Session One

1. The first meeting of the Working Group commenced with welcoming remarks by the Co-Chair, H.E. Ambassador Londoño Soto, Permanent Representative of Colombia to the UNOG. Ambassador Londoño outlined the significance and objectives of this Working Group, highlighting the aim “to recommend ways and means of encouraging Member States and non-State actors to promote the inclusion of the prevention and control of NCDs within responses to HIV/AIDS and programmes for sexual and reproductive health and maternal and child health, as well as other communicable disease programmes, such as those on tuberculosis, including as part of wider efforts to strengthen and orient health systems to address the prevention and control of NCDs through people-centred primary health care and universal health coverage”.

2. Ambassador Londoño urged Working Group members to identify and showcase programmatic convergences and synergies in order to move integration forward. The Co-chair also underlined that the health sector cannot mobilize the NCD agenda alone, we will need to call on all relevant stakeholders, within and beyond the health sector, and that the WHO GCM/NCD is well positioned to facilitate this wider engagement.

3. Ambassador Londoño conveyed the apologies from her Co-chair, Dr Naoko Yamamoto, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare of Japan, for her delay in joining the group until later. Ambassador Londoño proceeded to introduce all Working Group members present.
4. Dr Bente Mikkelsen, Head a.i. of the Secretariat for the WHO Global Coordination Mechanism for the prevention and control on NCDs (GCM/NCD) presented her welcoming remarks, highlighting that:

- In nominating national experts for this Working Group, countries have showcased the priority they give to the NCD agenda as a development issue, and the important role they place on the sharing of knowledge and best practices in order to mobilize action on NCDs at the global, national and local levels.
- The selection process for Working Group members was a clear example of a transparent Member State-driven process. WHO Member States have offered their expertise, knowledge and experience in order to ensure alignment of the outcomes of this Working Group with national priorities and needs. The GCM Secretariat will do its best to protect this alignment and will support the Working Group towards clear and concrete recommendations for all Member States.
- Member States request tangible recommendations they can implement.
- The Working Group’s valuable deliberations and interaction should not be limited to the three in-person meetings in Geneva, but take full advantage of the many options for inter-sessional work.

5. The Working Group agreed to appoint Dr Jonathan Klein as Rapporteur for the meeting.

6. H.E. Ambassador Londoño moved for the adoption of the provisional agenda for the meeting of the Working Group, with no objections.

7. Members were invited to identify any new ‘Declaration of Interests’ since submitting their information to the WHO GCM/NCD. No new information was presented.

8. Dr Oleg Chestnov, Assistant Director-General for WHO’s Noncommunicable Diseases and Mental Health Cluster, joined the meeting and added his opening remarks and warm welcome. Dr Chestnov highlighted the following:

- The valuable opportunities for integration of NCDs in many other program areas have been identified very early on (2011 and 2014 Political Declarations, WHO’s Global NCD Action Plan, Regional Action Plans, etc) with proven impact on health and development metrics, especially in resource-constraint LMIC.
- NCD program integration ultimately addresses the urgent issue of strengthening integrated people-centered health systems.
- The urgency and relevance of program integration has been elevated even more by the “integrated and indivisible” SDG focus.
- However, few countries have been able to move ahead with integration of NCDs even into these specific program areas, due to knowledge gaps and lack of policy guidance.
• Dr Chestnov identified the “low-hanging fruit” to fast-track effective and integrated NCD management through these programmatic areas, which promotes co-benefits, cost-effectiveness and efficiency of resource.
• Countries need to identify key partners who can facilitate scale-up of integrative initiatives (Donors, innovators, policy makers, civil society, etc).

9. Dr Bente Mikkelsen provided an overview of the WHO GCM/NCD’s role and its 2016-2017 work plan1.

Session Two

10. Dr Guy Fones, Adviser to the WHO GCM/NCD Secretariat, gave an overview of this Working Group’s role and responsibilities.

11. In a valuable exercise, H.E. Ambassador Londoño stimulated the Working Group members’ inputs regarding their expectations for the outcomes of the Working Group, which included:

• The recommendations should be country-led, country-owned and outcome focused.
• The deliberations should identify a clear definition of integration and identify implementable “best buys” for integration.
• Recommendations should identify a set of pre-requisites for effective integration at country-level, particularly with limited resources.
• Recommendations need to be tailored and adaptable to country contexts, including low-income settings.
• Recommendations must address vertical programme integration, identifying convergences, commonalities and co-benefits between NCDs and specific programme areas, but also go further to consider horizontal integration across programmes.
• Recommendations should highlight the importance of population-based prevention of co-morbidities and common risk factor identification and management.
• The need to build “business case” for integration, with clear language for all audiences: government policy-makers, civil society, health professionals, other sectors, etc.
• The deliberations should consider national multisectoral and multistakeholder coordination mechanism or platforms for cross-sectoral integration of NCDs.

