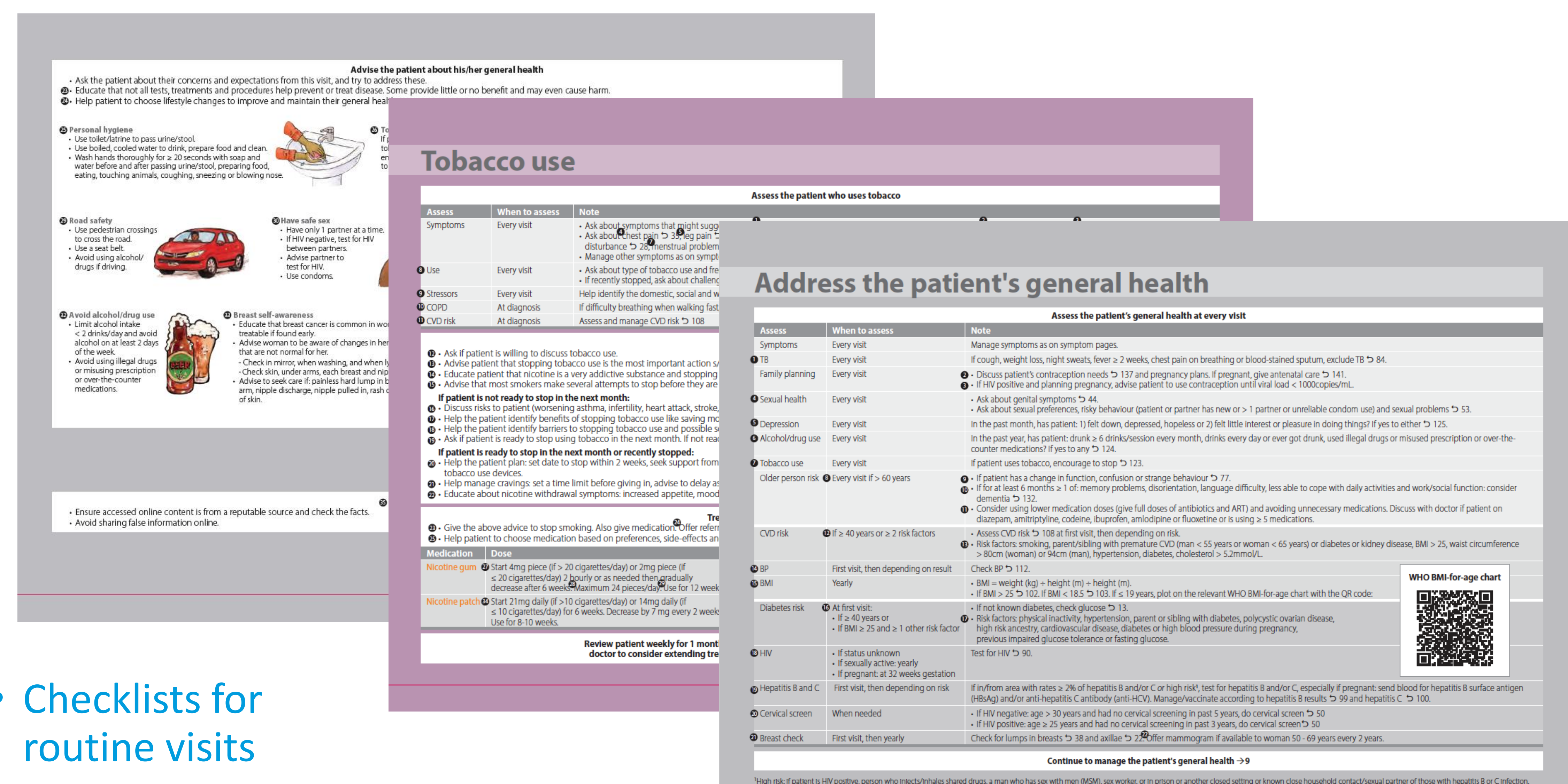


Dizziness

Chest pain

- Protocols for management of common symptoms & syndromes caused by NCDs

Guidance on health promotion & disease prevention



Advise the patient about his/her general health

- Ask the patient about their concerns and expectations from this visit, and try to address these.
- Educate that not all tests, treatments and procedures help prevent or treat disease. Some provide little or no benefit and may even cause harm.
- Help patient to choose lifestyle changes to improve and maintain their general heal

Personal hygiene
- Use toilet/latrine to pass urine/stool.
- Use boiled, cooled water to drink, prepare food and clean.
- Wash hands thoroughly for ≥ 20 seconds with soap and water before and after passing urine/stool, preparing food, eating, touching animals, coughing, sneezing or blowing nose.

Road safety
- Use pedestrian crossings to cross the road.
- Use a seat belt.
- Avoid using alcohol/drugs if driving.

Have safe sex
- Have only 1 partner at a time.
- If HIV negative, test for HIV between partners.
- Advise partner to test for HIV.
- Use condoms.

Avoid alcohol/drug use
- Limit alcohol intake < 2 drinks/day and avoid alcohol on at least 2 days of the week.
- Avoid using illegal drugs or misusing prescription or over-the-counter medications.

Breast self-awareness
- Educate that breast cancer is common in wo treatable if found early.
- Advise woman to be aware of changes in her that are not normal for her.
  - Check in mirror, when washing, and when l
  - Check skin, under arms, each breast and nip
- Advise to seek care if: painless hard lump in b arm, nipple discharge, nipple pulled in, rash o of skin.

- Ensure accessed online content is from a reputable source and check the facts.
- Avoid sharing false information online.

Tobacco use

Assess the patient who uses tobacco

Assess	When to assess	Note
Symptoms	Every visit	• Ask about symptoms that might sugg • Ask about chest pain ⮌ 33, leg pain • disturbance ⮌ 28, menstrual problem • Manage other symptoms as on sympt
Use	Every visit	• Ask about type of tobacco use and fre • If recently stopped, ask about challeng
Stressors	Every visit	Help identify the domestic, social and w
COPD	At diagnosis	If difficulty breathing when walking fast
CVD risk	At diagnosis	Assess and manage CVD risk ⮌ 108

- Ask if patient is willing to discuss tobacco use.
- Advise patient that stopping tobacco use is the most important action s
- Educate patient that nicotine is a very addictive substance and stopping
- Advise that most smokers make several attempts to stop before they are

If patient is not ready to stop in the next month:
- Discuss risks to patient (worsening asthma, infertility, heart attack, stroke,
- Help the patient identify benefits of stopping tobacco use like saving mo
- Help the patient identify barriers to stopping tobacco use and possible s
- Ask if patient is ready to stop using tobacco in the next month. If not read

If patient is ready to stop in the next month or recently stopped:
- Help the patient plan: set date to stop within 2 weeks, seek support from tobacco use devices.
- Help manage cravings: set a time limit before giving in, advise to delay as
- Educate about nicotine withdrawal symptoms: increased appetite, mood

Tre
- Give the above advice to stop smoking. Also give medication. Offer referr
- Help patient to choose medication based on preferences, side-effects an

Medication	Dose
Nicotine gum	Start 4mg piece (if > 20 cigarettes/day) or 2mg piece (if ≤ 20 cigarettes/day) 2 hourly or as needed then gradually decrease after 6 weeks. Maximum 24 pieces/day. Use for 12 week
Nicotine patch	Start 21mg daily (if >10 cigarettes/day) or 14mg daily (if ≤ 10 cigarettes/day) for 6 weeks. Decrease by 7 mg every 2 week Use for 8-10 weeks.

