AMSANT comments on priorities for inclusion in the 2018-2023 Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan

May 2018

Recommendations

1. Strengthen Aboriginal leadership in oversighting the implementation and evaluation of this plan.
2. Increase the focus on social determinants particularly in the area of housing.
3. Improve the focus on nutrition and food security including policy changes such as remote food subsidies and a sugar tax.
4. Adopt evidence-based alcohol control policies reduce the supply of alcohol, including through adoption of a floor price and a risk based licensing scheme.
5. Develop a national core primary health care services framework.
6. Cost the core policy across urban, rural and remote regions.
7. Fund core service implementation over a five-year period.
8. In consultation with NACCHO and the affiliates, finalise and implement the national CQI framework.
9. Address systemic racism in the mainstream health system by establishing a national CQI system and appropriate KPIs on cultural safety and Aboriginal access to care in hospitals.
10. Develop a plan in consultation with the states to transition government primary health care to community control and support expansion of ACCHSs in urban and regional areas including through satellite clinics.
11. Prioritise ACCHSs for SEWB funding for Aboriginal people and undertake a needs-based planning approach through jurisdictional forums to allocate this funding.
12. Ensure greater accountability for training providers to achieve successful outcomes across health professions for Aboriginal and Torres Strait Islander people with targets proportional to the projected population needs.
13. Increase scholarships and traineeships for Aboriginal people working in ACCHSs as part of a broader strategy on increasing the Aboriginal workforce.
14. Develop a plan to support ACCHSs with capacity to become NDIS providers in consultation with NACCHO, the affiliates and NDIA.
15. Incorporate Indigenous data sovereignty principles into the evaluation and monitoring approach.
16. Ensure midwifery is a core essential service for all ACCHSs.
17. Embed nutrition, alcohol and tobacco programs targeting pregnant women into broader community wide strategies.
18. Scale up nurse home visiting program so there is high population coverage.
19. Develop and implement a national core services for Aboriginal children policy that spans clinical care but also early learning programs, family support and nurse home visiting.
20. Ensure suitable referral options are available for common childhood and adolescent issues including early intervention for developmental delay, parenting programs, primary mental health and SEWB services and child and adolescent psychiatric services.

21. Further develop the multidisciplinary workforce required to prevent, delay and manage complex chronic disease and better resource health promotion /prevention in this area.
22. Support ageing in country and growth of a community controlled aged care sector.
23. In partnership with the sector develop targets and indicators that reflect the breadth of comprehensive primary health care including critical non-clinical components such as cultural safety and community engagement and health promotion.

1 Governance and leadership

There is a lack of national leadership over the health plan particularly since the abolition of the National Aboriginal and Torres Strait Islander Health Equality Council and rejection the Uluru Statement. Too often, decisions are made by COAG without Aboriginal input. This needs to change if decisions are to be made that reflect Aboriginal communities' aspirations.

Jurisdictional Forums are important but are not robust in each jurisdiction. The NTAHF functions well but even in the NT, the NTAHF is sometimes informed of important decisions about resource allocation rather than being consulted or asked to make the decision.

There also needs to be greater recognition of the role of ACCHSs in making local decisions based on their community needs as this is insufficiently recognised in the Plan. Community control is undermined if government sets all the priorities. There is evidence from Canada that transitioning to community control reduces ambulatory care related hospitalisations and that the effect is greater if services have more autonomy in how they achieve outcomes (Lavoie et al. 2010).

Recommendation 1: Strengthen Aboriginal leadership in oversighting the implementation and evaluation of this plan.

2 Social determinants

AMSANT is pleased about the emphasis on social determinants but believes this section could be stronger and should provide accountability measures around key social determinants.

2.1 Housing

Housing is not emphasised as a key social determinant when evidence suggests that overcrowded and poor quality housing is the most important factor driving poor school attendance rates (Guthridge et al. 2015) and in driving high rates of communicable diseases of poverty such as RhD, trachoma and pneumonia.

There is evidence that there is growing inequality within the Aboriginal community with reduction in incomes in remote areas (Markham et al. 2016). The life expectancy of remote Aboriginal people is only improving slowly and tragically, in the NT, female life expectancy may also be dropping (AIHW 2017). The failure to improve social determinants in remote areas is a risk to any continued improvement in life expectancy and must be prioritised.

