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DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ON

THE 2019 PRINCE MAHIDOL AWARD CONFERENCE HELD IN BANGKOK, THAILAND, 29TH JANUARY- 3RD FEBRUARY, 2019

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ABBREVIATIONS

HTA	Health Technology Assessment
HITAP	Health Intervention and Technology Assessment Program
NCDs	Non-Communicable Diseases
MoU	Memorandum of Understanding
NHSO	National Health Security Office
PMAC	Prince Mahidol Award Conference
SDGs	Strategic Development Goals
UHC	Universal Health Coverage
UCS	Universal Coverage Scheme
WHO	World Health Organizations

1.0 PREFACE

The Departmental Committee on Health had been invited by the Ministry of Health to attend the 2019 Prince Mahidol Award Conference in Bangkok, Thailand. On this basis, the following constituted the delegation:

1. Hon. Sabina Chege, MP - Chairperson & Leader of Delegation
2. Hon. (Prof) Mohamud Sheikh Mohammed, MP
3. Mr. Abdirahman Gele Hassan - Clerk Assistant III

Appreciation

Hon. Speaker Sir,

The Committee is grateful to the Offices of the Speaker and the Clerk of the National Assembly for facilitating the delegation's attendance to the Prince Mahidol Award Conference.

Pursuant to Standing Order 199(6), it is now my pleasant duty to table the Report of the Committee on the 2019 Prince Mahidol Award Conference, for consideration and adoption by the House.

Signed ..... **Date** 26/3/19.

Hon. Sabina Chege, MP

Chairperson, Departmental Committee on Health

2.0 BACKGROUND

The Prince Mahidol Award Conference (PMAC) is an annual international conference focusing on policy-related health issues. The PMAC 2019 was co-hosted by the Prince Mahidol Award Foundation, the Thai Ministry of Public Health, Mahidol University, the World Health Organization, the World Bank, U.S. Agency for International Development, Japan International Cooperation Agency, the Rockefeller Foundation, with support from other key related partners. The Conference was held in Bangkok, Thailand, from 29th January to 3rd February 2019. The theme of the conference was "*The Political Economy of Non-Communicable Diseases: A Whole of Society Approach*".

The general objective of the conference was to identify major bottlenecks, root causes and propose solutions at national and global level to accelerate implementation of non-communicable diseases prevention and control. The total registered participants for the conference were 1,090 participants, from 77 countries.

3.0 THEMATIC AREAS

Non-Communicable Diseases: Critical health agenda around the world

More than a decade into the 21st century, the health community is grappling with epidemiological and demographic transitions. In this regard, non-communicable diseases (NCDs) have overtaken infectious diseases as the leading cause of mortality globally. This shift challenges traditional development thinking, which has long focused primarily on infectious diseases and maternal and child mortality as priorities for international actions. While continuing to combat infectious diseases and maternal and child conditions, the world needs to address the emerging NCD challenges. Besides, it is imperative to explore and analyze the slow progress in addressing NCDs despite a number of global and national commitments.

NCDs, which include cardiovascular diseases (CVD), cancer, diabetes and chronic respiratory diseases, are the leading cause of death and a prominent cause of disability worldwide, accounting for more than 36 million lives lost each year and 15 million premature deaths. Moreover, around 70% of the world's poor now live

in low and middle-income countries, where economic growth and modernization have opened wide the entry point for the spread of unhealthy lifestyles.

The majority of the health burden from NCDs are attributable from four major behavioral risks including, but not limited to, unhealthy diet, tobacco use, harmful use of alcohol and physical inactivity. Most of the aforementioned risks are preventable. High blood pressure accounts for more than 7.5 million deaths annually. The second leading cause of NCDs is tobacco use, which contributes to 5.1 million deaths each year, followed by high blood glucose (3.4 million deaths).

Complex Interaction Between Health, Economic Growth and Development

NCDs have been recognized as a public health catastrophe, not only for human health, but also in the economic arena due to premature mortality which leads to lost productivity and endangers industry competitiveness across borders.