Review patient weekly for 1 mont doctor to consider extending tre

Address the patient's general health

Assess the patient's general health at every visit

Assess	When to assess	Note
Symptoms	Every visit	Manage symptoms as on symptom pages.
TB	Every visit	If cough, weight loss, night sweats, fever ≥ 2 weeks, chest pain on breathing or blood-stained sputum, exclude TB ⮌ 84.
Family planning	Every visit	• Discuss patient's contraception needs ⮌ 137 and pregnancy plans. If pregnant, give antenatal care ⮌ 141. • If HIV positive and planning pregnancy, advise patient to use contraception until viral load < 1000copies/mL.
Sexual health	Every visit	• Ask about genital symptoms ⮌ 44. • Ask about sexual preferences, risky behaviour (patient or partner has new or > 1 partner or unreliable condom use) and sexual problems ⮌ 53.
Depression	Every visit	In the past month, has patient: 1) felt down, depressed, hopeless or 2) felt little interest or pleasure in doing things? If yes to either ⮌ 125.
Alcohol/drug use	Every visit	In the past year, has patient: drunk ≥ 6 drinks/session every month, drinks every day or ever got drunk, used illegal drugs or misused prescription or over-the-counter medications? If yes to any ⮌ 124.
Tobacco use	Every visit	If patient uses tobacco, encourage to stop ⮌ 123.
Older person risk	Every visit if > 60 years	• If patient has a change in function, confusion or strange behaviour ⮌ 77. • If for at least 6 months ≥ 1 of: memory problems, disorientation, language difficulty, less able to cope with daily activities and work/social function: consider dementia ⮌ 132. • Consider using lower medication doses (give full doses of antibiotics and ART) and avoiding unnecessary medications. Discuss with doctor if patient on diazepam, amitriptyline, codeine, ibuprofen, amlodipine or fluoxetine or is using ≥ 5 medications.
CVD risk	If ≥ 40 years or ≥ 2 risk factors	• Assess CVD risk ⮌ 108 at first visit, then depending on risk. • Risk factors: smoking, parent/sibling with premature CVD (man < 55 years or woman < 65 years) or diabetes or kidney disease, BMI > 25, waist circumference > 80cm (woman) or 94cm (man), hypertension, diabetes, cholesterol > 5.2mmol/L.
BP	First visit, then depending on result	Check BP ⮌ 112.
BMI	Yearly	• BMI = weight (kg) ÷ height (m) ÷ height (m). • If BMI > 25 ⮌ 102. If BMI < 18.5 ⮌ 103. If ≤ 19 years, plot on the relevant WHO BMI-for-age chart with the QR code:
Diabetes risk	At first visit: • If ≥ 40 years or • If BMI ≥ 25 and ≥ 1 other risk factor	• If not known diabetes, check glucose ⮌ 13. • Risk factors: physical inactivity, hypertension, parent or sibling with diabetes, polycystic ovarian disease, high risk ancestry, cardiovascular disease, diabetes or high blood pressure during pregnancy, previous impaired glucose tolerance or fasting glucose.
HIV	• If status unknown • If sexually active: yearly • If pregnant: at 32 weeks gestation	Test for HIV ⮌ 90.
Hepatitis B and C	First visit, then depending on risk	If in/from area with rates ≥ 2% of hepatitis B and/or C or high risk[1], test for hepatitis B and/or C, especially if pregnant: send blood for hepatitis B surface antigen (HBsAg) and/or anti-hepatitis C antibody (anti-HCV). Manage/vaccinate according to hepatitis B results ⮌ 99 and hepatitis C ⮌ 100.
Cervical screen	When needed	• If HIV negative: age > 30 years and had no cervical screening in past 5 years, do cervical screen ⮌ 50 • If HIV positive: age ≥ 25 years and had no cervical screening in past 3 years, do cervical screen ⮌ 50
Breast check	First visit, then yearly	Check for lumps in breasts ⮌ 38 and axillae ⮌ 22. Offer mammogram if available to woman 50 - 69 years every 2 years.

WHO BMI-for-age chart

Continue to manage the patient's general health →9

[1]High risk: if patient is HIV positive, person who injects/inhales shared drugs, a man who has sex with men (MSM), sex worker, or in prison or another closed setting or known close household contact/sexual partner of those with hepatitis B or C infection.

8

- Checklists for routine visits

Algorithms for chronic conditions

Chronic arthritis

❶ • If patient has episodes of joint pain and swelling that completely resolve in between, consider **gout** → 135.
❷ • The patient with chronic arthritis has had continuous joint pain for at least 6 weeks. Distinguish me

❸ **Osteoarthritis** likely if:
- Affects joints only.
- Weight-bearing joints and possibly hands and feet.
- Joints may be swollen but not warm.
- Stiffness on waking lasts less than 30 minutes.
- Pain is worse with activity and gets better with rest.

If inflammatory arthritis likely or uncertain

Assess the patient w

Assess	When to assess	Note
Symptoms	Every visit	Manage symptoms as on sy
❺ Activities of daily living	Every visit	Ask if patient can walk as w
❻ Sleep	Every visit	If patient has difficulty sleep
❼ Depression	Every visit	In the past month, has pati
❽ Joints	Every visit	Look for warmth, tendernes
Body Mass Index (BMI)	At diagnosis	BMI = weight (kg) ÷ height
❿ CRP/ESR, Rheumatoid factor (RF), FBC	If inflammatory arthritis likely or unsure	If ESR/CRP raised or RF posit
⓫ HIV	At diagnosis	Test for HIV ⮌ 90.

Advise the patient w

⓬ • If BMI > 25, advise to reduce weight to decrease stress on weight-bearing joints like knees and feet.
⓭ • Encourage the patient to be as active as possible, but to rest with acute flare-ups.
⓮ • Refer patient and carer for education about chronic arthritis, to available local support group or help
⓯ • Ensure the patient using disease modifying medication knows to have regular blood monitoring dependin

Treat the patient w

⓰ • If inflammatory arthritis or difficulty with activities of daily living, refer to physiotherapist or occupat
⓱ • Give paracetamol 1g 6 hourly as needed for pain. If no response and inflammation is present in the p
⓲ • Rheumatoid arthritis must be treated early with disease modifying anti-rheumatic medication to co
⓳ • If specialist unavailable within 1 month and inflammatory arthritis likely, doctor to start prednisolon

Review monthly until symptoms controlled, then 3-6 m

㉑ [1]Avoid if peptic ulcer, asthma, hypertension, heart failure or kidney disease.

Alcohol/drug use

❶ **Hazardous alcohol use is a pattern of use that puts the patient at risk of dependence and physical, mental and social harm. Any drug use is hazardous.** If patient uses tobacco ⮌ 123.

