



**World Health
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REGIONAL OFFICE FOR **Europe**

**Workshop on implementation of the
Package of essential
noncommunicable (PEN) disease
interventions for primary health care
in the central Asian republics**

**Bishkek, Kyrgyzstan,
8–9 October 2015**

ABSTRACT

A workshop held in Bishkek, Kyrgyzstan on 8–9 October 2015 reviewed progress with the implementation of the WHO Package of essential noncommunicable (WHO PEN) disease interventions, with a specific focus on implementation of the WHO PEN protocol 3 on chronic respiratory diseases. The Meeting was organized by the WHO Regional Office for Europe in the context of the Project on the Prevention and Control of Noncommunicable Diseases (NCD Project), financed through a voluntary contribution of the Ministry of Health of the Russian Federation. It aimed to support member countries in the implementation of the WHO PEN protocols and to establish a platform for regular discussion of issues of common interest in their implementation. Participants also attended two symposia organized by the International Primary Care Respiratory Group, taking place at the same time. The outcome was a plan for developing this community of practice further to provide support with the implementation of the WHO PEN and its protocols.

Keywords

CHRONIC DISEASE – prevention and control
PRIMARY HEALTH CARE
DELIVERY OF HEALTH CARE
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RESPIRATORY TRACT DISEASES – prevention and control
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Abbreviations

COPD	chronic obstructive pulmonary disease
CVD	cardiovascular diseases
NCD	noncommunicable diseases
WHO PEN	WHO Package of essential noncommunicable disease interventions
SCORE	Systematic COronary Risk Evaluation
STEPS	Stepwise Approach to Surveillance of Noncommunicable Diseases

Introduction

Background

Effective approaches to reduce the burden of noncommunicable diseases (NCD) and achieve the global target of a 25% reduction in premature mortality by 2025 from such diseases require a mixture of population-wide and individual interventions. Such cost-effective interventions have been identified, are already available and include methods for early detection of NCDs and their diagnoses using inexpensive technologies, pharmacological and non-pharmacological approaches for modifying NCD risk factors and affordable medications for prevention and treatment of heart attacks and strokes, diabetes, cancer and asthma. The WHO Package of essential noncommunicable (PEN) disease interventions is a conceptual framework for strengthening the equity and efficiency of primary health care in low-resource settings. It defines a minimum set of essential NCD interventions to be implemented and comprises four protocols: (i) prevention of heart attacks, strokes and kidney disease; (ii) health education and counselling for healthy behaviour; (iii) management of asthma and chronic obstructive pulmonary disease (COPD); and (iv) assessment and referral of women with suspected breast or cervical cancer.

A workshop to review progress on implementing the WHO PEN interventions, with a specific focus on implementation of protocol 3 on chronic respiratory disease, was held on 8–9 October 2015 in Bishkek, Kyrgyzstan. The event was hosted by the Ministry of Health of Kyrgyzstan was organized by the WHO Regional Office for Europe in the context of the Project on the Prevention and Control of Noncommunicable Diseases (NCD Project), financed through a voluntary contribution of the Ministry of Health of the Russian Federation.

Dr Samat Toimatov, Head of the Organization of Medical Service and Medicines Policy Department, Ministry of Health, Kyrgyzstan, welcomed participants on behalf of the Minister of Health. The seminar was topical because Kyrgyzstan was following the path to prevention and early detection and the WHO PEN tool was important to improve health outcomes. He expressed his gratitude to participants and hoped that new information from the Meeting would facilitate implementation of the programmes.

Participants' attention was drawn to commitments made in the United Nations High-level Declaration on the Prevention and Control of Noncommunicable Diseases¹ and to achieving the global target of a 25% reduction in premature mortality from NCDs by 2025.

Three countries were already implementing the WHO PEN through pilot projects (Kyrgyzstan, Tajikistan and Uzbekistan), one country was about to embark on a feasibility study (Republic of Moldova) and another country was observing (Kazakhstan). Each country had brought a multidisciplinary group of people involved in WHO PEN work at national or district level. The disciplines represented at the Meeting through these teams included cardiology, pulmonology, endocrinology, family medicine, postgraduate education and training, nursing and health information. In addition, the WHO National Professional Officers for Kyrgyzstan, Republic of Moldova, Tajikistan and Uzbekistan and the Regional Office Coordinator of NCD Surveillance

¹ Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. New York: United Nations; 2012 (http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf , accessed 9 January 2016).

participated to provide continuity and support to the teams and links to other relevant work and opportunities. The programme is in Annex 1 and the list of participants is in Annex 2.