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1 All presentations shared during the first Working Group meeting are available on the WHO GCM/NCD website at http://who.int/global-coordination-mechanism/publications/en/ and in the Working Group’s Community of Practice at http://gcmportal.org/workinggroup3-1.
• Recommendations should highlight the importance of training and capacity-building of community health work force.
• Deliberations should consider the lack of evidence-based knowledge, data and innovation on effective integration.

12. H.E. Ambassador Londoño repeated a similar exercise to garner country-level challenges for effective integration of NCDs. Some comments highlighted the following:
• Sectors beyond the health sector have to be brought in when considering integrative initiatives.
• The lack of leadership and poor coordination at country level on integrative initiatives.
• Much of the discussion on integration focuses on funding gaps, rather than on country-level cross-sectoral accountability.
• The lack of monitoring and evaluation frameworks that assess impact of integration across programs.
• The lack of clearly defined co-benefits of implementing best buys across programmes.
• Integration cannot be seen as the panacea; multisectoral coordination and collaboration must also be considered.

13. Dr Naoko Yamamoto joined the meeting and took her place as Co-chair, immediately highlighting the following issues:
• The need to return to the high-level global commitments adopted on integration as a strong starting point.
• The relevance of country ownership of the Working Group outcomes, based on a common language for all stakeholders.
• The need to re-consider the notion of vertical vs. horizontal integration towards a more complementary formula.

14. H.E. Ambassador Londoño outlined the structure for the remainder of the first meeting of the Working Group, which included:
• Day 1, Session 2: Focus on gathering information and discussing opportunities, barriers and solutions to integration of NCDs with HIV and TB programme areas
• Day 1, Session 3: Focus on gathering information and discussing opportunities, barriers and solutions to integration of NCDs with MCD and SRH programme areas
• Day 2, Session 1: Opening to the second day
• Day 2, Session 2: Focus on gathering information and discussing opportunities, barriers and solutions to achieving people-centred healthcare
Day 2, Session 3: Overall review of discussions and expectations; discussion of a roadmap and report to be produced by the Working Group, schedule of proposed upcoming meetings; closing remarks and thanks

Ambassador Londoño reminded all participants that the discussions during these sessions should build on the policy briefs and discussion paper provided as background resources.

15. On behalf of the WHO Secretariat, Dr Nathan Ford, Project Manager for HIV Treatment and Care in WHO’s HIV/AIDS Department, presented on NCD integration with HIV programmes, and took questions from the floor. Dr Ford highlighted that a critical lesson-learned from the HIV experience is that a clear pathway for effective integration is de-specialization towards community-level management; that patient advocacy groups are critical and essential; and that the NCD community needs to attract donors, policy makers and professionals with clear local evidence-based data on NCDs.

16. On behalf of the Secretariat, Dr Knut Lonnroth, Medical Officer in WHO’s Policy, Strategy and Innovations Department, discussed NCD integration with TB programmes, and took questions from the floor. Dr Lonnroth emphasized that NCDs and TB share clear linkages on risk factors and their prevention and that is where the implementation of integrative initiatives should focus, underpinned by integrated monitoring and surveillance structures.

17. On behalf of UNAIDS, Dr Peter Godfrey-Faussett, Senior Adviser for the Office of the UNAIDS Science Panel, presented on NCD integration with HIV/AIDS programmes, and took questions from the floor. Dr Godfrey-Faussett highlighted that there are ample opportunities to identify synergies between prevention of NCD and of HIV/AIDS, particularly when addressing the urgent need to change behavioural trends for NCD management and also given that HIV has learned how to build effective chronic care systems. He confirmed that UNAIDS has put forth integrated targets that include NCDs, particularly in regards to prevention and behaviour change. He also reminded all that defining the co-benefit’s and cost-efficiency of integrating both frameworks will ultimately benefit health results for so many patients with co-morbidities.

18. Dr Mwangi, presented fellow Working Group members on “Integration of NCDs prevention and control and HIV programmes and services” with a country case example of Kenya, where he highlighted that although there is already strong evidence on the co-benefits of integration of NCDs and HIV, there is still lack of sustainable commitment from government-level policy makers. On the ground, many governments need to prioritize specific agendas, and NCD action plans do not transcend or make a strong
enough case. He also referred to the need to strengthen engagement with and advocacy from civil society to mobilize action on NCDs and integrative approaches.

19. Dr Nyirenda followed with a presentation of a country case example, focusing on “Integration of HIV and NCD care – case study from Malawi”, which showcased an innovative multistakeholder steering committee that address the integration of HIV and NCDs, including supply chain and procurement of essential medicines for both.