Assess the patient with hazardous alcohol use or *any* drug use

Assess	Note
Symptoms	❷ • If recently reduced/stopped use and is restless, agitated, difficulty sleeping, confu ❸ • If patient has suicidal thoughts or plans ⮌ 75. • If abnormal thoughts or behaviour ⮌ 77. • If aggressive/violent or disruptive behaviour ⮌ 76.
Hazardous/ harmful use	❹ • Use is hazardous if: > 4 drinks[1]/day if man, or > 2 drinks[1]/day if woman; or ≥ 6 dr ❺ • Use is **harmful** if it has caused physical (like injuries, liver disease, stomach ulcer),
❻ Dependence	Patient is **dependent** if ≥ 3 of: strong need to use substance; difficulty controlling
❼ Stressors	Help identify the domestic, social and work factors contributing to alcohol/drug us
❽ Depression	In the past month, has patient: 1) felt down, depressed, hopeless or 2) felt little inte
❾ Infections	If injecting drugs or having sex under influence of drugs/alcohol: screen for STIs ⮌ 4

Advise the patient wi

❿ • If pregnant/planning pregnancy or breastfeeding, advise to avoid alcohol/drugs complet
⓫ • Suggest patient seeks support from close relatives/friends who do not use alcohol/drugs
⓬ • Discuss risks/harms that using alcohol/drugs may cause. Allow patient to decide for him

⓭ **Hazardous alcohol use without dependence**
- If **harmful drinking**, pregnant, previous dependence or contraindication (like hepatitis C, chronic hepatitis B or liver damage, mental illness), advise to stop alcohol completely. Avoid drinking places and keeping alcohol at home.
- If none of above and patient chooses to continue alcohol, advise low-risk use: ≤ 2 drinks[1]/day and avoid alcohol at least 2 days/week.

If alcohol/drug dependence, d

⓰ • Arrange inpatient detoxification if previous withdrawal delirium/fits or failed detoxification, pre
• Doctor can do outpatient detoxification programme if none of the above. Ensure patient ha

Substance	Detoxification programme - write d
⓱ Alcohol (start only if no alcohol in past 8 hours)	⓲ • Give thiamine 100mg orally daily for d ⓳ • Give diazepam 10mg 6 hourly orally fo
⓴ Cannabis/stimulant drug	If needed, treat anxiety, restlessness, irrit
Benzodiazepines	㉑ • Avoid suddenly stopping benzodiazep ㉒ • Replace benzodiazepine patient is taki each week until 40mg daily, then decre

㉓ **If harmful use, review in 1 month then as needed. If on detoxificati**

[1]One drink is 1 tot of spirits, or 1 small glass (125mL) of wine or 1 can/bottle (330mL) of beer.

Diabetes: routine care

❶ **Give urgent attention to the patient with diabetes and any of:**
- Chest pain ⮌ 35
- Fitting ⮌ 15
- Decreased consciousness, drowsiness
- Confusion or unusual behaviour
- Weakness or dizziness
- Shaking
- Sweating
- Palpitations
- Rapid deep breathing
- Nausea or vomiting
- Abdominal pain
- Thirst or hunger
- Temperature ≥ 38°C
- Dehydration: dry mouth, poor skin turgor, sunken eyes, BP < 90/60, pulse ≥ 100

Check random fingerprick glucose:

❷ Glucose < 4mmol/L
❸ • If alert, give oral glucose 20g. If unable to take orally, give instead 25mL glucose 50% IV over 1-3 minutes. Repeat if glucose < 4mmol/L after 15 minutes.
• Give the patient food as soon as s/he can eat safely.
• Identify cause and educate about meals and doses ⮌ 111.
• If incomplete recovery, refer same day. Continue glucose 5% 1L 6 hourly IV.
• Discuss referral if on gliclazide or insulin.

❹ Glucose > 11mmol/L with symptoms

❺ Glucose > 11mmol/L without symptoms
Check urine for ketones.
≥ 2+ ketones | 1+ or no ketones
- Give sodium chloride 0.9% 1L IV over 2 hours then 1L 4 hourly.
- Refer urgently.

Give routine diabetes care below.

Assess the patient with diabetes

Assess	When to assess	Note
Symptoms	Every visit	Manage symptoms as on symptom pages. ❻ Ask about chest pain ⮌ 35, leg pain ⮌ 59 and sexual problems ⮌ 53.
❼ Depression	At diagnosis and if control poor	In the past month, has patient: 1) felt down, depressed, hopeless or 2) felt little interest or pleasure in doing things? If yes to either ⮌ 125.
❽ Alcohol/drug use	At diagnosis and if control poor	In the past year, has patient: 1) drunk ≥ 6 drinks/session, 2) used illegal drugs or 3) misused prescription or over-the-counter medication? If yes to any ⮌ 124.
❾ Family planning	Every visit	Assess patient's contraception needs ⮌ 137. If pregnant or planning pregnancy, refer for specialist care.
BMI (weight)	Every visit	BMI = weight (kg) ÷ height (m) ÷ height (m). Aim for BMI < 25. If ≥ 25, manage the overweight patient ⮌ 102.
❿ CVD risk	At diagnosis, then yearly	Assess CVD risk ⮌ 108. Start simvastatin if CVD risk > 20% ⮌ 111.
⓫ BP	Every visit	If known hypertension ⮌ 113. If not, check BP: if ≥ 130/80 ⮌ 112.
⓬ Eyes	At diagnosis, 2-yearly and if problems	Arrange eye and visual assessment.
⓭ Feet	Visual: every visit, comprehensive: at diagnosis, yearly and if problems	⓮ • Visual assessment: look for ulcers, calluses, redness, warmth and deformity. Check shoes for appropriate shape, size and sole wear. ⓯ • Comprehensive assessment: visual assessment as above, foot pulses, reflexes, sensation in toes and feet. If ulcers ⮌ 69 and discuss/refer.
⓰ HbA_{1c} (glucose control over past 3 months)	⓱ 6 monthly if < 7%, 3 monthly if ≥ 7% or after treatment change	• If HbA_{1c} < 7%: continue same treatment for diabetes. • If HbA_{1c} ≥ 7%: if adherent, step up treatment. If not adherent, educate on importance of adherence and repeat after 3 months.
⓲ Fingerprick glucose	If urgent attention needed or HbA_{1c} unavailable	• If > 11mmol/L or < 4mmol/L: manage urgently as above. • If 7-11mmol/L (fasting): if adherent, step up treatment. If not adherent, educate on importance of adherence and repeat after 3 months. • If 4 - 6.9 mmol/L (fasting): continue same treatment for diabetes.
Urine dipstick	At diagnosis, then yearly	If protein, start angiotensin-converting enzyme (ACE) inhibitor if not already on it ⮌ 111. If no protein and not on ACE inhibitor, send urine for ACR.
⓳ Urine albumin creatinine ratio (ACR)	At diagnosis, then yearly	If raised, exclude urine infection, repeat after 3 months to confirm diabetic kidney disease and start ACE inhibitor ⮌ 111. If raised with next check, discuss/refer.
⓴ Creatinine and eGFR	At diagnosis, then yearly	If eGFR < 60mL/min/1.73m², repeat after 3 months. If still <60mL/min/1.73m², refer to doctor.
㉑ Total cholesterol	㉒ At diagnosis, then yearly	㉓ If cholesterol > 8mmol/L, start simvastatin ⮌ 111 and refer.