There has been a concern amongst economic experts worldwide that NCDs will undermine not only the global GDP in monetary values but also labor supply and capital accumulation. Though, currently the burden of NCDs is borne mostly by high income countries, the NCD prevalence increases in leaps and bounds in low and middle-income countries due to steep economic and population growth.

Global political movement, WHO and NCDs: Process-Target-Best buys

2011 marked a historic event when the UN General Assembly passed the Political Declaration on NCD prevention and control, reiterating the significance of NCD programs and the role of multiple stakeholders beyond the health sector. The issue of NCDs is the second health agenda after HIV/AIDS, which was proposed into the United Nations General Assembly High Level Meeting in 2011.

In 2013, the World Health Assembly endorsed the Global Action Plan (GAP) for the Prevention and Control of NCDs 2013-2020, which highlighted the proven cost-effective population-wide and individual-targeted interventions, known as '*Best Buys.*'

Since then, WHO Regional Offices have been working with Member states to provide technical services and other support to accelerate implementation of the

GAP on NCDs and these best buys in the member states, but the progress remains uneven.

SDGs, Universal Health Coverage and Health Systems strengthening

In 2015, the global community reaffirmed the commitment of tackling NCDs, mental health and nutrition problems through the adoption of the Sustainable Development Goals. The sustainable development agenda covers the targets and indicators on reduction of premature mortality from NCDs, hunger and malnutrition, mental health and substance abuse. It has proven that tackling NCDs needs united efforts from the whole of government through effective multi-sectoral actions.

Focusing on both processes and outcomes, the SDGs reaffirm commitment and provide guidance and monitoring framework for NCD prevention and control programs, at both national and international levels.

Universal Health Coverage (UHC), identified as a target under the Strategic Development Goals, is both the goal and means by itself. UHC is particularly crucial for the management of NCDs, nutrition and mental health, in particular for health system responses. Not only screening, diagnosis and treatment, UHC also contributes to disease prevention and health promotion. Scaling up implementation of NCD *best buys* interventions is therefore clearly part of the path towards UHC.

Political Economy of NCDS: Players, Powers and Policy Processes

Non-Communicable diseases (NCD) epidemic constitute one of the major challenges for development in the 21st century, in terms of health and well-being as well as obstacle for socio-economic development in all societies. NCD are the leading causes of morbidity and mortality. The number of premature deaths from NCD continues to rise disproportionately in low income and lower middle-income countries where 47% (7 million) of premature deaths from NCDs occur.

NCD has got significant global political attention, since adoption of the Political Declaration on NCD prevention and Control at UN General Assembly in 2011; leading to the adoption of nine Global Voluntary Targets in 2013 covering targets

on premature mortality, risk reduction and national system response; and reducing premature mortality from NCDs by one-third in 2030.

Population-based preventive intervention can prevent half up to two-third of premature deaths, while effective individual-targeted health care can prevent one-third up to half of premature deaths. Evidence also confirms that investment for only one to three dollars per capita per year could make significant NCD premature mortality decline.

Political economy recently emerged as an innovative tool to better addressing policy agenda and program, beyond linear technocratic approach. It focused on both politics and economics and interaction between them; power and resources, how they are distributed and contested and the resulting implications for development outcome; it also considers underlying interests, incentives, historical legacies, prior experiences, social trends and how factors impede change.

While policy direction to tackle NCD is pretty clear, governments often find it difficult to safeguard the health and well-being of their population, in the context of multiple stakeholders with different and common values and interests, unevenly distributed influence, and with restricted capability.

With the aim of fostering and enhancing global momentum for NCD prevention and control, PMAC 2019 introduced an unconventional outlook on NCD epidemic, through political economy perspective. It provided conceptual platforms to articulate better understanding of NCD determinants through political economy lens, promote comprehensive system approach to address NCD and unfold hindrance of and strategize roles of governments.