Objectives and expected outcomes

In the WHO European Region, four countries had embarked on implementing the WHO PEN interventions and more countries were set to join them during 2015 and 2016. These pioneer countries were at different stages of implementation and had taken different approaches according to their national contexts. In general, most experience so far had lain with implementation of protocols 1 and 2; there was less experience with protocols 3 and 4. The Workshop provided an opportunity for the teams from these countries to meet together for the first time and share experience on the approaches taken and why, progress to date, successes achieved and challenges faced. It aimed to support member countries in the implementation of the protocols and to establish a platform for regular discussion of issues of common interest in their implementation. It was expected to lead to the development of a plan for mutual support at intercountry and regional levels to support the implementation of the WHO PEN in the Region. The Workshop was timed to take place at the same time as the Kyrgyz National Congress of Respiratory and Allergic Diseases /Euro-Asian International Primary Care Respiratory Group Symposium so as to allow participants to benefit from the resources and expertise present at the Congress and to continue working on the implementation of protocol 3 for management of asthma and COPD.

Progress with implementation of WHO PEN in primary health care

The WHO PEN protocols were designed for use in low-resource countries and settings. Countries in the Region appeared to be finding them useful but were interpreting and adapting them according to context. Some countries were moving on to implement cardiometabolic risk assessment and management in parallel, using equivalent tools at primary care level such as the European Society of Cardiology Systematic COronary Risk Evaluation (SCORE) risk charts. In either case, opportunities were available to support the implementation of effective interventions for NCD prevention and control through broader work to strengthen health systems and NCD policy frameworks.

Tajikistan

The population of Tajikistan was 8 million. Although it was now considered a low-middle income country, it was the poorest country represented at the Meeting. Over three quarters (77%) of deaths are caused by cardiovascular diseases (CVD). A national strategy entitled Future Opportunities for the Prevention and Control of NCDs and Injuries 2012–2015 had been drawn up and a working group established to implement it. Progress to date included an inter-agency round table in June 2015 to review and strengthen the approach.

The WHO PEN package had been introduced in 2014 and was being implemented in Dushanbe and seven pilot districts with mainly rural populations. Primary care capacity assessments had been carried out and, after adaptation and translation of the protocols into local languages, training seminars had been held for doctors in the districts. Three protocols were being implemented; the fourth had been translated and the working group was preparing for its implementation as well.

The first focus was on cardiometabolic risk assessment because of the high mortality and the possibility of linking with national protocols. From April to June 2015, monitoring and evaluation of primary health care had been conducted in the pilot areas. As a result the plan of action had been revised. Successes had included a more accurate understanding of the capacity of primary care for prevention and control of NCDs and analysis of the actual situation in the country. The evaluation exercise had found that paper reports differed from the reality. The WHO PEN protocols were being introduced into the mainstream through inclusion in the curricula for under- and postgraduate education. Groups working on healthy lifestyles were being increasingly effective. A health information system had been set up and national health monitoring indicators had been revised. Among the challenges remaining was the lack of financial capacity to hold workshops throughout the country. The plan was, therefore, to expand gradually so that during 2014–2016 almost half (27, 47.4%) of all districts would be covered, leaving nine cities and 30 districts to cover. Cross-sectoral cooperation had been strengthened, awareness-raising activities had been carried out among health care workers and the public about the benefits of healthy living, and NCD prevention mechanisms were being continually improved.

