- Summary report by Co-Chairs -

**DAY 1 – 20 June 2016**

**Session One**

1. The second 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. H.E. Ambassador Londoño expressed her personal honour to again serve as Co-chair and her pleasure in welcoming the Working Group members to their second meeting. The Co-chair highlighted the following overarching key issues regarding the second meeting:
   a. The main objectives of this meeting were to consider inputs and perspectives from key stakeholders relevant to the mandate of the Working Group; incorporate these perspectives, as appropriate, to the deliberations from the first meeting; and draft concrete and implementable recommendations which would be made available for public comment through the group’s Interim Report.
   b. The group needs to start its deliberations on a solid and comprehensive understanding of the concepts on programme and service delivery integration.
   c. Working Group member should identify additional national, regional and global stakeholders and events, to further stimulate the discussions.

2. Ambassador Londoño also conveyed the sincere apologies from her fellow appointed Co-chair, Dr Naoko Yamamoto, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare of Japan, who could not join the Working Group for the second meeting. Ambassador Londoño then proceeded to invite Dr Fran McGrath to accompany her in the role of Co-chair, standing in for Dr Yamamoto in her absence.

3. Dr Bente Mikkelsen, Head a.i. of the Secretariat for the WHO Global Coordination Mechanism for the prevention and control on NCDs, presented welcoming remarks on
behalf of Dr Oleg Chestnov, Assistant Director-General, WHO Noncommunicable Diseases and Mental Health Cluster, highlighting that:

- Member States need to recall that valuable opportunities for integration of NCDs in many other program areas have already been identified (2011 and 2014 UNGA Political Declarations, WHO’s Global NCD Action Plan, Regional Action Plans, etc) with proven impact on health and development metrics, especially in resource-constrained LMIC.
- NCD program integration ultimately addresses the urgent issue of strengthening integrated people-centered health systems and realizing UHC.
- There are some very promising examples/innovations that are being piloted, particularly with HIV, TB and MCH health, that need to be urgently disseminated and scaled up.
- 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.

4. H.E. Ambassador Londoño introduced the Working Group members present in the meeting, and highlighted the 3 Working Group members who could not join this second meeting, namely Dr Mariam Al-Jalahma, Professor Moffat J. Nyirenda and Dr Mohammad Shaukat Usta, but who have all confirmed their attendance for the third meeting. Ambassador Londoño highlighted that the Secretariat would personally brief the three members who could not attend on the outcomes of this meeting.

5. H.E. Ambassador Londoño moved onto restating the mandate, the significance and objectives of the Working Group, and outlined the structure of the second meeting.
   - Day 1, Session 2: Discussion and adoption of definitions and key concepts
   - Day 1, Session 3, 4 and 5: Stakeholder Hearing
   - Day 2, Session 1: Discussion and Identification of key elements from Stakeholder Hearing
   - Day 2, Session 2: Discussion of draft recommendation
   - Day 2, Session 3: Discussion of structure and content Interim Report

6. Dr Mikkelsen welcomed the Working Group on behalf of the WHO GCM/NCD Secretariat with emphasis on the scope and purpose and outcome of the Working Group, as detailed in the background documents for this meeting. She also highlighted the need to consider developing strong business/investment cases for integrative strategies and policies; the importance of identifying the co-benefits for both NCDs and specific program area; the critical need for more and better context-specific data and evidence-base on integration;
and the critical value of advocacy and mobilization of civil society in order to progress towards effective integration.

7. The Working Group agreed to appoint Dr Rosalind Vianzon as Rapporteur for the meeting and Ms Anneli Sammel as Rapporteur for the Stakeholder Hearing.