The Political Economy of the Determinants of NCDs: Accelerating Actions for Prevention

Non-communicable diseases (NCDs), such as cardiovascular diseases, cancer, chronic obstructive pulmonary disease, diabetes and mental illnesses are the leading causes of morbidity and mortality, claiming 41 million out of 56 million annual deaths globally in 2016. The global premature deaths from NCDs, that is, the deaths between the ages of 30 and 69, are of particular concern.

NCDs have been recognized as a significant development challenge and human rights issue, as they impede social and economic development and are driven by underlying social, economic, political, environmental and cultural factors. Therefore, responding to NCDs and their shared risk factors, such as tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol, along with environmental risk factors (e.g. air pollution), is not simply a matter of changing individual health behaviours in isolation. Technical solutions to development problems would not work if they were not aligned with political economy concerns.

Leadership and action from the health sector is critical to respond to NCDs. However, there is a need for robust and coherent national policies and strategies in all sectors with an increased focus on the social, environmental and commercial causes of NCDs, requiring a whole-of-society and whole-of-government approach to address the underlying determinants. Inter-sectoral collaboration encompassing both health and relevant non-health sectors is necessary in combating NCDs at global, regional, national and local levels. The approach has been endorsed at the highest political level and is reflected in political documents, such as the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020 and the 2030 Agenda for Sustainable Development.

Although progress on chronic NCD prevention and control has been slow, there is now strengthened global support for action. The three High-level Meetings on NCDs have contributed to rising political attention to preventing chronic diseases globally. However, for countries to make progress in the implementation of high-level commitments, domestic solutions need to reflect local historical, political, cultural and institutional legacies.

The commercial determinants of Non-Communicable Diseases

Key risk factors of NCDs are strongly associated with patterns of consumption and easy access to unhealthy products. Corporate influence is usually exerted through five main channels: increasing control over production and investment by large

corporates; increasing control over marketing, particularly marketing to children, to increase the appeal and acceptability of unhealthy products; lobbying, which can negatively influence policies related to plain packaging and minimum drinking ages; corporate social responsibility strategies, to enhance positive image and extensive supply chains to exert influence all over the world.

From the NCD perspective, health outcomes are determined by influencing the social environment in which people live and work: the availability, cultural practices and prices of unhealthy products. Hence, the rise of non-communicable diseases is a manifestation of a global economic system that currently prioritizes wealth creation over health creation. Many problems and solutions to address the risk factors lie outside the health sector, in the domains of finance, trade and investment policies.

Commercial determinants of health are a sub-set of the social determinants of health with which they interact, such as education, occupation, income, ethnicity, race, access to healthcare and structural determinants (socio-economic and political context) and affect individuals throughout the life course, as they shape disease risk factors and ultimately disease across the life span. The life-course approach to analyzing the social determinants also provides an opportunity to identify potential entry points for action.

Unhealthy commodities industry and harmful corporate practices; lobbying by trans-national corporation, digital marketing, and interferences by industry to policy makers; and perceived conflict of interest between regulators, government officials and industries, regulatory capture and industry funded research and foundation are some of the commercial determinants of NCD.

4.0 STRENGTHENING COLLABORATION BETWEEN KENYAN MINISTRY OF HEALTH AND THAI MINISTRY OF PUBLIC HEALTH

4.1 Introduction

The Government of Kenya announced its vision to achieve the Universal Health Coverage (UHC) by 2022 and expressed an interest to learn from the Thai experience and exchange knowledge on the topic. Over the years

there have been meetings between senior dignitaries from the Kenya and Thai governments.

In November 2018, members of the Health Benefits Advisory Panel, the Ministry of Health (MoH) Kenya, and County representatives, visited the Health Intervention and Technology Assessment Program (HITAP) to learn more about the Universal Health Coverage system in Thailand and the role of Health Technology Assessment. Through this engagement, the Kenyan delegates and partners, such as the International Health Policy Program (IHPP), the National Health Security Office (NHSO), HITAP, and Access and Delivery Partnership (ADP), outlined priority areas of work and next steps for collaboration.