110

- Standardized decision-making for longitudinal care
- History, examination, tests and health education incorporated

DG Priorities: WHO Agenda for Recovery, Renewal, and Readiness

Priority 2: To support a radical reorientation of health systems towards primary health care, as the foundation of universal health coverage - Measurable impact

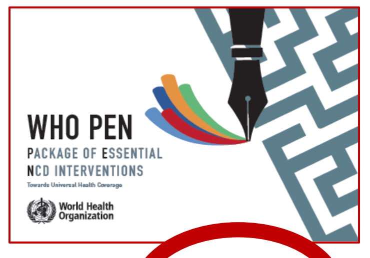
- ✓ **Accelerated progress towards UHC**
- ✓ improved access to quality essential health services and health commodities
- ✓ SDG 3.8.1; reduced number of people suffering financial hardship
- ✓ SDG 3.8.2; halt the rise in financial hardship in 25 countries by 2025).

- ✓ **Accelerated health outcome improvements across programmes, tailored to country context**
  - Countries that had high **maternal mortality** ratios (MMR >420/100000) in 2010 on track by 2025 to reduce MMR by at least two-thirds by 2030; by 2025, 90% pregnant women to attend four or more antenatal care visits; 90% births to be attended by skilled health personnel; 65% of women to be able to make informed and empowered sexual health decisions.
  - Countries on track to reduce **child deaths** to a neonatal mortality rate of < 12 deaths per 1,000 live births, and an under-five mortality rate of < 25 deaths per 1,000 live births, by 2030
  - Reduce the number of '**zero dose immunized**' children by 25% by 2025, and by 50% by 2030 (from 14 million in 2019).
  - **Infectious disease** targets by 2025: 90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services; 0% of TB-affected families face catastrophic costs due to TB and TB incidence halved vs 2015; at least 75% reduction in global malaria case incidence compared with 2015.
  - **Non-communicable diseases** on track for one-third relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases by 2030 (vs 2015); at least 50% of eligible people receive drug therapy and counselling to prevent heart attacks and strokes; a 25% relative reduction in the prevalence of raised blood pressure (vs 2010) or contain the prevalence of raised blood pressure, according to national circumstances; halt the rise in diabetes and obesity.

- ✓ **Country-specific PHC improvements to deliver these outcomes**,
- ✓ e.g. per capita PHC-specific health expenditure; government PHC spending as percentage of total government health expenditure; health facility and health worker density/distribution; availability of essential medicines; improved patient-reported experiences and/or perceptions of health systems and services; reduced 30-day case fatality rate (for acute myocardial infarction or stroke) and/or reduced hospital readmission rate for tracer conditions; increased consistency of country health financing measures with good practice.

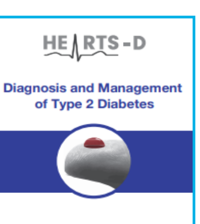
Strengthening NCD services through PHC : Tools and Guidance

Programmatic Approach

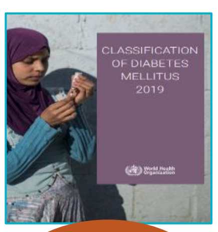


2020

2020



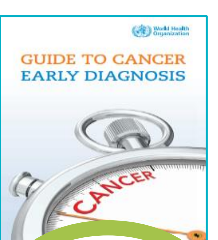
2019



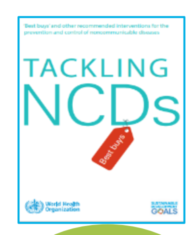
2019

2018

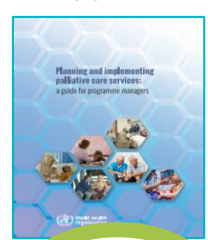
2018



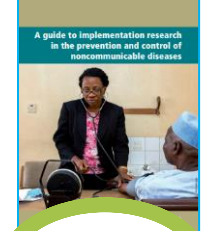
2017



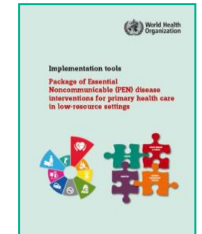
2017



2016

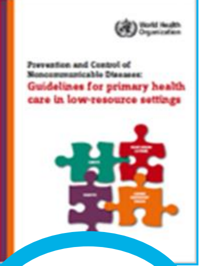


2016

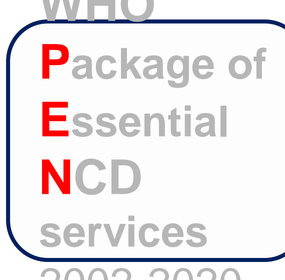


2016

2013



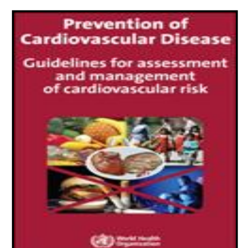
2012



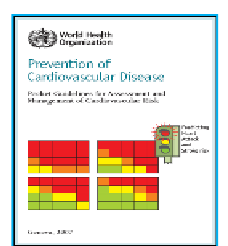
WHO
Package of
Essential
NCD
services
2002-2020

2010

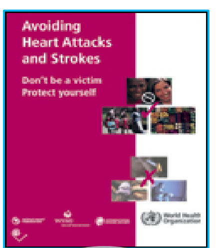
2007



2007



2007



2005

2002

Strengthening NCD services through PHC : Technical guidance at the core

Tools and Guidance

- A menu of policy options of affordable interventions (Appendix 3)
- Technical Packages: WHO PEN, HEARTS, SHAKE, MPOWER, SAFER, ACTIVE
- Facility Based & Program Monitoring Data
- Palliative Care in Primary Care
- Be Healthy Be Mobile Handbooks for NCD
- Guide for Integration of NCD into the health system
- Sensory functions Disability and Rehabilitation Tools

'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases

TACKLING NCDs

Best buys

Strengthening NCD services through PHC : Tools and Guidance

The organization of prevention and management of NCD (health) services at primary and all levels of care through strengthening of health systems

…..so that people receive the care they need, when they need it, in ways that are user friendly, achieve the desired results and ensuring that use of those services does not expose to financial hardship.