8. Ambassador Londoño moved for the adoption of the provisional agenda for the meeting, with no objections.

9. Members were invited to identify any new ‘Declaration of Interests’ since submitting their information to the WHO GCM/NCD.
   - Dr Jonathan Klein declared that he worked for NCD Child, which was invited as a stakeholder to the Stakeholder Hearing.
   - Dr McGrath declared that she had recently been appointed to a national industry-led working group reviewing marketing to children, including food and beverages.
   - Ms Sanne Frost Helt declared that her country of origin, Denmark, funded some of the attending Stakeholders.
   - Dr Kibachio Joseph Mwangi declared that he was an IFPMA participant.

10. These new declarations of interest were considered and duly evaluated by the Secretariat, who concluded that they did not represent a conflict of interest.

Session Two

11. The Working Group continued the virtual discussion exercise initiated in the Working Group’s Community of Practice (CoP), launched in preparation for the second meeting in Geneva. Dr Guy Fones, Advisor at the WHO GCM/NCD, gave a brief summary of the outcomes of the virtual exercise and guided the discussion during this session. The main objective was to agree on the key concepts of integration, best practices, potential efficiency gains from integration at different levels of health service delivery and key principles for successful health systems integration. The aim was to guide the Working Group members in identifying the relevant information they may wish to collect during the Stakeholder Hearing, and detect gaps that could be addressed through their recommendations.

12. Working Group members agreed that the virtual discussion exercise had proven very useful, and suggested adding the following points:
   - The group needs to consider how to best define NCD programme integration when evaluating it in relation to the complementary horizontal or downstream integration and vertical or upstream integration of health care services.
• This will be facilitated by developing a comprehensive log frame (matrix) that captures the different levels and layers of integration (Refer to Appendix 1).
• The deliberations on integration should consider different contexts, including resource settings.

Session Three

13. Dr Frances McGrath launched the Stakeholder Hearing by introducing its format. The hearing was divided into 5 thematic sessions, according to the Working Group mandate, and each was guided by a moderator selected from among the Working Group members. In each session, up to five relevant thematic stakeholders were invited. The Working Group would be offered presentations from some of the stakeholders\(^1\), followed by an interactive structured discussion around facilitating questions which stakeholders had been given beforehand. After the structured discussion, Working Group members were invited to put forth spontaneous questions or to give comments. The Stakeholder Hearing would be webcast and made available on the WHO GCM/NCD web page.

14. The first session of the Stakeholder Hearing, integration of NCDs with people-centered primary health care (PHC) and universal health coverage (UHC), was also moderated by Dr McGrath, in representation of the Co-chairs. She welcomed the stakeholders and familiarized them with the flow and format of the session. The invited stakeholders were the following:

- WHO Health Systems and Innovation; Service Delivery and Safety; Services Organization and Clinical Interventions: Dr Hernan Montenegro;
- International Federation of Red Cross and Red Crescent Societies (IFRC): Ms Sol Eggers-Mancera;
- International Federation of Pharmaceutical Manufacturers and Associations (IFPMA): Mr Alec Van Gelder, presenting on the Healthy Heart Africa Initiative;
- UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA): Dr Yousef Shahin;
- WHO Health Workforce: Dr Giorgio Cometto.

15. Mr Van Gelder, on behalf of IFPMA, gave a presentation on the Healthy Heart Africa Initiative, as an example of a public-private partnership for integration of NCDs.

16. Dr Cometto, on behalf of the WHO Health Workforce, delivered a presentation on WHO’s Global Strategy for human resources for health.

17. On behalf of UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), Dr Shahin delivered a presentation on UNRWA’s strong and effective NCD Programme.

18. Stakeholders took turns in sharing their organizations’ perspectives on the facilitating questions, followed by an interactive discussion between the Working Group and the stakeholders, concluding with the following key messages:
   - Strong and sustained leadership is essential to support integrative focus between NCDs and communicable disease, which could improve access for people/groups where stigma is an issue.
   - The importance of considering health workforce requirements when designing/supporting comprehensive and integrated people-centered services, including mapping resource needs, competency frameworks and health workforce performance tools.
   - The critical need for NCD competencies to be embedded in health workforce training and the importance of appropriate accountability for delivery of integrated services at the point of care, and in communities/systems.
   - Prevention and promotion of healthy lifestyles must be a basic pillar for integration as well as for population-based health services.
   - The importance and difficulty in moving from piloting to mainstreaming integrated services. The gap in evidence to inform implementation needs to be filled.
   - Whether integration prioritizes a system-wide, multisectoral or multistakeholder focus depends on the context. Integration needs to be context-sensitive.
   - There are already many examples of the benefits of integration which need to be disseminated, for example: life-style tools for the 3 levels of prevention; the use of eHealth; and the strengthening of community and family level support.