The Prince Mahidol Award Conference (PMAC) was identified as a fitting platform to continue the dialogue on collaboration and to formalize the relationship between the Kenyan and Thai Governments, by signing a Memorandum of Understanding (MoU). With various partners attending PMAC, the event provided an opportunity to connect with global health experts and organizations to initiate and strengthen partnerships to support the Kenyan Governments vision for UHC. The objective of the meetings over the course of the visit was to articulate further the details of the areas of collaboration among the delegates, Thai partners and international partners.

Health Technology Assessment (HTA) is a multi-disciplinary process to evaluate health technologies. HITAP has supported development of HTA in Thailand since its establishment through research and development of a fundamental system for HTA, capacity strengthening for HTA at both individual and organizational levels as well as for the Thai HTA Health systems, assess health technologies and policies in regard to public priority, research dissemination to policy makers, medical practitioners, and the general public and through development of organizational management and encouragement of connections between academics and involved parties at both national and international Health Technology Assessment organizations.

HTA was introduced in 2009 and HITAP plays a key role in developing the mechanism during the first five years before returning the secretariat function to

NHSO in 2014. However, HITAP remains the secretariat of the Health Economic Working Group and the Working Group on Price Negotiation.

Current governance structures that support the use of HTA to inform health benefit package in Thailand are NHSO Board Chaired by Health Minister, National Drug Committee chaired by Prime Minister, Health Benefit Package sub committee and Health Economic Working Group (NHSO & HITAP secretariat).

The major role of HTA in Thailand is Pharmaceutical reimbursement, non-pharmaceutical benefit and public policy evaluation. HTA-informed coverage decisions in Thailand. High cost with resource constraints, lack of systematic process and pressure on policy makers were some of the challenges in the benefit package development.

4.2 Signing of Memorandum of Understanding

On Friday 1st February 2019, Professor Emeritus Piyasakol Sakolsatayadorn, Minister of Public Health of Thailand and Mrs. Sicily Kariuki, Cabinet Secretary for Health of Kenya, signed a Memorandum of Understanding on Health Collaboration between the Ministry of Public Health of the Kingdom of Thailand and the Ministry of Health of the Republic of Kenya.

5.0 HEALTH SYSTEM IN THAILAND: A SOLID PLATFORM FOR SUCCESSFUL IMPLEMENTATION OF UNIVERSAL HEALTH COVERAGE

5.1 Introduction

Thailand health development since 1970s has been focused on investment in the health delivery infrastructure at the district level and below and on training the health workforce. Deliberate policies increased domestic training capacities for all cadres of health personnel and distributed them to rural and underserved areas. Since 1975, targeted insurance schemes for different population groups have improved financial access to health care until universal coverage was implemented in 2002. Despite its low gross national income per capita in Thailand, a bold decision was made to use general taxation to finance the Universal Health Coverage Scheme without relying on contributions from Members.

Thailand has become internationally known for its success with Universal Health Coverage (UHC) policy and health development. Non-communicable diseases accounted for 71.3% of total mortality in 2015 and demand effective policy response in primary prevention and to contain the commercial determinants of health, particularly tobacco, alcohol and unhealthy diets.

Universal Coverage, Social Security scheme and Civil Servants Medical Benefit Scheme are the three main health insurance schemes. A combination of all these health insurance schemes results in 99.47% universal coverage among the entire population.

Thailand has 55 specialized hospitals, 28 regional hospitals, 87 provincial/university hospitals, 79 district hospitals and 9,788 health centers. Health technology consumes a significant health budget, 47(%) of government spending.

5.2 Health Systems Development: A Historical Perspective

Health systems has been focused on controlling infectious diseases such as smallpox, improving access to safe water and sanitation, and extending health services through outreach activities in remote areas. Health development started as an integral part of the National Economic and Social Development Plan, which led to the establishment of the National Population Policy in 1970 and the National Expanded Programme of Immunization in 1976. Large-scale investment in health infrastructure at district and sub-district levels began during the fourth National Economic and Social Development Plan in 1977.