Recommendation 2: Increase the focus on social determinants particularly in the area of housing.

2.2 Nutrition and food security

Nutrition and food security (which has a strong link to obesity) is still poorly addressed – with a focus on certain groups such as pregnant women rather than community-wide strategies (Rosier 2017). A more systemic and multi-level response is required which tackles the upstream determinants of poor nutrition (Tilton and Thomas 2012). The food basket survey demonstrates that the cost of a basket of food suitable for a family of four was 53% higher in remote stores than in Darwin and required 34% of the family income to purchase (NT Department of Health 2014).

A tax on sugar has been shown to be effective in reducing consumption and is projected to lead to the biggest health gains, particularly for people on the lowest incomes (WHO 2015). Taxes work best in combination with subsidies that increase the affordability of healthy foods such as fruit and vegetables (Cobiac et al. 2017). The impact on additional food costs for consumers can be offset by hypothecating the tax to subsidise fresh fruit and vegetables in rural and remote areas.

Recommendation 3: Improve the focus on nutrition and food security including policy changes such as remote food subsidies and a sugar tax.

2.3 Alcohol

Alcohol is a major social determinant with evidence that it causes approximately 8% of the burden of disease although this will be higher in some regions (Al Yaman 2017). Alcohol control policies are the most effective way to reduce alcohol related harm although treatment services are still a critical part of the response. The NT is leading Australia with the implementation of a raft of alcohol control measures. These include a floor price and a risk based licensing scheme. Jurisdictions should be encouraged to implement evidence based reforms on alcohol regulation given that this is critical to reducing harm to Aboriginal and other people. The Implementation Plan should include measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including through adoption of a floor price and a risk based licensing scheme.

Recommendation 4: Adopt evidence-based alcohol control policies reduce the supply of alcohol, including through adoption of a floor price and a risk based licensing scheme.

2.4 Racism

Racism is a key social determinant of poor health and wellbeing. The experience of racism may affect the physical, social and emotional wellbeing of Aboriginal people through multiple pathways. By being embedded in the ways that the health system operates, systemic racism further contributes to ill health through creating a barrier to access for Aboriginal people, and through differential access to timely health procedures (Cunningham 2002, Valery et al. 2006).

Measures for addressing racism within the mainstream health system include increasing accountability for cultural safety and establishing a national CQI system to reward quality improvement processes for hospitals in meeting the needs of the Aboriginal communities they serve, including through establishing and reporting on appropriate KPIs (see 5 *Mainstream health system*).

The capacity of ACCHS to deliver culturally safe care creates an environment where Aboriginal people do not encounter racism and this is reflected in the clear preference shown for the use of ACCHSs. Expansion of Aboriginal community controlled health services is therefore a positive

measure in lessening the racism experienced by Aboriginal people (see *6 Growth of the ACCHS sector and transition to community control*).

3 Core PHC services

The NTAHF has developed a core services framework /policy that has shaped service delivery within Aboriginal PHC across the NT. A study to estimate the cost of implementing the full core services model has been recommended by the NTAHF as well as the review of the health component of the Northern Territory Intervention (Allan and Clarke 2011). A costing study in a well-resourced ACCHS in Central Australia found that this service was under funded by about $1000 per person to implement the core services for chronic disease (Gador Whyte et al. 2014). Clearly there is likely to be substantial funding gaps given that only chronic disease was considered in this analysis.

A national core services framework should be developed which covers the span of comprehensive PHC. It may need to be adapted to a certain extent for regional priorities and the cost of implementing the framework will vary across remote, regional and urban services. As already recommended in the NT, the core services should also be costed and funded – not only in the NT but across Australia.

Recommendation 5: Develop a national core primary health care services framework.

Recommendation 6: Cost the core policy across urban, rural and remote regions.

Recommendation 7: Fund core service implementation over a five-year period.

4 CQI framework

It is disappointing that the national CQI framework has not been finalised despite the extensive consultation. This is an example of stop/start government processes that cause services and communities to be sceptical about government reform. Resources need to be allocated to finalise this framework in partnership with NACCHO and the affiliate network.