Uzbekistan

The national nutrition and NCD strategy had been approved in 2015. The WHO PEN was being implemented in the context of the Health-3 project funded by the World Bank with the support of WHO. At national level, a coordination body comprised the treatment and prevention department of the Ministry of Health and leading specialists, the Health-3 project and the WHO Country Office. The current clinical guidelines needed to be revised so it was a good time to introduce the WHO PEN package. Protocols 1, 2 and 3 had been adapted by a national working group and approved by the Ministry of Health. The coordination body had identified two pilot regions in Fergana and Kashkadarya, one with a high-density population and the other with low density in the rural areas, and selected four medical facilities (three rural with a population of at least 6000 and one urban family polyclinic) in each oblast. An initial capacity assessment of a random sample of 50 primary care centres had been conducted in 2013 and repeated in pilot facilities in 2015. With support from the Health-3 project and WHO, a series of technical workshops had been carried out. The technical working group had developed a comprehensive training course for trainers and held two four-day events to prepare national trainers. A further such course was planned for the first week of November 2015 to introduce basic approaches in pre- and post-diploma education. The technical working group had also developed a set of standard indicators for monitoring and evaluation which were used internally for clinical audits as part of continuing improvement and for external audit by independent observers. These had been used in baseline monitoring of the implementation of the WHO PEN in September 2015 which had comprised a review of indicators, observation of general practitioner consultations, exit interviews with patients and a review of the quality of a sample of medical records. Self- or peer-assessment was undertaken monthly and external reviews quarterly. The pilot projects have been successfully initiated and an individual patient follow-up template introduced into the WHO PEN.

The implementation of the WHO PEN was being supported by an NCD population-based approach. In the pilot regions, intersectoral coordinating councils under the local governing authority involved the local governor's and municipal offices, the oblast health department, other local state sectors, nongovernmental organizations and the mass media. An action plan for comprehensive interventions on NCD prevention and control had been developed and introduced and it was hoped to implement initiatives such as health-promoting schools, healthy cities/

villages and healthy workplaces (starting with health facilities). Barriers to the implementation of the WHO PEN included a lack of basic equipment and access to basic diagnostic tests as well as shortages of basic drugs in primary care. A further challenge was to ensure and strengthen a sustainable reporting system on NCD and risk factors.

For the future, the coordination body hoped to collect evidence of the cost-effectiveness of and economic benefits from implementation of the WHO PEN for future public financing for NCD. CVD risk assessments were to continue, with the development of examples of best practices, in the pilot facilities and regions in 2016, followed by a planned roll-out of the experience nationwide during 2017–2020.

Republic of Moldova

In 2014, the estimated population of the Republic of Moldova was 2.9 million. In 2013, the Stepwise Approach to Surveillance of Noncommunicable Diseases (STEPS) survey on the prevalence of NCD risk factors in the population had yielded good data: 41% of men used tobacco daily, 29% of men binge drank, and 38% of men and 11% of women aged 18–44 years already had three or more risk factors for NCD. While the population prevalence of hypertension was 40%, it was detected in only 10–12% of patients. Primary health care facilities carried out cardiovascular risk factor checks in patients over 40 years, using the SCORE charts to measure body mass index, cholesterol, glycaemia and lipids. Patients aged over 45 years were also routinely screened annually for diabetes using fasting blood glucose; this had been incorporated into the pay-for-performance scheme in January 2013. Patients' adherence to daily anti-hypertensive treatment was low at around 27%, however, and attendance at diabetes and hypertension schools was also low. The country was not yet implementing the WHO PEN protocols but was in the process of designing a feasibility study using protocols 1 and 2 to start in 2016 which would compare the WHO PEN with routine practice. This was likely to take place in two health centres, each covering a population of around 5000 patients.

Kyrgyzstan

The population of Kyrgyzstan was 5.9 million. The relevant authorities had been implementing the WHO PEN since 2015, focusing on 10 pilot sites in Bishkek which were all family medicine centres. A working group consisted of individuals who had been certified for interactive training. During May–June 2015, members of the working group had developed an educational programme and materials which could be delivered in seminars and as part of continuing education for family medicine centres and doctors. Since July 2015, they had also developed a monitoring system to assess knowledge, expertise, use of materials, examination tactics and a number of clinical indicators based on the clinical information form. Information from outpatient medical cards was entered into an electronic database each day, allowing members of the working group to have an overview of, for example, coverage of patients, completeness of clinical data collection and the proportion of patients with high risk scores. It also allowed them to compare how well centres were doing. They planned to link these data with long-term indicators such as CVD incidence and mortality.

Implementation of the WHO PEN protocols was being integrated into other functioning programmes and projects such as those on health care reform, community-based action and results-based financing, some of which involved other donors. The working group faced some practical challenges, however. While it had made changes in the curricula for postgraduate training of family doctors and undergraduate training of students, there was a lack of handouts

and materials for the doctors and the teachers needed further training. Cholesterol was not routinely measured; although the STEPS survey had shown that it is high at a population level, use of the nomogram without cholesterol meant that a lot of patients appeared to have a low overall risk. The work of the health promotion units, who were aware that too few patients were being referred, could also be made more effective. The high cost of drugs, statins in particular, meant that patients often stopped taking the prescribed drugs after one to two months.