Session Four

19. The second session of the Stakeholder Hearing, integration of NCDs with HIV/AIDS programs, was moderated by Dr Joseph Kibachio Mwangi. He welcomed the stakeholders to the session and familiarized them with the flow and format of the session. The invited stakeholders were the following:
   - WHO HIV/AIDS, TB, Malaria and Neglected Tropical Diseases; HIV Treatment and Care: Dr Meg Doherty;
   - UNAIDS: Ms Celeste Maria Sandoval, Senior Advisor;
   - UNITAID: Ms Carmen Perez Casas.

20. On behalf of UNAIDS, Ms Sandoval presented on HIV and NCD integration, highlighting opportunities, challenges and foreseen benefits of integration.
21. On behalf of UNITAID, Ms Perez Casas delivered a presentation on the UNITAID Strategy and the UNITAID model and how this could eventually benefit NCDs.

22. On behalf of WHO HIV Treatment and Care, Dr Doherty presented on WHO’s consolidated guidelines on treating and preventing HIV and highlighted the opportunities for and co-benefits from integration with NCDs.

23. Stakeholders took turns in sharing their organizations’ perspectives on the facilitating questions, followed by an interactive discussion between the Working Group and the stakeholders, concluding with the following key messages:

- Pending challenges for effective integration include siloed program funding; lack of multisectoral action; lack of practical guidance or best practices; risk of overburdening the health workforce from over-dependence on task shifting, and weak monitoring and evaluation frameworks.
- Opportunities for integration with HIV/AIDS include simplified treatment, point of care diagnostics, trained workforce, monitoring and evaluation, and research gaps.
- When addressing funding gaps, it is often more an issue of efficiency of use of available resource than a lack of resources.
- When addressing the issue of national or regional coordination mechanisms for NCDs, instead of investing in parallel structures, some countries should consider building on existing strong multisectoral coordination mechanisms such as those already in place for HIV/AIDS.
- Momentum for NCD integration should be built around innovation, investment cases and civil society engagement and mobilization.

24. The third session of the Stakeholder Hearing, integration of NCDs with Tuberculosis (TB) programs, was moderated by Dr Dyah Erti Mustikawati. She welcomed the stakeholders to the session and familiarized them with the flow and format of the session. The invited stakeholders were the following:

- WHO HIV/AIDS, TB, Malaria and Neglected Tropical Diseases; Global TB Programme; Policy, Strategy and Innovations: Ms Hannah Monica Dias;
- The Global Fund to fight AIDS, Tuberculosis and Malaria: Dr George Shakarishvili;
- Stop TB Partnership: Ms Colleen Daniels.

25. On behalf of WHO’s Global TB Programme, Ms Dias presented on the End TB Strategy, highlighting the many successful experiences in integrating TB with NCDs.

26. On behalf of the Global Fund, Dr Shakarishvili presented on the organization’s Integrated Approach to Health, with a strong focus on NCDs.
27. Dr Mustikawati guided stakeholders in sharing their organizations’ perspectives on the facilitating questions, followed by an interactive discussion between the Working Group and the stakeholders, concluding with the following key messages:

- Integrative initiatives should prioritize identifying where services are most needed at the country level and allocate the services there.
- Stakeholders mentioned examples of catalytic funding that assisted countries develop prerequisites and capacity for effective integration.
- Many countries require focused support in developing proposals for integrated approaches – this is needed to ensure that integration efforts are easily scalable and sustainable.