Recommendation 8: In consultation with NACCHO and the affiliates, finalise and implement the national CQI framework.

5 Mainstream health systems

There needs to be greater accountability for the cultural safety and effectiveness of mainstream services, particularly hospitals and specialist services, in providing care to Aboriginal people. AMSANT suggests that all hospitals should report on a panel of indicators which would measure cultural safety and access to care.

There has been substantial evidence that Aboriginal people get less access to hospital/specialist care compared to non-Aboriginal people (AIHWb 2017). Rates of some key sentinel procedures such as angioplasty for acute coronary syndrome, and cataract surgery disaggregated by Aboriginality would provide some indication of relative access to care.

Indicators such as discharge against medical advice suggest a failure to communicate and/or a lack of cultural safety in hospitals. For instance, a study in Alice Springs Hospital found that the majority of Aboriginal people did not know why they were in hospital (Einsiedel 2013). Evidence of

improvement in rates of sentinel procedures and unplanned discharges/discharges against medical advice would provide good evidence of improvement in access and cultural safety.

Recommendation 9: Address systemic racism in the mainstream health system by establishing a national CQI system and appropriate KPIs on cultural safety and Aboriginal access to care.

6 Growth of the ACCHS sector and transition to community control

It is pleasing that ACCHSs are recognised as central to improving Aboriginal health in the implementation plan. However, there are still very large populations that do not have access to an ACCHS. In the NT, around 60% of the episodes of care provided by the Aboriginal PHC system is provided by ACCHSs, leaving a significant proportion of Aboriginal people without access to an ACCHS. Transition to community control has been slow with only three regions in active transition. Over the last six years, only two clinics have transitioned and these have all been in East Arnhem. Risk aversion and stop-start funding have hampered outcomes, and the process is particularly lacking in support in areas where there is no ACCHS to build upon. For example, West Arnhem needs to start an ACCHS from the ground up, compared to Maningrida (where there is a well-established ACCHS providing services in partnership with government), and East Arnhem where additional clinics are being incorporated into a large regional ACCHS (Miwatj). However, with the right sustained support, establishment of new ACCHSs is achievable, as Sunrise and KWHB have shown.

The Commonwealth needs to take more leadership and responsibility for transitioning clinics and also commit to fully funding all Aboriginal PHC services once transitioned to community control, leaving the States to provide hospital and specialist services. There also needs to be sufficient funding for infrastructure given that many state clinics are unsuitable and it is not reasonable for ACCHSs to be left with the legacy of the lack of investment.

Benefits of community control include: greater cultural safety, higher proportion of the workforce being Aboriginal, greater career progression of Aboriginal people (as evidenced by the high proportion of CEOs and senior managers who are Aboriginal in the sector), and a much more comprehensive approach to delivering primary health care. ACCHSs have since their early development incorporated SEWB services /mental health and AOD services within primary health care. This is now expanding to early childhood, youth work, aged care and disability services. Aboriginal controlled organisations can access and engage hard to reach people within Aboriginal communities and multiple studies have shown that Aboriginal people prefer to attend an ACCHS. The ACCHS model has been shown to reduce mortality and outcomes across a range of areas including child health, mental health and chronic disease (AHMRC 2015). International research has documented reduced avoidable hospitalisations when government clinics transitioned to community control (Lavoie et al. 2010). However, it is important that any evaluation of the benefits and risks of transition to community control does not just focus on narrow clinical indicators such as reduced hospitalisation.

Transition to community control needs to be better supported across jurisdictions that have significant government Aboriginal PHC. There needs to be targets and timetables with some accountability back to government for not meeting these timetables.

In urban areas, access and quality of care has been improved in Alice Springs and Darwin by developing satellite clinics. The Federal Government should support this across Australia with

additional funding. Regional towns with no access to an ACCHS should be prioritised for the establishment of an ACCHS or extension of an existing ACCHS to cover that population.

Recommendation 10: Develop a plan in consultation with the states to transition government primary health care to community control and support expansion of ACCHSs in urban and regional areas including through satellite clinics.