Sensory functions
Diabetes
Cancer
CRD
CVD
Oral health
Mental health

NCD
SRH
CD

Integrated People-Centred Health Services

NCD services integrated

Link existing NCD, CD & SRH services

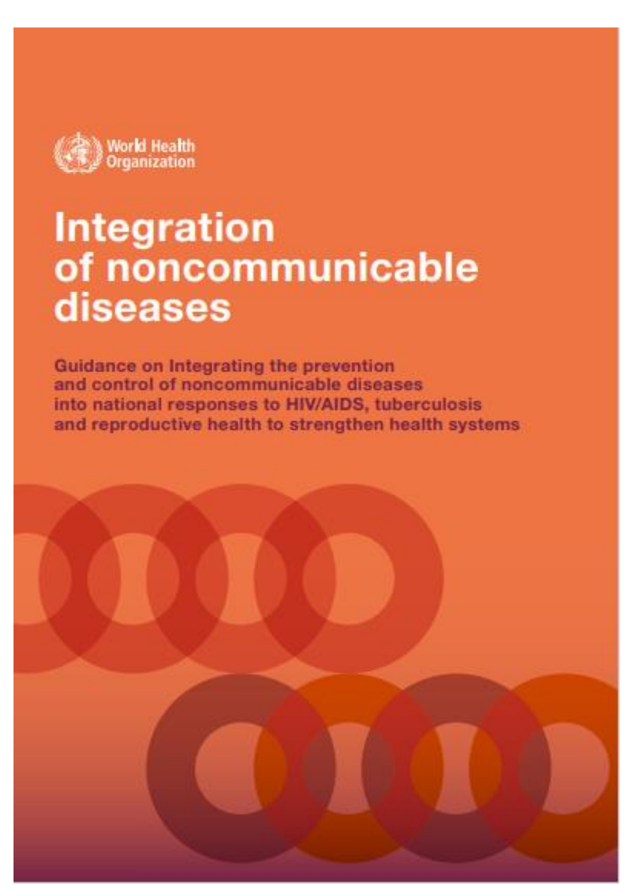
NCD, CD & SRH integrated across health system

Maximizing impact and outcomes of NCD, CD & SRH response

Prevention
Diagnosis
Treatment
Rehabilitation
Community Care

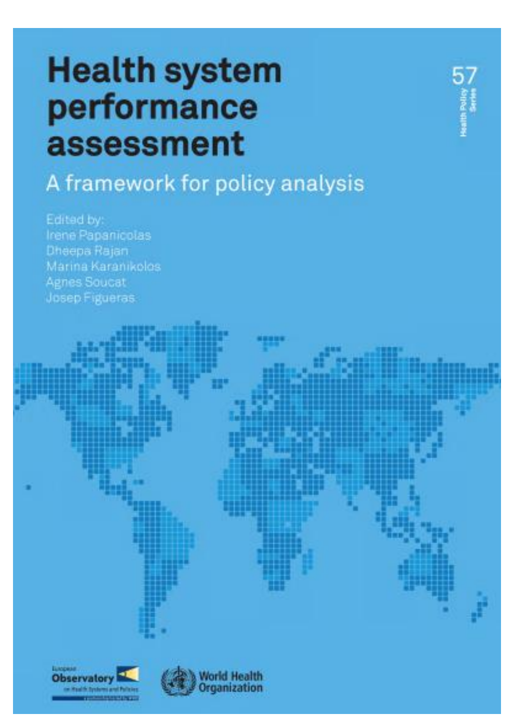
Strengthening NCD services through PHC : Tools and Guidance

Guidance on Integration of NCD into other programs and the Health System



Domains of Actions

Health System Readiness (Maturity)



https://www.who.int/publications/i/item/9789240042476

HS(P)A Framework

CONTEXT (SOCIAL, ECONOMIC POLIITICAL & CULTURAL)

Health system functions and sub-functions

Intermediate objectives

Final goals

Universal Health Coverage

Resource Generation

Governance

Service Delivery

Financing

Efficiency of service delivery

Equity of service delivery

Effectiveness

Safety

User experience

Access

Quality

health system Efficiency

health system Equity

System responsiveness

Health improvement

Financial protection

HEALTH SYSTEM

HEALTH DETERMINANTS (ECONOMIC, SOCIAL, ENVIRONMENTAL, BEHAVIORAL)

Structural links

Performance links

Strengthening NCD services through PHC : Tools and Guidance

Health System Strengthening for NCD

Strengthening health system response to NCDs

Governance

- NCD in NHPSP
- Integration Policy
- NCD Investment Case

Health financing

- NCD in UHC Benefit package
- Financing for NCD

Medicines & tech

- Intensify Advocacy
- Pricing and Affordability
- Procurement and Supply Chain management

Health workforce

- NCD Competency Framework
- NCD Workforce planning
- Capacity building

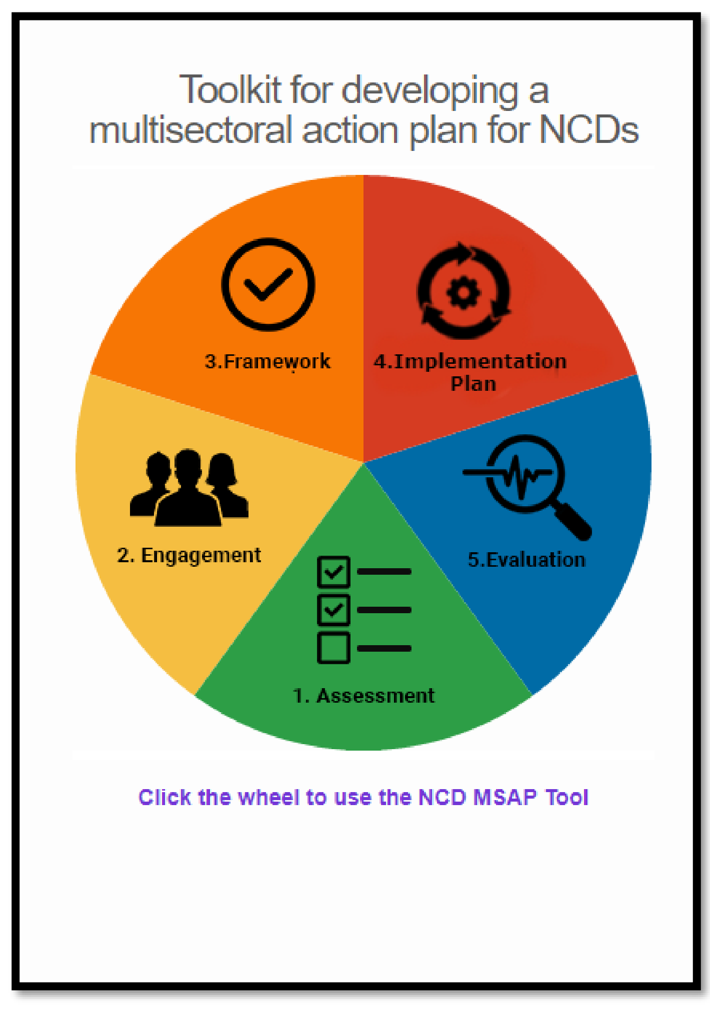
Service delivery

- Integrated Chronic Care
- Community Mobilization

Health information

Strengthening NCD services through PHC : Tools and Guidance

Governance



Overarching guidance

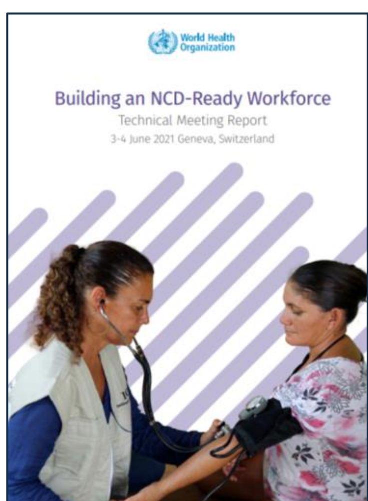
- National Health Sector Plan
- UHC Policy and Plans