Full coverage of district hospitals was achieved by 1990 and was followed by a decade of health-centre development in 1992-2001. By the 2000s, all sub-districts had a health centre. The district health system, consisting of health centres and a district hospital, is the backbone of health development. A health centre serves 3000-5000 people, whereas a district hospital typically serves 30000-50000 people and has 30-150 beds, depending on the local population size. A health centre is staffed by a team of three to five nurses and paramedics, whereas a 30-bed district hospital is staffed by three to four general practitioners, 30 nurses, two

to three pharmacists, one to two dentists, and more than 20 paramedics and other administrative staff.

The health centre is the first point of contact by the population and provides primary health care such as basic treatment, prevention and health promotion through nurses and public health workers. District hospitals provide more comprehensive secondary-level curative services, prevention and health promotion, and admission facilities.

During the era of district health-systems investment, provincial hospitals received less infrastructure development support than district hospitals did, but there was a greater focus on strengthening their clinical capacities by training additional specialists. Despite rapid private sector growth at various times, including private hospitals in the main cities, the public sector dominates the Thai health delivery system.

In 1972, the Thailand Ministry of Public Health introduced a 3-year mandatory rural health-service placement for all medical and nursing graduates and, subsequently, dentists and pharmacists. The policy equitably enforced the same for medical graduates from private medical schools. The mandatory rural service policy was accompanied by financial incentives such as a hardship allowance and incentives for out-of-hours work. Non-financial incentives such as annual recognition awards for dedicated front-line workers were also organized regularly by various agencies, and the MOPH provided housing benefit in all health centres and district hospitals as in-kind support to ensure 24-hour services.

In 1994, the MOPH introduced a special track to recruit high-school students from rural and underserved areas for medical and nursing education on the condition that they worked in their home districts upon graduation. To increase medical production capacities, the MOPH strengthened its regional hospitals as clinical training centres for students in years 3-6 of the special track programme.

Recognizing the potential of nursing, the MOPH has since 1946 compensated for the limited training capacities in government universities by establishing nursing

and midwifery colleges that are licensed and certified by the Thai Nurse and Midwifery Council.

The Government of the Kingdom of Thailand introduced a low-income Scheme for poor and vulnerable populations in 1975 for poor households with no co-payment; the Civil Servant Medical Benefit Scheme (CSMBS) for government employees and their defendants in 1980; a voluntary community based health insurance for the informal sector in 1983 and initiated a health Card Project for an annual premium of 500 Thai Baht (the equivalence of $20 at the time) per household up to five members. In 1990, a Social Security Act covering private sector employees was enacted which introduced a comprehensive social security system including pension, disability compensation, and funeral grants and is financed by equal tripartite contributions from a payroll tax paid by employers, employees and the government.

Despite much effort by the Royal Government, 30% of the population was still uninsured by 2001. In April, 2001, a Universal Health Coverage Scheme (UCS) was piloted in six provinces and rolled out nationwide by April, 2002. In parallel, a legislative process enacted a National Health Security Act in November, 2002. Thai people referred to the UCS as the "30-Baht Scheme", reflecting the political slogan "30 Thai Baht treats all diseases" used to promote the scheme and highlight the comprehensiveness of the benefit package. 30 Thai Baht (about $1) was the co-payment for an outpatient visit or an admission paid by the non-poor.

The UCS was established to cover members of the low-income Scheme, the Health Card Project, and the 30% of the population that were uninsured. Currently, the UCS, CSMBS, and social health insurance collectively comprise universal health coverage, although there is some variation in their design features.

The National Health Security Act establishes the National Health Security Office (NHSO), a statutory agency that manages UCS, is mandated among others to collect, gather and analyze information in regard to the implementation of public health service, disburse health service expenses and examine documents and evidence of any claims and reimbursement of public health service expenses. A

National Health Security Fund is established in the NHSO with the objective to support and promote the provision of health service by service units.

The rapid implementation of the UCS was made possible by the Civil Registration and Vital statistics system, established in 1956, which mandates the registration of all births and deaths and assigns a unique citizen ID number to each citizen, making it possible to identify all members of the UCS and register them with a preferred provider network.

Improved fiscal space from economic development, political leadership and commitment, and health systems readiness were enabling factors for the adoption and successful implementation of the UCS.