7 SEWB/mental health

The Commonwealth Government has stated that it is implementing the recommendations of the Mental Health Commission Report *Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Service*. A key recommendation of that report was that mainstream health services had largely failed Aboriginal people and that funding should be preferentially directed to ACCHSs and then to Aboriginal PHC (Mental Health Commission 2015). AMSANT is pleased that the Commonwealth Department of Health has funded increased capacity for SEWB/mental health services for Aboriginal people. However, it is disappointing that this funding was provided directly to the PHNs with ACCHSs having to compete against mainstream providers. We understand that there was no direction to PHNs to prioritise ACCHSs. In the NT, there was a needs-based planning process overseen by the Aboriginal PHC Working Group of the NTAHF which allocated the funding equitably across the Aboriginal PHC system with prioritisation of communities that had little or no access to SEWB/mental health services.

Some Aboriginal people do not have access to an ACCHSs and there are some Aboriginal people who choose to go elsewhere for some or all of their care. However, we believe that ACCHSs should generally have been prioritised for this funding and that accountability measures should be instituted for mainstream providers to be culturally safe and effective for Aboriginal people who choose to use them.

AMSANT does not support the decision to move SEWB/AOD funding to PM&C. Indigenous health is holistic and splitting one important component into another Department has contributed to fragmentation of funding.

Recommendation 11: Prioritise ACCHSs for SEWB funding for Aboriginal people and undertake a needs-based planning approach through jurisdictional forums to allocate this funding.

8 Workforce

Workforce turnover has been shown to be particularly high in government PHC clinics in the NT and we know anecdotally that this is also an issue in very remote ACCHSs (Russell et al. 2017). One of the key recommendations made in a study which demonstrated this extraordinarily high turnover was to focus on growing and developing the capacity of the Aboriginal workforce. Aboriginal workforce is crucial to a culturally competent and effective service.

There needs to be accountability around improving Aboriginal workforce participation. In the NT, a clear contributor to the stagnation in the number of AHPs is issues with the training provider for AHPs.

There also needs to be greater funding for supporting traineeships within ACCHSs and more funding for scholarships in areas such as medicine, allied health and nursing as well as management training.

Recommendation 12: Ensure greater accountability for training providers to achieve successful outcomes across health professions for Aboriginal and Torres Strait Islander people with targets proportional to the projected population needs.

Recommendation 13: Increase scholarships and traineeships for Aboriginal people working in ACCHSs as part of a broader strategy on increasing the Aboriginal workforce.

9 NDIS

Aboriginal people with disability need to have a choice of an Aboriginal community controlled disability provider wherever possible, with ACCHSs being the obvious choice to either become disability providers or auspice new organisations. There is already very concerning feedback about the lack of cultural competence of mainstream providers. Care planners are failing to obtain enough information from the patient, family and health service to inform the plan, resulting in patients missing out on essential services. Lack of cultural competence of the care planners and failure to use interpreters and/or involve the right family in discussions are key reasons for poor quality assessments. In the NT, facilitation of ACCHSs to enter into the NDIS scheme is clearly a priority where markets have been described as "thin" and where ACCHSs are well placed to expand into disability services. Already there have been clear benefits for resourcing NDIS coordinators within ACCHSs and this needs to be expanded and supported long term in order to ensure that Aboriginal people get assessed in a culturally appropriate way and transition into appropriate care plans. Even if ACCHSs decide not to become NDIS providers, they will provide an essential role in supporting clients to access the scheme and this needs to be supported.

NIDS needs to be reformed in order to reduce the risk to Aboriginal providers, participants and their families. NACCHO and affiliates have developed a key position paper with recommendations to enable our sector with consultation underway with NDIA regarding the strategies required to implement these.

Recommendation 14: Develop a plan to support ACCHSs with capacity to become NDIS providers in consultation with NACCHO, the affiliates and NDIA.

10 Evaluation and Monitoring

There needs to be strong Aboriginal leadership of the evaluation and monitoring strategy as this is deficient across key areas.

Indigenous data sovereignty is a growing movement to ensure that Aboriginal people have control of data that is about them. The Commonwealth Government should move towards adopting data sovereignty principles.

There is a strong emphasis on the nKPIs as an evaluation tool. The nKPIs are important but not sufficient. They neglect key areas of health care delivery such as SEWB, early childhood and non-clinical areas such as cultural safety and community engagement, and health promotion /prevention.