The working group's future plans included continued the training of managers to monitor the data collected from the cards, the use of incentives to motivate doctors, and further analysis and refinement of the WHO PEN indicators. They hoped to expand the project in Bishkek from January 2016.

Discussion and identification of common issues

A summary of the session drew out common issues. Progress was being made. The intention of the WHO PEN had been to contribute to strengthening the building blocks of health systems, and the Meeting had thrown up the following examples.

- For *leadership and governance*, each country had described its own multidisciplinary working group and connections between this work and the broader NCD policy context, including a description by Uzbekistan of the government of WHO PEN by intersectoral committees at local level.
- Examples of links with results-based *financing* projects had been described.
- The WHO PEN facility assessments and reviews had been instrumental in highlighting the reality of the gaps in provision of *medical products and technologies*.
- As regards *health information*, a number of countries had given examples of how they had identified and used indicators for monitoring process and quality, and how they planned to link to outcomes.
- Training of both doctors and nurses was a key feature of the work with the *health workforce* through training of trainers and seminars for family doctors. Examples were also given of mainstreaming the WHO PEN protocols through reviews of the curricula for under- and postgraduate education, and of shifting tasks from doctors to nurses.
- As regards *service delivery*, the WHO PEN was serving as a means of improving more equitable access to at least a basic level of care, and examples were given of how service delivery had been linked with continuous quality improvement and clinical audit.
- Work with the WHO PEN to implement a set of clinical interventions was being supported by broader health promotion work with *people* at the community level to reinforce health-promoting messages and environments and to make healthy choices the easy choices.

Site visits

Participants visited two polyclinics that were implementing the WHO PEN: family medicine centres 2 and 4. Both were in the city of Bishkek but in contrasting settings. Participants visited surgeries, met doctors and nurses using the tools, saw the materials being used and got an opportunity to look in more detail at the system for collecting data and monitoring performance.

International Primary Care Respiratory Group Symposium

Participants were invited to join the two symposia of the Central Asia International Primary Care Respiratory Group, which were taking place under the auspices of the Kyrgyz National Congress of Respiratory and Allergy Diseases. Both sessions gave an overview of modern recommendations at primary health care level, the first for COPD and the second for asthma.

Individual meetings with countries

Individual meetings were convened with each of the WHO PEN country teams plus the observer country. Representatives of each country were asked to give their views of the Workshop so far, to highlight two things they had learnt that would be useful for their own work and to discuss plans for the future together with any specific support required.

In general, participants appreciated the opportunity to hear other countries' experiences and the different approaches taken and to reflect on their own practices as a result. All teams had found something of interest and learnt new things. The field visits were particularly useful and several participants had gained new insights into the potential role of medical nurses and monitoring systems. Some mentioned that even where they had their own protocols, they could see that the WHO PEN added value because of its focus on family doctors and comprehensive approach to strengthening implementation through training, supportive materials, assessments of facilities, performance review and links to clinical audit and quality improvement. They also appreciated the focus in the WHO PEN on prevention, identification and management of risk factors, rather than just on treatment as was the case with some of their other protocols. Some teams were already adjusting their action plans as a result of what they had learnt.

Use of the WHO PEN in central Asia: focus on protocol 3 and chronic respiratory disease

The aim of this session was to see what specific progress countries had made in implementing the WHO PEN protocol 3 or equivalent interventions for chronic respiratory disease (CRD), and to discuss what was needed to support this work. Of the four main NCDs, relatively little priority had been given to asthma and COPD although they shared common risk factors. Exposures started early in life and both tobacco smoke and air pollution (indoor and outdoor) were key risk factors, although there were also associations with diet, physical inactivity, alcohol use and poverty. Monitoring of both diseases was poor (incidence, prevalence and mortality) and clinically the diseases were under-recognized, detected late in their course and frequently under-treated. Access to basic drugs and equipment such as spirometry could be a challenge. A comprehensive approach to lung health was broader than just implementation of clinical protocols and also required strong action on, for example, tobacco control, air pollution and promotion of physical activity. A WHO survey had found that over 80% of European countries had CRD guidelines but fewer than 30% of countries were implementing them. There were a number of relevant WHO tools and guidance beyond protocol 3 which might already be familiar to countries, such as the Practical Approach to Lung Health and the Integrated Management of Childhood Illness, which could take a more syndromic approach. Countries might also be using international guidelines such as the global strategy for diagnosis, management and prevention of COPD and the pocket guide for asthma management and prevention as well as European Respiratory Society guidelines. A recent strategic technical meeting on CRD in WHO

headquarters had brought together experts to begin reviewing the recommendations in protocol 3 in the context of these other tools.