The MOPH had introduced a voluntary migrant health insurance in 2001 that was funded by annual premiums paid by migrant workers and extended migrant-friendly health services using migrant health volunteers. In 2016, the health coverage for non-Thai citizens covered 34% of the 3.4 million migrants (mostly unregistered) and their dependents.

For the UCS, the NHSO purchased services from public and private provider networks through annual contractual agreements using dual system of capitation and diagnostic-related groups. Capitation payment linked with the number of registered members, a call centre for grievance management and disputes settlement and the annual public hearing for members of the UCS are designed by the NHSO to increase health-care provider accountability.

Thailand strengthened and sustained its institutional capacity in health technology assessment by creating the Health Intervention and Technology Assessment Programme, which prioritizes the inclusion of new medicines into the National List of Essential Medicines and new interventions into the UCS benefit package.

Strategic purchasing by the NHSO helps the primary health care system improve in the detection, screening, prevention, and effective coverage of several non-communicable diseases such as diabetes, hypertension and cervical cancer. Achieving the mortality targets for non-communicable diseases requires the whole government, not just the MOPH, to counteract the strong influence of commercial

determinants and the resistance from tobacco, alcohol, and obesogenic food industries.

UHC has reduced the prevalence of households facing catastrophic health expenditure and medical impoverishment and reduced the probability of catastrophic health expenditure and reduced out-of-pocket spending in high-income households. The UCS thus provides a safety net to all people.

Although most countries target various population groups using different sources of finance, the last phase of achieving UHC is usually to cover the uninsured population that is mostly engaged in the informal sector. The financing choice between voluntary contributions and general taxation for the population will rely on an informed and bold political decision. General taxation must be supported by adequate fiscal space and political commitment to increase the fiscal space for health.

The population's health and longevity have been vastly improved with more people than ever gaining access to high quality public health services.

The Committee visited Bankhen Health Promoting Hospital on 2nd February, 2019 and was informed that the health centre carries out an outreach program accompanied by monks and other volunteers, three to four times a week and also conducts NCD screenings. During its visit, the Committee observed that the health centre had all the necessary equipment and facilities of a major hospital and noted that Thailand Government had put great focus on development of health centres.

The delegation thereafter visited the NHSO offices where it toured the call center that provides a 24-hour service managed by staffs that work in three shifts. All complaints received are addressed within thirty (30) days.

5.3 Lessons Learned from Thailand's Universal Health Coverage (UHC)

The conference drew the following lessons;

1. Extensive geographical coverage of functioning primary health care provides a solid platform for implementing UHC.

2. Rural recruitment, hometown placement, and financial and non-financial incentives can improve the availability of health workers in underserved areas and strengthen primary health care.
3. The district health system is a strategic hub for translating UHC policy into pro-poor utilization and benefit incidence.
4. A tax-financed universal coverage scheme proved the most feasible and progressive route to achieve UHC in the context of a large informal sector.
5. A comprehensive benefit package, with minimal co-payment at the point of service, prevents catastrophic health spending and protects households from being impoverished.
6. Well-designed strategic purchasing organizations and provider-payment methods support efficiency, cost containment and equity outcomes.
7. Stringent health technology assessment for inclusion of new medicines and interventions into the benefit package enhances health systems efficiency.
8. An understanding of the political economy of health and the importance of good governance, an active citizenry and civil society, provision of evidence, and ethical leadership help manage tensions and conflicts and safeguard the interests of members of the Universal Health Coverage Scheme.

5.4 Conclusion

In conclusion the conference resolved as follows;

1. Nations need to take urgent action to combat climate change and its impacts, and ensure healthy lives and promote well-being for all at all ages, including by reducing premature mortality from non-communicable diseases (NCDs) by one third by 2030 through prevention and treatment, ending malnutrition in all its forms, and promoting mental health and well-being.
2. There is a growing burden of non-communicable diseases and low middle-income countries experience a vast majority of premature deaths from NCDs (86%).
3. Recognizing the UN Decade of Action on Nutrition (2016-2025), Members States should commit for better nutrition and healthy diets and ensure implementation of coherent policies and effective programmes.