28. Dr Jonathan Klein moderated the fourth session of the Stakeholder Hearing on integration of NCDs with maternal, child and adolescent health (MCH) by welcoming the stakeholders to the session and familiarizing them with the flow and format of the session. The invited stakeholders were the following:

- WHO’s Family, Women’s and Children’s Health; Department of Maternal, Newborn, Child and Adolescent Health: Dr Nathalie Roos;
- UNICEF; Dr Luwei Pearson;
- NCD Child; Ms Amy Eussen
- Elizabeth Glaser Pediatric AIDS Foundation: Ms Tamar Gabelnick.

29. Dr Roos delivered a presentation on behalf of WHO’s Maternal, Newborn, Child and Adolescent Health, highlighting the valuable interconnections between these different program areas and NCDs.

30. On Behalf of NCD Child, Ms Eussen presented on the organization’s integrative approaches to NCD prevention and treatment for children and adolescents.

31. On behalf of the Elizabeth Glaser Pediatric AIDS Foundation, Ms Gabelnick presented on successful integrative initiatives with NCD screening and maternal, newborn and children’s health.

32. Representing UNICEF, Dr Pearson presented on a case of integration for maternal and children’s health and beyond.

33. Dr Klein guided stakeholders in sharing their organizations’ perspectives on the facilitating questions, followed by an interactive discussion between the Working Group and the stakeholders, concluding with the following key messages:

- Possible barriers to effective integration include the lack of strong government leadership (which should be within Ministries of Health); access and affordability, the need to incorporate a specific focus on children and adolescents; and weak advocacy and community engagement strategies.
• The discussion highlighted several opportunities: promoting and implementing the concept of “One stop shop” for service delivery; enhanced sustainability of funds and resources; building on existing strong social movement frameworks, especially regarding the empowerment of youth and women; strengthening accountability frameworks; and holding international partners, including UN agencies and donor countries accountable for their commitments.

• The value of empowering people, patients and civil society to move any health agenda forward was emphasized.

34. The fifth and final session of the Stakeholder Hearing, integration of NCDs with sexual and reproductive health (SRH), was moderated by Ms Sanne Frost Helt. She welcomed the stakeholders to the session and familiarized them with the flow and format of the session. The invited stakeholders were the following:
  • WHO’s Family, Women’s and Children’s Health, Program on Reproductive Health and Research: Dr Ian Askew;
  • Action Canada for Sexual Health & Rights: Ms Meghan Doherty.

35. Dr Askew presented on behalf of WHO’s Reproductive Health and Research and the robust opportunities for integration with NCDs.

36. On behalf of Action Canada for Sexual Health & Rights, Ms Doherty delivered a presentation on lessons-learned from SRH approaches.

37. The key messages collated from this session were the following:
  • SRH offers a wide potential for integration both for screening and prevention. Women and adolescents attending SRH services are typically not sick and therefore more open to receiving additional information focused on prevention, e.g. on nutrition, etc.
  • Co-benefits are also strong: Integration may allow people to attend SRH services on a more regular basis and can even make SRH seem less controversial in some contexts; the possibility of using comprehensive sexual education as entry point to enable health issues to reach young people; woman can be provided with a more comprehensive health care package than they currently do, this can be used as a vehicle for improving adherence.
  • SHR is chronically underfunded, like NCDs, and there is a risk of competing for funds.
  • M&E is a difficult issue as it is often siloed.
  • Challenges still exist in the need for pre-service training to cover the range of health issues, task shifting and sharing for integrated approach and review of policies, procedures and guidelines to accommodate integration.
  • Male involvement/engagement, the demographic dividend and labour force issues were also strongly highlighted.
38. Dr McGrath concluded the day’s proceedings by thanking all Working Group members for their active engagement, and invited them to continue identifying further opportunities to engage with additional stakeholders, if necessary.