Kyrgyzstan

Kyrgyzstan had the highest mortality rates from respiratory diseases in the Region. The main risk factors were tobacco smoking (45% of men) and indoor air pollution from combustion of biomass as a fuel for cooking and heating. Respiratory symptoms were more common among highlanders than lowlanders for these reasons. There were serious problems with the availability of essential drugs and equipment for patients with COPD at primary health care level. An assessment of primary health care facilities when the implementation of the WHO PEN began had found that while all 10 pilot family medicine centres had peak flow meters, none had oxygen cylinders and few had spacers or nebulisers. Spirometry was only available at tertiary level. Salbutamol inhalers and amoxicillin were widespread but few pilot centres had access to beclomethasone or ipratropium bromide inhalers. Protocol 3 had provided a good platform for updating and developing the national COPD guidelines and for specifying a minimum set of equipment for family medicine centres. Its recommendations could be adapted to the context of each country and updated to include access to spirometry and prolonged bronchodilators. Scales for assessing and monitoring the severity of symptoms would also be useful.

Uzbekistan

Clinical protocols on pulmonology had been developed with an algorithm and protocol 3 had been approved and integrated with the algorithm. This work had been considered and linked with the national programmes on physical activity and healthy lifestyles. Facilities had been equipped at *rayon* level with the recommended equipment. Clinical tests were undertaken in primary health care facilities but nurses needed training to interpret the findings and in practical skills. The postgraduate institute was working on upgrading skills for what was feasible at primary health care level, and was already adapting protocol 3.

Tajikistan

The country had the same problems and goals as those mentioned by the other countries. Priority was being given to CRD diseases in the young, 15% of whom had bronchial asthma. Protocol 3 had been in use since 2013. Seminars had been held in the pilot districts and 400 primary health care doctors had been trained. Compared with 2013, the incidence rate of COPD rose in 2014 which could have been because doctors were working better and the detection rate had improved. Medical follow-up rates had also risen. The preceding discussion had given the country representatives a better understanding of the use and limitations of the peak flow meter.

Republic of Moldova

The WHO PEN had not yet been implemented but some basic items, such as peak flow meters and spirometry, were accessible at *rayon* and district level and asthma drugs were fully reimbursed. Clinical protocols were in place, but the other countries' presentations had made clearer the importance of focusing on risk factors and taking a comprehensive approach. The WHO PEN implied teamwork and the need to engage nurses. At present nurses were underused and staffing rates were low, especially in rural areas. It was clear that prior to implementing the WHO PEN, a situation analysis was important and training essential.

Discussion and identification of common issues

The WHO PEN protocol 3 seemed to have been very useful to countries. It was serving as a basis for generating engagement and for recognizing a basic threshold of care that needed to be achieved and made accessible for all. Notwithstanding this, countries were also adapting the protocol and already thinking beyond the WHO PEN. Hearing what other countries were doing, and being able to quote their initiatives within their own countries as to what was possible, could be used by country teams as leverage to go further. There were, however, still some issues around access to basic drugs and technologies.

The emphasis on risk prevention and stopping smoking was good. It was questioned whether nicotine replacement therapy was easily available and on the essential medicines lists of countries and WHO. Patients with COPD had to stop smoking, while smoking by health care workers needed to be addressed since it could influence patients. Patients with CRD had multiple morbidities which also needed to be borne in mind.

As regards training needs, health care staff did not just need knowledge on what to do, they also needed to be enabled to do it. Periodic joint clinics between pulmonologists or experienced staff and primary care doctors could help them to gain confidence and practise what they had been taught. On the topic of equipment, not every practice needed to have its own spirometer if resources did not allow for that; one in a local centre or lead medical centre could be accessed by a cluster of practices.

Monitoring implementation was important and the resulting data could be fed back to clinicians to support and encourage them.