Recommendation 15: Incorporate Indigenous data sovereignty principles into the evaluation and monitoring approach.

11 Life course approach

11.1 Maternal health

Community based midwifery is a key service that should be available in all ACCHSs, as a resident service in most and a visiting service in smaller organisations. Female Aboriginal health practitioners and/or community based workers are also key to increasing access and improving engagement, provision of clinical care (for AHPs) and health promotion in this area.

Reduction in tobacco and alcohol in pregnancy are important but are much more likely to be successful and sustainable if they are embedded in effective, well-resourced, community-wide approaches to reducing smoking and alcohol related harm. Narrow programs focusing on Aboriginal women have been somewhat disappointing, particularly in tobacco, and they can be stigmatising (Passey et al. 2013). Alcohol control policies, as have been implemented in the Fitzroy Valley, are critical to reducing FASD.

Similarly, nutrition programs targeting pregnant women are not likely to be particularly effective when food prices and poverty rates are high. Targeted programs need to be supported by jurisdictional and policy changes as outlined above. Nutrition programs also need have community leadership and operate at multiple levels rather than being narrowly directed at one target group.

Nurse family visiting programs need to be scaled up whilst ensuring fidelity to improve population coverage. The Olds Australian Nurse Family Partnership program is very strongly evidence-based and there is now emerging evidence from Central Australian Aboriginal Congress of a marked impact on child protection notifications and out of home care.

Recommendation 16: Ensure midwifery is a core essential service for all ACCHSs.

Recommendation 17: Embed nutrition, alcohol and tobacco programs targeting pregnant women into broader community wide strategies.

Recommendation 18: Scale up nurse home visiting program so there is high population coverage.

11.2 Childhood

The NTAHF has endorsed a core services approach to early childhood as outlined in the policy: *What are the key core services needed to improve Aboriginal child outcomes in the NT. Progress and possibilities.* This sets out some key principles for effective early childhood services including that they must be evidence based, culturally appropriate and have Aboriginal leadership and co-design where possible. Programs should also be trauma informed and be of sufficient intensity and duration to make an optimal difference.

Core services were described across categories of antenatal and post-natal care, clinical child health care, nurse home visiting, quality early learning, parenting programs, supporting vulnerable families, nutrition and care for children with physical and developmental disabilities (NTAHF 2016). AMSANT recommends this as a national approach. The health sector sees families with young children regularly and has a key role as a service provider in this age group.

Health checks for children are prioritised in the plan. AMSANT agrees that health checks are important but they will only improve outcomes if referral services are available and effective. These include early intervention for developmental delay (a critical service), family support/parenting programs and ENT and dental services. Health promotion messages about healthy food may have

little impact on parents when faced with high food costs and crowded poorly functioning housing. A narrow emphasis on health check-ups without assessing referral pathways and ensuring these services are accessible and appropriate may have limited outcomes. The need to ensure appropriate referral options was a key lesson of the child health check initiative undertaken as part of the NTER (Allan and Clarke 2011).

Recommendation 19: Develop and implement a national core services for Aboriginal children policy that spans clinical care but also early learning programs, family support and nurse home visiting.

11.3 Adolescents

Again, health checks are useful but referral options are needed. In the NT, there is a dearth of culturally appropriate child and adolescent psychiatric services. There also needs to be youth friendly SEWB/mental health services.

Recommendation 20: Ensure suitable referral options are available for common childhood and adolescent issues including early intervention for developmental delay, parenting programs, primary mental health and SEWB services and child and adolescent psychiatric services.

11.4 Adults

Cancer screening services are critical but there is a lack of access to affordable accessible training for skills like cervical screening. This needs to be rectified.

There needs to be a greater emphasis on a public health approach to prevention and delay of chronic disease rather than just screening and treatment. The most effective approach to this will be through improved social determinants but health promotion and prevention approaches within primary health care are also important. These need to be better developed and then evaluated.

Chronic complex disease care requires a multidisciplinary approach with strong allied health and Aboriginal practitioner input. Peer worker approaches may be useful and should be supported and evaluated. Implementing a core services approach will ensure that the full gamut of services required to prevent and manage chronic diseases are resourced.

Recommendation 21: Further develop the multidisciplinary workforce required to prevent, delay and manage complex chronic disease and better resource health promotion /prevention in this area.