20. The Working Group broke out into smaller groups for discussions on integration of NCDs into HIV and TB programme areas. The discussions centred around the following questions:
   - What definition of ‘integration’ should this Working Group adopt?
   - What are the key opportunities, barriers, and solutions to integration of NCDs in HIV and TB programme areas?

21. Each sub-group reported to the Co-chairs with key messages from their discussions. The Co-chairs briefly summarised these key messages, as follows:

   - A definition of integration must try to encompass the many dimensions of integration, for example not only synergies with treatment and management of integrated programs but also a focus on screening, prevention, integrated data collection, country context variables, etc.
   - To encourage integration, it is vital that countries develop a strong business case for integration, for different audiences, one that also demonstrates impact on national development status.
   - Each Member State must take ownership of integration, including establishing national frameworks/coordinating bodies to deliver country-context integrated health services at local, primary levels.
   - There are many opportunities for NCDs to learn from successful HIV and TB programmes, particularly on de-specialization of service delivery and strong engagement with civil society and advocacy by patient groups.
   - Countries require clear and concrete domestic data on NCDs to make the case for integration with HIV and TB, particularly with donors who have prioritized other programmatic areas.
   - HIV and TB have focused resources on primary and community health service delivery.
   - Although there are many innovative integration initiatives between NCDs and HIV/TB, a systematic evaluation and monitoring framework is still missing.
22. The Working Group members agreed on the key messages above. Youth voices in the room (interns at international organisations) added to these messages by highlighting the importance of youth and civil society engagement and action.

**Session Three**

23. On behalf of the WHO Secretariat, Dr Anthony Costello, Director of WHO’s Maternal, Newborn, Child and Adolescent Health Department, presented on NCD integration with MCH platforms to the Working Group, and took questions from the floor. Dr Costello underscored the need to address the fragmentation of the different streams within MCH when considering integrative approaches with NCDs and highlighted the strong community engagement within MCH that could benefit NCDs.

24. Ms Allison Goldstein, Consultant at WHO’s Prevention of Noncommunicable Diseases Department, presented on the collaborative public-private mobile technology initiative led by WHO and ITU, ‘Be Healthy Be Mobile’, which is currently run in nine countries focusing on smoking cessation, ageing and TB and cervical cancer. It provides tool kits to implement these programs and a monitoring framework to assess their impact.

25. Dr Erazo, presented fellow Working Group members on “Evaluation of a program aimed to reduce obesity in pregnant women” with a country case example from Chile, specifically focused on combatting obesity in pregnant women, which highlighted the challenges that health systems have in regards to education and behavioural changes.

26. Dr Klein presented fellow Working Group members on “Medical Home and Primary Child and Adolescent Healthcare in Communities” with a country case example from the US, centred around the national life-course initiative, Bright Futures, that supports children from birth to adolescence. This initiative could be analysed further to identify how it could be adapted to LMIC, particularly its strong advocacy component.

27. The Working Group broke out into smaller groups for discussions on integration of NCDs and MCH/SRH platforms.

28. Each sub-group reported to the Co-chairs with key messages from their discussions. The Co-chairs briefly summarised these key messages, which included:

- MCH platforms have greater potential for NCD integration, compared to other programmatic areas.
- MCH/SRH platforms have a strong focus on a health systems and evidence-based interventions for life-cycle approaches.
• Adolescent health is an underserved area with important opportunities for integration.
• NCDs is a big issue for children, not only when considering prevention, but also in treatment of NCDs.
• MCH/SRH platforms can also incorporate domestic violence and substance abuse issues.
• MCH/SRH and NCDs are not only about behaviour changes, but also about policy development and governance structures.

29. Dr Yamamoto concluded the day’s proceedings by thanking all Working Group members for their active engagement with the issues, and the support by all WHO Secretariat staff. Working Group members were invited to an evening reception in WHO.

**DAY 2 - 5th April 2016**

30. Welcome from the Co-chair, H.E. Ambassador Londoño, who also invited Dr McGrath to step up as her temporary Co-chair for the rest of the meeting, in Dr Yamamoto’s absence.

31. Ambassador Londoño invited a youth representative, Miss Rosie Baker (Intern at WHO GCM/NCD) to report on a social media post about youth engagement and mobilisation around NCDs, which had sparked a lively online debate and increased attention. The Secretariat highlighted that the WHO GCM/NCD-led Global Communications Campaign on NCDs, that will be launched later in 2016, could follow up on this enthusiasm to continue engaging youth voices.

32. A comprehensive summary of the first day of discussions was provided by the Rapporteur, Dr Klein. The summary, which identified the many elements in this report, was accepted by the Working Group.