NCD specific guidance and tools

- Toolkit for developing multisectoral action plan for NCDs

Strengthening NCD services through PHC : Tools and Guidance

Workforce



Overarching guidance

- WHO Global Strategy on Human Resources for Health: Workforce 2030

NCD specific guidance

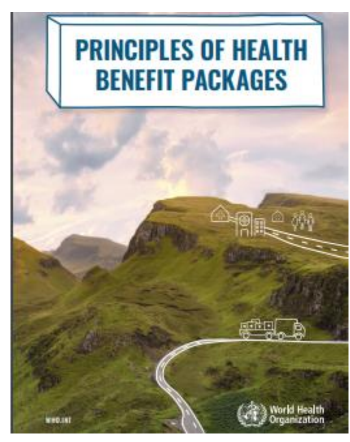
- Pathway to building an NCD-ready workforce

Tools/Technical products

- Guidance on evidence-based task sharing mechanisms between health workers for essential NCD services (June 2023)
- NCD Prevention and Control competency-based Learning framework (Dec 2023)

Strengthening NCD services through PHC : Tools and Guidance

NCD Prioritisation and Financing



Overarching guidance

- Principles of Health Benefit Packages

NCD specific guidance

- Approach to the prioritisation of NCD interventions

Tools/Technical products

- UHC Compendium
- NCD Finance Needs Tool

Using the UHC Compendium at country level to develop a "package"

List of interventions for consideration

UHC Compendium

Should not be considered in this context (e.g. BOD, CEA, Affordability, required technology etc)

Requires additional information for decision making

Corresponds to disease burden and is likely to be cost-effective and affordable, or is a core requirement of PHC

Global Health Estimates

Mapping to Burden of Disease

WHO CHOICE

Cost-Effectiveness Analysis

Dialogue until comprehensive **single list of services** is agreed including information on **who pays for services** and **where they are delivered**

Budget Impact and Feasibility

One Health Tool

Additional Value Based Criteria

Other Tools

Clinical Continuity

Slider

Strengthening NCD services through PHC : Tools and Guidance

NCD Prioritization and Financing

Country Support

Strategic Roundtable
14-15 July 2020

Regional listing

UHC Compendium

DCP III

INTERVENTION LISTINGS

NCD Input

Cost Assessment

Global Strategic Guidance

NCD Approach to Benefit Package

NCD in UHC Benefit Package ROADMAP

World Health Organization

THE WORLD BANK

RTI INTERNATIONAL

Assessment

Regional Dialogue

Regional Adaptation

Tailored guidance

Data: Country Assessment

Dialogue for NCD in UHC BP

Decision making support

Knowledge sharing

Country Implementation & Enforcement

Monitoring & Evaluation

Strengthening NCD services through PHC : Tools and Guidance

NCD Medicines and Health Products

Ensuring quality, safety and efficacy of health products

- Regulatory system strengthening
- Assessment of the quality, safety and efficacy/performance of health products through prequalification
- Market surveillance of quality, safety and performance

Improving equitable access

- Research and development that meets public health needs and improves access to health products
- Application and management of intellectual property to contribute to innovation and promote public health
- Evidence-based selection and fair and affordable pricing
- Procurement and supply chain management
- Appropriate prescribing, dispensing and rational use

Overarching guidance

- Access to Medicines and Health Products Roadmap

NCD specific guidance

- Guidance for improving access to NCD medicines and health products

Tools/Technical products

- Register for publishing contributions from the pharmaceutical and health technology industry to national responses for SDG 3.4 on NCDs

Pathway for Access to NCD Care & Treatment (NCD-PACT)

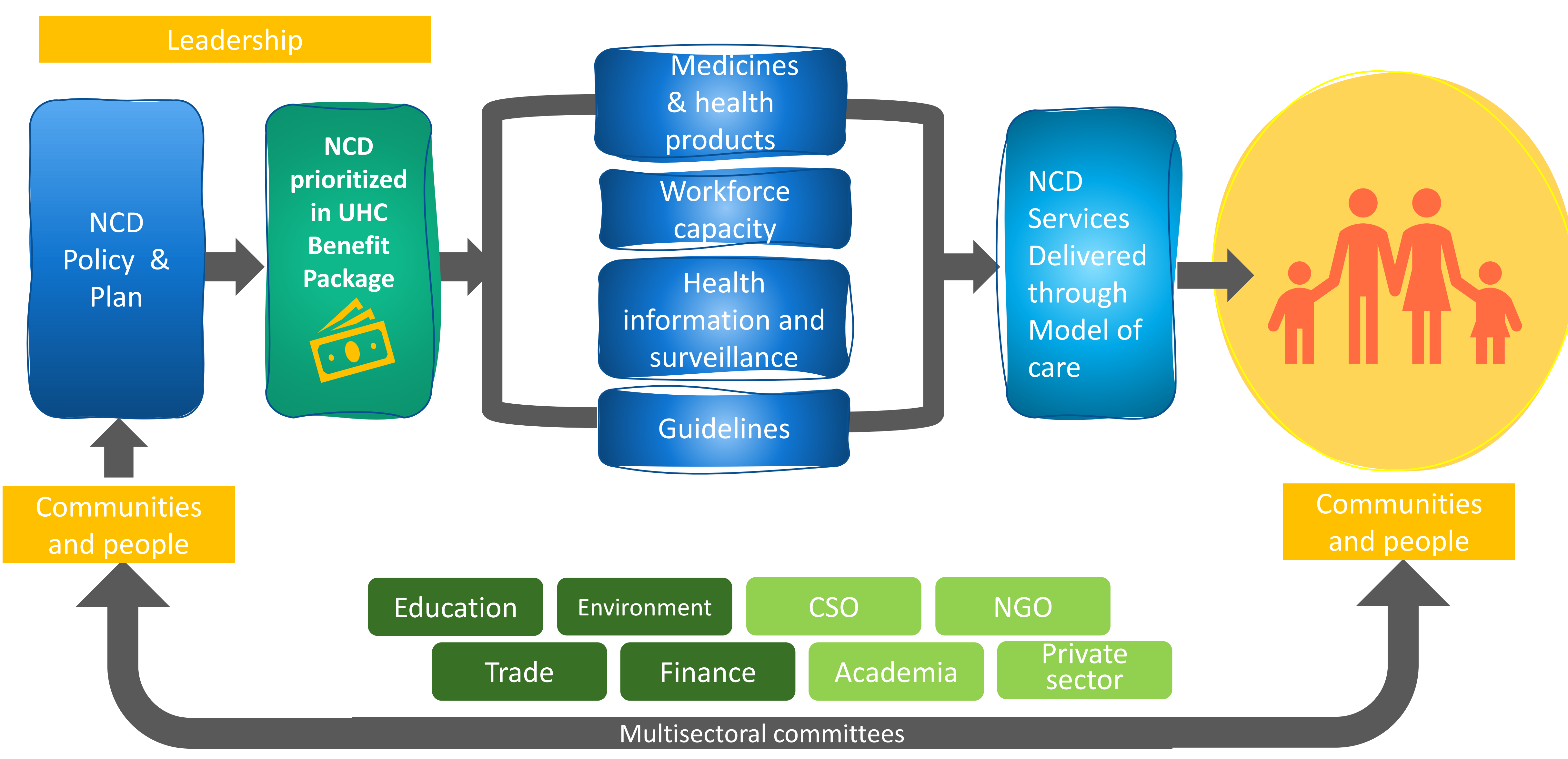
Strategic Areas

Partnerships → Integration → Patient Access

There are three strategic areas of work to support the NCD department toward addressing the barriers to access and contributing to the measurement of the SDG 3.4, 3.8, and 3b.