Finally, only one team had mentioned the patient's view, even though it was increasingly being realized that patients' opinions were important and that they had the power to express themselves.

Conclusions and next steps

The Uzbekistan country team felt that the countries present were united by common goals and had a lot to share and discuss with each other. Their working group suggested, therefore, that countries might meet in quarterly seminars in the partner countries. This would allow discussion of specific tools, field visits and in-depth work on specific themes of common interest. Such meetings might be coordinated by an intercountry working group. This team was interested in how specialists and family doctors work together, linking the WHO PEN work with broader work on healthy lifestyles and on research on cost-effectiveness. Uzbekistan offered to host the next meeting.

There was general agreement with the proposal. The Kyrgyzstan team expressed interest in discussing: (i) as an early topic, training approaches and curricula with the aim of adapting and aligning curricula, and (ii) indicators and monitoring. The Tajikistan team suggested that development of a central Asian association on NCDs could be useful as the country teams developed tools to manage NCDs and become more independent. The internet also gave them possibilities for communicating and sharing materials with each other between meetings. Tajikistan offered to host a subsequent meeting in 2016.

In discussion, it was felt that, given the resources available, it might be more realistic to meet as a group two or three times a year, although countries could share materials and communicate between themselves. Events such as the forthcoming Regional Office International Conference on Cardiovascular Diseases and the forthcoming International Primary Care Respiratory Group Conference in Amsterdam in May 2016 could present opportunities to meet. The officers concerned at the Regional Office would work with WHO colleagues and teams to develop the proposals further and facilitate these exchanges.

Annex 1

PROVISIONAL PROGRAMME

Thursday, 8 October

- 13:00–13:15 Welcome and introductions
Nominated representative of Ministry of Health responsible for WHO PEN implementation, Dr Jarno Habicht, WHO Representative, Kyrgyzstan
Provisional agenda and expected outcomes
Dr Jill Farrington, Senior Technical Officer, Division of Noncommunicable Diseases and Promoting Health through the Life Course, WHO Regional Office for Europe
- 13:15–15:00 Progress with implementation of the Package of essential noncommunicable disease (PEN) interventions for primary health care
Facilitator: *Dr Jill Farrington*
Implementation of WHO PEN tool in central Asia: approach taken and progress to date
- Invited short presentations from Kyrgyzstan, Tajikistan and Uzbekistan
 - Invited short presentations from observer countries, if present (Republic of Moldova)
- Discussion and identification of common issues
- 15:45–18:00 Site visits to local sites for the implementation of WHO PEN
Key trends, issues and strategic options for NCDs, their risk factors and determinants in the WHO European Region

Friday, 9 October

- 08:00–15:00 Participants join the Kyrgyz National Congress of Respiratory and Allergic Diseases/Euro-Asian International Primary Care Respiratory Group Symposium
- 08:00–09:30 Central Asia International Primary Care Respiratory Group Symposium (part 1): Modern Recommendations for COPD at the Primary Health Care level
- 09:30–11:00 Central Asia International Primary Care Respiratory Group Symposium (part 2): Management of Bronchial Asthma at the Primary Health Care level
- 11:00–13:00 Optional: educational school for family doctors: new clinical guidelines for respiratory diseases in Kyrgyzstan
In parallel: meetings to be scheduled between the WHO Secretariat and country teams
- 14:00–15:00 Optional: international collaboration with International Primary Care Respiratory Group Symposium, European Respiratory Society and European Lung Foundation: respiratory projects in Kyrgyzstan “Healthy Lung for Life – Clear Air in Kyrgyzstan”

- 15:00–16:30 In parallel: meetings between the WHO Secretariat and country teams
Essential noncommunicable disease interventions for primary health care in low/
middle resource settings: use of the WHO PEN protocol 3
Overview of WHO PEN tools and implementation in WHO European Region:
Dr Jill Farrington
Implementation of WHO PEN protocol 3 on COPD and asthma: what is needed
for successful implementation?
- Presentations by country WHO PEN teams
 - Discussion with contributions from international and national faculty and WHO PEN teams.
 - Reflections: Dr Hilary Pinnock, International Primary Care Respiratory Group
- Summary: *Dr Jill Farrington*
- 17:00–18:30 Conclusions and next steps
Reflections on findings and discussions from the workshop and development of
plan of action for country support

Annex 2

LIST OF PARTICIPANTS

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