**DAY 2 – 21 June 2016**

39. H.E. Ambassador Londoño welcomed Working Group members to the second day of the meeting and highlighted that the day’s activities, focused on the formulation of draft recommendations, were critical for ensuring the added value of the Working Group’s final report. Ambassador Londoño outlined the expectations for the second day, which were to identify key elements from the Stakeholder Hearing that could enhance their deliberation on these draft recommendations, and to conclude with clear and precise draft recommendations.

40. A comprehensive summary of the first day of discussions was provided by the Rapporteur, Dr Sammel. The summary, which identified many elements in the Working Group’s discussion on key concepts regarding integration and the outcome of the Stakeholder Hearing, was accepted by the Working Group.

41. To start the discussion on the recommendations, Ambassador Londoño suggested dividing the two-hour session into two sections: the first dedicated to a spontaneous and inclusive brainstorming exercise on possible recommendations, bringing together and building on all the resources that had been shared and discussed, including the background paper, policy briefs, country cases and the Stakeholder Hearing; then dedicate the second part to grouping and focusing these ideas in order to agree on certain strategic areas the recommendations should address, and, in line with these areas, draft concrete preliminary recommendations.

42. Before the lunch break, Working Group members agreed on a change of agenda, in order to allocate additional time after lunch to continue the discussion on the recommendations.

43. From this active and comprehensive session, the preliminary outline for the draft recommendations is as follows:

**OVERARCHING**

*Introductory message: Setting the scene*

1. NCDs must be clearly included in national UHC strategies to ensure a comprehensive, integrated approach and sustainability
2. NCDs in the SDG-era: strengthen political commitment for a cross-sectoral integrated approach
3. Mobilize NCDs based on human rights, equity and poverty eradication and included in national social/development plans
4. National NCD responses should be driven by a focus on people, families and communities in line with a life-course approach and population-based health care delivery strategies
5. Government responsibility and leadership is essential, but governments can’t address NCDs alone: they require partnerships including with NSA (PPP), national multisectoral coordination, collaboration with stakeholders, donor engagement
6. Involvement/engagement/empowerment of youth/family/communities/patients is needed in policy decisions; this helps ensure, among other priority issues, quality and inclusive decision-making
7. Define context-specific business cases for integration. Integration is not possible without making the investment/business case for integration: financing for NCDs
8. Health care systems need to prioritize disease prevention and health promotion
9. Multisectoral NCD policies/strategies need to focus on reducing disparities through economic and educational interventions
10. Existing service-delivery programs can be enhanced/improved/made more efficient by incorporating NCDs: Co-benefits—integration goes both ways, other programs also benefit from NCD integration
11. Research and innovation on NCDs:
   o implementation research
   o evidence-base for integration

**GOVERNANCE/UPSTREAM/VERTICAL**

*Recommendations:*

1. All programmatic area funding and service delivery should support people-centred, population-based programmes and health care systems
   o People-, family-, community-focus/Life-course approach strategies
2. Country health strategies need to prioritize integration, based on context-specific evidence, citing business cases and concrete models for NCDs – both prevention and treatment access - including NCD specific indicators
   a. burden of disease, health and economic impact, action vs inaction
   b. Highlighting tools (WHO)
3. Promotion/preventive approaches should be the foundation of a multisectoral NCD response: through comprehensive primary prevention and early intervention
4. Support from international development partners and intergovernmental organizations for implementation, should support and provide follow-up of
integrative NCD strategies aligned w/ country priorities (Donors, development aid agencies, UNIATF, UNDAF, CCS, Development plans)

5. Ensure integration of NCDs and other program areas, in particular HIV, TB, MCH, SRH, supported by focused and shared joint-indicators, using people-centered PHC and UHC approaches.