4. Recalling the Addis Ababa Action Agenda on Financing for Development, there is need to recognize price and tax measures on tobacco as an effective and importance means to reduce tobacco consumption and associated health-care costs while representing a potential revenue stream for financing for development.
5. There is need to establish and regularly convene multi-sectoral coordination structures that enable effective cross-sectoral actions including safeguarding and managing conflicts of interests, which unduly influence NCD prevention and control policies.
6. Increase domestic financing and accelerate investments in NCD prevention and control based on investment case derived priorities and increase availability and accessibility of technical assistance.
7. Develop gender-sensitive approaches to delivering population and individual services and inclusion of children and younger people in all aspects of NCD prevention and control policies and strategies; recognizing that major risk factors are shaped early in life.
8. Minimize policy incoherence across government agencies, which weaken NCD prevention and control policies and programmatic actions.
9. Governments to raise public and political awareness on NCDs and their economic burdens through the life-course, their risk factors, and health service access, development of health workforce, strengthen NCD health literacy in the population, underscoring the need for all stakeholders to accelerate effective and equity-based responses.
10. Nations to create and strengthen a national monitoring and evaluation system that contribute to increased accountability for commitments made on NCD prevention and control and reporting progress.
11. Raise political attention to addressing environmental determinants and risks for NCDs and support the scale up of integrated approaches with a focus on addressing the relationship between air pollution and premature deaths from NCDs, as well as other key environmental and climate-related risk factors of NCDs.

12. Support, develop and strengthen public-private partnerships, while ensuring that such partnerships effectively address any conflicts of interests between economic interests or incentives and public health, giving priority to the right to health, the commitments made for NCD prevention and control, and the pledge to leave no one behind.

6.0 COMMITTEE OBSERVATIONS

The Committee made the following observations from its participation in the conference;

1. Current medical and nursing curricula, particularly in low- and middle-income countries, have not kept pace with the changing dynamics of public health, health policy and health demographics. As a result, medical education in these countries does not adequately cover the prevention and control of NCDs.
2. NCDs cause the highest burden of disease across the world, and yet financing of NCD prevention and control is largely inadequate. NCDs are rooted in the social, economic, environmental and commercial determinants of health and cannot be stopped through individual action alone.
3. Despite availability of scientific evidence and cost-effective interventions, implementation of high-level commitments has been slow in many low and middle-income countries.
4. It is important to ensure that healthcare workers are trained to have clinical competency in global health and primary care and understand the preventive strategies for NCDs and their social determinants.

7.0 COMMITTEE RECOMMENDATIONS

Having noted the observations, the Committee makes the following recommendations:-

1. The Ministry of Health should create public awareness and improve health literacy programs throughout the country especially on NCDs. The Ministry to further raise awareness about the public health burden caused by NCDs & the relationship between NCDs, poverty and social and economic development.

2. KEMRI to invest in priority NCD-related policy and implementation research to evaluate health impacts of public policies on food security, trade, agriculture, and rural/urban development, as well as analysis of enablers and barriers to establishing cross-sectoral coordination mechanisms.
3. The Ministry of Health and the Commission for Higher Education should re-orient medical education and training by introducing competency-based, health system-connected curricula that reflect national needs and priorities. In addition, continuous education should incorporate knowledge of social determinants for NCD prevention to respond to the demands of evolving health systems, changing disease patterns and growing patient expectations.
4. The Ministry of Health should integrate NCD into existing financing mechanisms and explore new innovative financing sources and models through bilateral & multilateral cooperation (e.g. catalytic trust fund for NCD). The Ministry of Health should prioritize health in public sector budget and ensure resource allocation for NCDs.
5. The Ministry of Health should establish effective multi-stakeholder and multi-sectoral coordination mechanisms at the highest level to ensure the whole of government, whole of society approach.
6. Public private partnerships must engage the right members from the start and manage conflict of interest between Ministries, civil societies and other relevant stakeholders.

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