1. **Advocacy and Partnerships**
   a) Private Sector engagement with the pharmaceutical and health technology industry
   b) Private Sector Reporting mechanism to register commitments and contributions
   c) Communications and Advocacy: Hard Talks and Spotlight Webinars
   d) Strengthened Partnerships and Coalitions: UN, Implementing Partners, Development Agencies
2. **Strategic integration of NCD medicines and health products with other health supply systems to build on existing investments, reduce inefficiencies, and scale access to NCD care and treatment**
   a) Normative Guidance and Products: MedMon Surveys, NCD forecasting and quantification tool, COVID19 report, Pooled Procurement Strategy, Cold Chain Integration, Products part of the MHP (PQ, Pricing/Transparency, Technical specifications)
   b) Innovation: Ensure access to public health-driven innovation – example heat stability for insulin
3. **Patient Access: Strengthening the value chain for NCD Medicines and Health Technologies**
   a) Country Support and joint missions with colleagues in the access to MHP division

Stepwise approach



Measure of success of strengthening the health system to deliver NCDs

Governance	Finance	Access to medicines and health products	Health workforce	Service delivery	Community
• Existence of NCDs in the national health plan outputs or outcomes • Alignment of the national multisectoral plan for NCDs with the national health sector plan • Existence of a national multisectoral commission, agency or mechanism for NCDs	• Availability of NCD services in National UHC benefit package/National essential services package • Out-of-pocket (OOP)- specific on NCDs • Per capita health expenditure (and NCD-specific)	Availability of essential NCD medicines Availability of essential NCD technologies	• Percentage of facilities offering NCDs services with staff trained in NCDs diagnosis and management	• Percentage of facilities offering NCD services according to national defined service package • Percentage of individuals with raised blood pressure under control • Percentage of people with good control of glycaemia • Asthma control • Population screening coverage for cervical cancer • Coverage of drug therapy and counselling to prevent heart attack	• Community engagement in service planning and organization

Strengthening NCD services in PHC : Practice & Case Studies

Norway NCD Flagship Initiatives: Nepal

Protocol

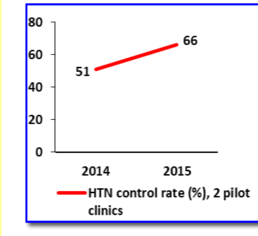
Health care facilities

- Health facilities function as a perfect team
- Most medicines and tests needed for common NCDs are available at the PHC level
- Institute refill, recall and reminder systems
- Referral and counter referrals

Patients

Receive coordinated referrals, follow-up care and essential diagnostics and treatment

Patient information



Medicines

Task sharing

Team-based care

A vision for Nepal Integrated NCD Care Model

Norway NCD Flagship Initiatives: Nepal

Objective:

- To identify and screen adult population for hypertension, diabetes and cervical cancer, COPD, mental illness in selected districts
- Initiate treatment
- Provide referral and follow-up care.

District/Province	Target population
Kailali	
Parsa / Province 2	683,556
Palpa / Lumbini	247,000
Manang / Gandaki	
Jajarkot / Karnali	200,016
Ilam / Province 1	313208
Kavrepalanchowk / Bagmati	370,000
Kanchapur / Sudur-Pashchim	535,075

- Multisectoral Steering Group
- Target Set for final NCD Plan
- Review and contribution of NCD to Health Finance Strategy
- Community Mobilization Plan initiated
- District Implementation ongoing in 2 districts

Strengthening NCD services in PHC : Practice & Case Studies

PEN Plus: AFRO

World Health Organization

Challenges

- Low level of awareness
- Increasing exposure to modifiable risk factors
- Poor access to prevention services
- Poor access to medicines

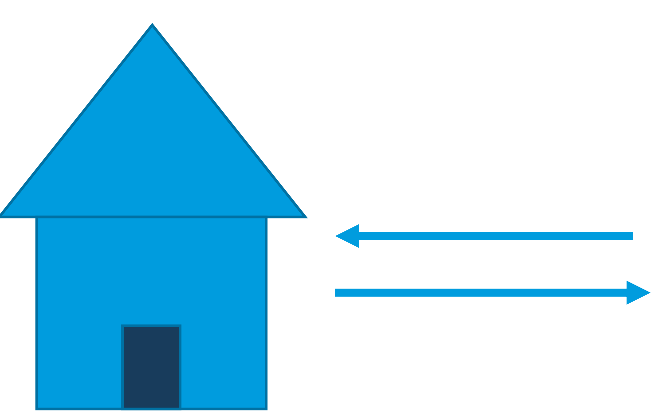
Challenges

- Limited capacity for longitudinal care diagnosis and management
- Non availability of protocols/guidelines
- Limited availability of basic equipment's and consumables
- M&E challenges
- Challenges with referral

Challenges

- Non availability of basic equipment and technologies
- Limited heath worker capacity
- Limited referral system
- Weak M&E
- Weak linkage with PHCs and higher level

community



PHC

1st level referral facility

Expected role

- Aware of risk factors
- Access to prevention ,early diagnosis and treatment

Expected role

- Availability of guidelines and drug and dose specific management protocols
- Clear and efficient referral mechanisms
- M&E that adequately tracks patient outcomes
- Appropriately skilled and resourced HR

Expected role

- Capacity to diagnose and manage chronic and sever NCDs
- Capacity to provide mentorship and supervision to PHCs
- Capacity to refer to higher levels
- Manage other chronic and sever NCDs
- Available essential medicines diagnostics and basic equipment's

PEN Plus: AFRO

AFR/RC72/4
4 July 2022

ORIGINAL: ENGLISH

REGIONAL COMMITTEE FOR AFRICA

Seventy-second Session
Lomé, Republic of Togo, 22–26 August 2022

Provisional agenda item 7

PEN-PLUS – A REGIONAL STRATEGY TO ADDRESS SEVERE NONCOMMUNICABLE DISEASES AT FIRST-LEVEL REFERRAL HEALTH FACILITIES

Report of the Secretariat

EXECUTIVE SUMMARY

1. Africa has a high burden of noncommunicable diseases (NCDs). Health care services for severe NCDs such as type 1 diabetes, advanced rheumatic heart disease, and sickle cell disease, are usually provided at tertiary facilities in most countries. This exacerbates health inequities and contributes to the high premature mortality from NCDs in the Region.