6. Government commitment on building adequate and sustainable health workforce to manage and integrate NCDs, including through continuous training and competency building.
   a. Training/competencies
      o Pre-service training
      o Review and update health workforce curricula and methods
      o Continuous training, updated protocols
      o Competencies, knowledge skills
      o Task-shifting/sharing when appropriate (to cover volunteers)
      o Performance measure, feedback and incentive for integration
   b. To ensure the promotion, implementation of NCDs High-level Commission within the health sector (as 2014 Political Declaration, para 30)

**SERVICE DELIVERY/DOWNSTREAM/HORIZONTAL**

1. UN Agencies’ technical assistance and guidelines should promote coordination, alignment and integration

2. Ensuring that quality NCD services are incorporated and integrated in PHC (i.e. PEN) and that referral systems are functional (eg – highly technically skill specialty care is available to back up screening programs, workforce.)

3. Integration at service delivery level should be comprehensive/horizontal, but may require starting from the successes of vertical programs; providing an “integration roadmap”
   o Value of providing a log frame as a tool for mapping entry points for integration across program areas and with PHC/UHC

4. Optimal and efficient use of existing or available human resources, in particular through “task-shifting/sharing”, complemented by adequate supervision and oversight and communication

5. Governments should invest in innovative technology, including e-Health and m-Health, to support integration, scale-up and outreach of NCD strategies and programs

44. In closing, the Co-Chairs thanked the Working Group members for contributing to engaging and productive sessions, which triggered in-depth, fruitful and focused conclusions. The Co-chairs also highlighted that the Stakeholder Hearings proved to be
an extremely valuable format to identify useful stakeholder perspectives and best practices on NCD integration.

45. As final information, the Co-chairs provided a summary of next steps before the third and final meeting of the Working Group (September 2016), as follows:

Next steps

a. To streamline the preliminary draft recommendations, avoiding duplication or weakening of current WHO technical guidelines and Member State-approved resolutions;
b. To coordinate with WHO colleagues and stakeholders to finalize the draft log-frame;
c. To continue relevant inter-sessional discussions on the Working Group’s Community of Practice;
d. To finalize draft interim report before end of July and make it available for a 6-week public consultation;
e. To evaluate consultations with additional stakeholders, if necessary.
APPENDIX 1

Global Coordination Mechanism (GCM/NCD) Working Group on the inclusion of NCDs in other programmatic areas

Proposed matrix for a log frame that identifies actions for integrating NCDs across programs and into PHC and UHC

| Where to integrate | HIV | TB | MCH | SRH | PHC | UHC | ... | ...
|--------------------|-----|----|-----|-----|-----|-----|-----|-----
<p>| Upstream/Vertical  | Governance |     |     |     |     |     |     |     |
|                    | Policy |     |     |     |     |     |     |     |
|                    | Planning |     |     |     |     |     |     |     |
|                    | Information systems |     |     |     |     |     |     |     |
|                    | Finance and Budgeting |     |     |     |     |     |     |     |
|                    | Supervision |     |     |     |     |     |     |     |
|                    | Workforce |     |     |     |     |     |     |     |
|                    | Training |     |     |     |     |     |     |     |
|                    | Incentives |     |     |     |     |     |     |     |
|                    | Supply chain/ Meds/Tech |     |     |     |     |     |     |     |
|                    | Admin/Backroom |     |     |     |     |     |     |     |
|                    | Monitoring &amp; Evaluation |     |     |     |     |     |     |     |
|                    | Partnership |     |     |     |     |     |     |     |
|                    | Donor Funding |     |     |     |     |     |     |     |
|                    | ... |     |     |     |     |     |     |     |
| Downstream/Horizontal | Prevention (1)/2/3 ° |     |     |     |     |     |     |     |
|                    | Screening |     |     |     |     |     |     |     |
|                    | Diagnosis |     |     |     |     |     |     |     |
|                    | Health education |     |     |     |     |     |     |     |
|                    | Enrolling to care |     |     |     |     |     |     |     |
|                    | Pharmacy |     |     |     |     |     |     |     |
|                    | Ambulatory care |     |     |     |     |     |     |     |
|                    | Acute care |     |     |     |     |     |     |     |
|                    | Palliative care |     |     |     |     |     |     |     |
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