11.5 Ageing on country

Ageing on country needs more support and development of a community controlled aged care sector.

Recommendation 22: Support ageing in country and growth of a community controlled aged care sector.

12 Targets

The clinical targets chosen are appropriate but narrow. Most do not have a strong evidence base linking achievement of the target to improved health outcomes. They are largely focused on screening and to a lesser extent, treatment of chronic disease. Clearly this is a high priority but there

needs to be a wider span of indicators that cover other key areas of health care delivery including cultural safety, health promotion/prevention and action on the social determinants.

Smoking targets are evidence based but tobacco control programs needs more investment in PHC. The targets should be reviewed to see if some can be included that better reflect the breadth of comprehensive primary health care.

Recommendation 23: In partnership with the sector develop targets and indicators that reflect the breadth of comprehensive primary health care including critical non-clinical components such as cultural safety and community engagement and health promotion.

References

Aboriginal Health & Medical Research Council. (2015). Aboriginal communities improving Aboriginal health: An evidence review on the contribution of Aboriginal Community Controlled Health Services to improving Aboriginal health. Sydney: AH&MRC.

AIHW (2017). NT Aboriginal Health Performance Framework

AIHW (2017b). Australian Aboriginal Health Performance Framework

Al-Yaman F. The Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people, 2011. *Public Health Res Pract.* 2017; 27(4):e2741732.

Allen and Clarke 2011, Evaluation of the Child Health Check Initiative and the Expanding Health Service Delivery Initiative: Final report, Department of Health and Ageing, Canberra.

Cobiac LJ Tam K, Veerman L, Blakely T Taxes and Subsidies for Improving Diet and Population Health in Australia: A Cost-Effectiveness Modelling Study. *PLoS Med*. 2017. 14(2): e1002232. doi:10.1371/journal.pmed.1002232

Cunningham J (2002). "Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous." *Medical Journal of Australia* 176(2): 58-62

Department of Health (2015). Market basket survey 2014

Gador-Whyte, A Wakerman J, Campbell D, Lenthall S, Struber J, Hope A and Watson C (2014), Cost of best-practice primary care management of chronic disease in a remote Aboriginal community. *Med J Aust* 2014; 200 (11): 663-666. || doi: 10.5694/mja13.11183

Guthridge S1, Li L1, Silburn S2, Li SQ1, McKenzie J2, Lynch J3.J Paediatr Child Health. 2015 Impact of perinatal health and socio-demographic factors on school education outcomes: A population study of Indigenous and non-Indigenous children in the Northern Territory. Aug; 51(8):778-86. doi: 10.1111/jpc.12852. Epub 2015 Mar 9.

Lavoie JG, Forget EL, Prakash T, Dahl M, Martens P, and O'Neil JD (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Soc Sci Med*. 2010 Aug; 71(4):717-24.

Einsiedel LJ, van Iersel E, Macnamara R, Spelman T, Heffernan M, Bray L, Morris H, Porter B, Davis A (2013) study. *Aust Health Rev*. May; 37(2):239-45. doi: 10.1071/AH11087.

Markham F and Biddle N 2016, Income, poverty and inequality. 2016 Census paper 2. CAEPR, ANU, Canberra

Mental Health Commission Report (2015) *Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Service*

Northern Territory Aboriginal Health Forum. What are the key core services needed to improve outcomes for Aboriginal children in the NT. Progress and possibilities?

Rosier K (Food insecurity in Australia: What is it, who experiences it and how can child and family services support families experiencing it? CAFCA Practice Sheet— August 2011

Russell D, Zhao Y, Guthridge S, Ramjan M , Jones M , Humphreys J and Wakerman J (20177). Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013–2015.Human Resources for Health2017**15**:52

Thomas D and Tilton E (2012) Northern Territory Lowitja nutrition round table report.

Valery P C, Coory M, et al. (2006). "Cancer diagnosis, treatment, and survival in Indigenous and non-Indigenous Australians: a matched cohort study." *Lancet* 367: 1842-1848.

World Health Organization. Fiscal Policies for diet and prevention of non communicable diseases. Technical meeting report, 5-6 May 2015, Geneva, Switzerland.