2. Since 2008, WHO has been providing support to Member States to implement the WHO Package of Essential NCD interventions for primary health care in low-resource settings (WHO PEN). The aim is to provide decentralized and integrated management of common NCDs at the primary health care level as well as strengthen capacity for referrals.

3. As part of the district health system, district hospitals are the main referral facility at the district level and provide administrative oversight to first-level care facilities and other health institutions within the district. Strengthening capacity for management of severe NCDs at this level of health service delivery is important for reducing premature mortality from NCDs.

4. The regional strategy aims to address the burden of severe NCDs among rural and unreached populations through decentralized, integrated outpatient services in first-level referral health facilities. It offers solutions to bridging the gap in access to care for severe NCDs in addition to strengthening the implementation of WHO PEN. The guiding principles include a whole-of-government approach, multisectoral collaboration, universal health coverage and partnerships.

5. This strategy proposes priority interventions covering training and mentoring of staff, resource

PEN-Plus- A regional strategy to address severe, chronic Noncommunicable diseases (NCDs) at first-level referral health facilities

[AFR-RC72-4 PEN-plus a regional strategy to address severe noncommunicable diseases at first-level referral health facilities.pdf (who.int)]

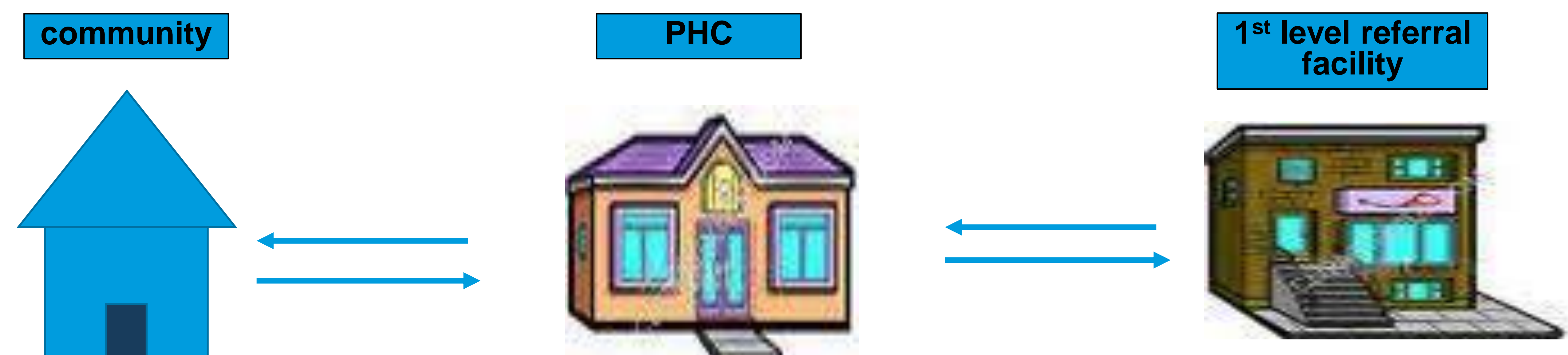
Strengthening NCD services in PHC : Practice & Case Studies

Integrated Model, PEN Plus : AFRO

A regional strategy to address severe*, chronic NCDs at first-level referral health facilities.

- **shared competencies** needed to deliver care for groups of related conditions through protocol development
- **decentralized**, integrated outpatient services
- strengthening the implementation of **WHO PEN**
- ensuring that the **capacity, infrastructure, and logistics** for care are available

*__Severe NCDs__ include sickle cell disease, type 1 diabetes mellitus, insulin-dependent type 2 diabetes and advanced rheumatic heart disease, cardiomyopathy, severe hypertension and moderate to severe persistent asthma.



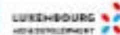
Strengthening NCD services in PHC : Practice & Case Studies

UHC Partnership: Support on NCDs part of Health System Strengthening

UNIVERSAL HEALTH COVERAGE PARTNERSHIP

Bridging the gap between global commitments and country implementation to achieve Universal Health Coverage

The UHC-P's programme of work is fully aligned with WHO's Strategy General Programme of Work adopted by Member States at the 71st World Health Assembly in May 2018.



COVID-19: Delivering UHC requires strengthening preparedness and health security

The COVID-19 pandemic tested health systems and exposed gaps in health security. More than ever, the UHC-P and its agility to support national priorities through flexible, multidisciplinary and responsive programming and funding proves crucial in addressing early recovery needs, and strengthening the preparedness and resilience of countries to protect their populations from future threats.

Achieving UHC requires a strong response to NCDs

NCDs kill over 40 million people each year, equivalent to 71% of all deaths globally. The UHC-P supports countries in delivering innovative and equitable solutions for the prevention and management of NCDs. During the COVID-19 pandemic and beyond, the UHC-P works to accelerate the robust expansion of essential NCD services and to ensure continuity of care even as countries face pandemics and other major threats to health.

Supporting countries to achieve UHC

Noncommunicable diseases (NCDs) & Health security and preparedness

> "COVID-19 is not just a global health emergency, it is a vivid demonstration of the fact that there is no health security without resilient health systems."
>
> Dr Tedros Adhanom Ghebreyesus, WHO Director-General

Reaching 115 countries

As the operational arm of the UHC2030, the global movement to build stronger health systems for Universal Health Coverage, the UHC Partnership translates global commitments to country level impacts, reaching the most vulnerable populations in 115 countries. **Here are some examples.**

COLOMBIA. Social Primary Health Care approach helps communities lead healthier lives and gain better access to health services.

EGYPT. The implementation of the Universal Health Insurance Law covers all Egyptians, while also securing credible funding.

ETHIOPIA. The insured population now benefits from improved access to medicines.

PHILIPPINES. UHC law automatically enrolls every Filipino citizen into the National Health Insurance Program.

SOUTH AFRICA. The Presidential Health Compact, a five-year roadmap for health systems strengthening towards UHC, was signed in 2019.

TIMOR LESTE. A Primary Health Care essential service package with comprehensive NCD services is helping address the burden of NCDs.

UKRAINE. Effective health financing reform helped increase primary health care access by 72%.

Read more stories from the field at www.uhcpartnership.net

UHC Partnership: Support on NCDs part of Health System Strengthening

NCD support for Timor-Leste

- UHC-P providing tools to develop and implement **essential service package** which addresses growing burden of NCDs.

- The **Primary Health Care Essential Service Package** (PHC-ESP) was finalized to reorient the model of health services towards integrated people-centred health services and

- WHO supported the Ministry to conduct **service consumption forecasts, costing, and implementation feasibility assessment of the PHC-ESP**, addressing the recent changing health care needs, including management of NCDs.

- WHO and EU, through the UHC Partnership, are co-chairs of the **Timor-Leste Development Partners Forum**.

- ACP funding to support **COVID-19 response**

What are the next steps?

- Develop and disseminate the tools and support countries in implementing NCD interventions through primary health care
- Systematic support to countries to
  - Strengthen prevention and disease focussed programmes
  - Promote integration of services to optimize NCD and health outcomes
  - Strengthen health system with the focus on delivery of NCD and health services
  - Move from catalytic to intensified support to countries for strengthening NCD services through PHC
- Sustained engagement of political leaders to invest in NCD prevention and control

Thank you