33. The Co-chairs reminded the Working Group members of the format for the remainder of the meeting, starting with a focus on people-centred primary health care.

34. On behalf of the WHO Secretariat, Dr Nuria Toro Polanco, Consultant for WHO’s Services Organization and Clinical Interventions, presented on the “WHO Framework on integrated people-centred health services” recently launched at the last WHO Executive Board meeting. Dr Toro addressed the issue that people-centred primary health services involves co-responsibilities between practitioners, patients and the community, among others, since an effective primary health service should be able coordinate beyond the health sector.
35. Dr Alexey Kulikov, Technical Officer for the UN Interagency Task Force on NCDs (UNIATF), and Matilda Burns, UNIATF Intern, presented to the Working Group on “UN Inter-Agency Task Force on the prevention and control of NCDs: moving forward multisectoral approaches”, highlighting how WHO supports Member States in delivering integrated people-centred health services in collaboration with other UN agencies, via the UNIATF.

36. Dr Al-Jalahma, presented fellow Working Group members, with a country case of Bahrain, “Integrating NCD Prevention & Management in PHC”. The comprehensive presentation demonstrated the real opportunities for NCD integration not only at primary health level, but also at community level, with an integrative approach for effective risk factor management including referral and follow-up. Important success factors for this initiative were a strong high-level coordination mechanism and trained health work force.

37. Dr Erazo presented on “Lessons learned in the implementation of strategies in schools: the case of Chile”, specifically addressing obesity in school children by focusing on behavioural changes.

38. In place of smaller breakout discussions, the Co-chairs facilitated a round-table discussion on opportunities, challenges and solutions for integration of NCDs in people-centred primary health services and overall priorities on cross-sectoral integration. Key messages from this session include the following:

- **Overall recommendations**
  - An appropriate definition of integration using inclusive language must be institutionalised, so it becomes a platform for discussion by a range of stakeholders
  - Each country must produce a business case for integration, using evidence to tailor the arguments to specific audiences, including patients, health professionals, and policy-makers
  - Entry points must be clearly identified: MCH is a key start point
  - Communities must be at the heart of integration of services

- **Barriers to be addressed**
  - Poor coordination within and between programmes
  - Lack of political leadership
  - Poor monitoring and surveillance systems

- **Opportunities for success**
  - Learn from successful HIV programmes: mobilise victims as advocates for change; share the powerful HIV platforms to reach donors and civil society
● Maternal and Child Health offers strong opportunities, e.g. to speak to patients when they are healthy and have a strong vested interest in seeking advice;
● WHO and UN can lead by example on the topic of integration, e.g. better coordination within and between departments and agencies.
● Integration of population-based prevention strategies with risk identification and management tailored for individuals
● Mobilise communities using evidenced-based data and best-buys

39. The next steps for the Working Group were discussed by the co-chairs and Working Group Members. They include:
   ● Identifying missing information needed to reach decisions on recommendations, including country-case studies and policy briefs
   ● Seeking advice on how to create business cases for integration, from stakeholders such as HIV communities, youth groups, health professionals etc. These groups should be consulted proactively as part of the process of forming recommendations, not reactively in response to recommendations.
   ● Working Group Members to submit ideas to the WHO GCM/NCD Secretariat on who to consult and what information is required before the second meeting of the Working Group.

40. The outline of the draft Working Group Report was discussed by all members. The draft outline for the report was presented and amended, where necessary, and finally supported by all members at this stage. Further inputs on this draft outline will be submitted by Working Group members to the Secretariat. The timeline for the next meetings was agreed (second meeting: 20-21 June 2016; third meeting: 26-27 September; virtual meeting as needed). It was noted that the Second meeting of the Working Group would include hearings and/or consultation with relevant stakeholders, for which Webex will be made available.

41. It was noted that the Co-chair, H.E. Ambassador Londoño, will present a summary of initial conclusions from this first meeting of the Working Group to WHO Member States on Thursday 7th April.

42. In closing the meeting, the Co-Chairs thanked Working Group members for contributing fully to the all discussions and the Secretariat for its support for the Working Group. The meeting closed at 5.35pm.
Next Steps

a. To hold a debriefing teleconference with the Working Group members who were unable to attend
b. All Working Group members are encouraged to join their community of practice at: http://gsmportal.org/workinggroup3-1/join
c. Solicit all presentations from WHO Colleagues and Working Group Members delivered at the first meeting of the Working Group
d. Solicit country case studies/best practices from the Working Group members
e. Circulate a draft report outline based on the Working Group meeting outputs and seek Working Group members’ additional feedback
f. Solicit additional suggestions and names of individuals for stakeholder consultations with Working Group members during the June meeting from Working Group Members
g. GCM/NCD to start planning the Second Working Group meeting taking place 20-21 June 2016