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Exploring Challenges of Access to Non-Communicable Disease (NCD) Prevention, Treatment and Care: A Qualitative Study on People Living with NCDs (PLWNCDS) in West Bengal, India

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Abstract:

BACKGROUND: People living with noncommunicable diseases (PLWNCDS) are often disproportionately affected due to adverse interaction with socioecological and biological factors. Hence, it is imperative to learn from their lived experience to gain a greater understanding of interactions as well as explore their priorities and needs in accessing care and identify areas of priority action through multistakeholder engagement.

MATERIALS AND METHODS: The qualitative study with grounded theory approach was conducted between October and December 2020. An online key-informant interview with the health policymaker, virtual group discussion with eight PLWNCDS, and in-depth telephonic interviews with five PLWNCDS were conducted, after obtaining informed consent using interview guide, developed, and validated by the experts. Data collection continued till data saturation was achieved. Transcripts generated from the interview recordings were coded using hand-code technique and analyzed thematically.

RESULTS: Challenges faced by PLWNCDS in accessing care were lack of empathy and support from health-care professionals, stigma, financial hardship, and hospital overcrowding. Caregivers emphasized on the felt need to involve civil society organizations (CSOs) in raising awareness toward noncommunicable diseases (NCDs) at family, community, and policymaking levels. The need for home-based NCD care and rehabilitation centers was voiced by the PLWNCDS. Impediments toward effective implementation of NCD policies were adoption of a “top-down” approach, poor awareness about government health insurance schemes, skewed distribution of empanelled hospitals in and around cities, nonavailability of qualified health-care professionals in underserved areas, aggravated allocation-utilization disparity during COVID-19 pandemic, and lack of robust information technology infrastructure to support access to telemedicine services.

CONCLUSION: The collective role of governments, CSOs, and health-care providers, along with meaningful involvement of PLWNCDS, would help to create an enabling environment for overcoming the challenges of access to care and thus achieve universal health coverage.

Keywords:

Grounded theory, health services accessibility, India, noncommunicable diseases, qualitative research

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Introduction

Noncommunicable diseases (NCDs) are the leading cause of deaths and disability globally, particularly in low- and middle-income countries (LMICs).^[1] In India, NCD burden is disproportionately higher, accounting for nearly 55% of “disability-adjusted life years” and about 60% of all deaths.^[1] Estimates suggest that 1 in 4 Indians are at risks of dying from NCD before they reach 70 years of age, and if not intervened timely, the total annual number of deaths from NCDs will increase to 55 million by 2030.^[2] In order to address the NCD burden, several policies have been outlined to integrate NCD prevention and control into the broader health and development agenda. In 2010, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke (NPCDCS) was thus launched to ensure a robust response toward NCD prevention and control.^[3] Later, it was integrated into National Health Mission (NHM) and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) to accelerate India’s progress towards the achievement of Sustainable Development Goal target 3.4, which aimed to curtail the premature deaths from NCDs by one-third by 2030.^[4,5] Despite these, disconnect was observed between the formulation and implementation of NCD-related policies that are locally appropriate and effective. Lately, the National Multisectoral Action Plan for the prevention and control of NCDs (2017–2022) underlined the need for “Whole-of-Society” and “Whole-of-Government” approach to make care pathways for people living with NCDs (PLWNCDs) more people centered and inclusive.^[6]

PLWNCDs, i.e., people with lived experiences of NCDs as well as those with active care partner experiences, are often disproportionately affected by the adverse interactions with socioecological and biological factors, around NCD prevention, treatment, support, and care, making them more vulnerable. Hence, gaining insights about their lived experience may provide an opportunity to build back better through a responsive health system that is inclusive. An initiative by the NCD Alliance, “*Our Views, Our Voices*,” was launched worldwide to promote the meaningful involvement of PLWNCDs in the NCD response by enabling individuals to share their views in order to take action and drive change. It aspired to advance the rights of PLWNCDs and combat stigma and discrimination. Healthy India Alliance (HIA) implements this initiative in India. The India Advocacy Agenda was developed in 2017 by PLWNCDs, in collaboration with HIA.^[7] The agenda advocated for a call for right-based NCD prevention, treatment, support, and care from four regions of the country.^[8]

Recognition of PLWNCDs as the “agents of change” for a comprehensive NCD response is pivotal. Their voices and views have the potential to provide insights in shaping future NCD programs that are inclusive and could cater to the need both at national and subnational levels. The themes arising from this participatory qualitative research would therefore help to identify areas of priority actions for a stronger NCDs response. Hence, the study was conducted to explore the challenges faced by PLWNCDs, including their caregivers, in accessing care and identify areas of priority action through multistakeholder engagement.

Materials and Methods

Study design and setting

This qualitative study followed a constructivist grounded theory (CGT) approach which helped in understanding the social process or phenomenon inductively and thereby constructing newer understandings from participants’ lived experiences. Since there has been no known theoretical framework explaining the role and challenges of PLWNCDs in accessing prevention, treatment, and care for NCDs, CGT has been used to generate conceptual frameworks in an inductive way.^[9-12]

Study participants and sampling

The participants in this study included health policymaker and PLWNCDs. The health policymaker was purposively chosen for the key-informant interview (KII) based on the involvement in NCDs policy development and implementation processes at national and regional levels. The PLWNCDs aged above 18 years and residing in West Bengal were purposively identified through two state-level civil society organizations (CSOs). They had a long history of living with NCDs and hence were able to share their lived experiences to inform action. The principal researchers, who had extensive experience in qualitative research, contacted potential participants over telephone, and after obtaining initial consent for interviewing, meetings were scheduled with the identified stakeholder and PLWNCDs.

Data collection tool and technique

Three approaches were used for qualitative data collection from October to December 2020. These included an online KII with a health policymaker, five in-depth interviews (IDIs) with PLWNCDs, and one virtual group discussion (VGD) with eight PLWNCDs [Table 1]. Saturation of information occurred after VGD. IDIs helped in exploration of individual experiences and perspectives, whereas VGD potentially enabled participant interactions and thereby stimulated the identification and sharing of various perspectives on the same topic in eliciting data

from the group of participants that they might not have conveyed individually. Data triangulation combining these approaches helped in broader understanding of the contextual factors. All interviews and discussions were conducted in local language (Bengali) over virtual platform and audio recorded and transcribed appropriately.

The first author moderated the interviews and discussions with the participants using qualitative interview guides which were developed following extensive review of literature and validated by the experts working in the field of NCDs. The questions contained in the KII guide revolved around three broad domains “problem from NCDs,” “NCD policy development and implementation process,” and “impact of the policy on existing NCD care” at national and regional levels. Guides used in VGD and IDIs inquired about the participant’s “experiences in accessing NCD prevention, treatment and care services” based on four key pillars identified in the India Advocacy Agenda of PLWNCDs – human rights and social justice; prevention; treatment, care, and support; and meaningful involvement. Interviews continued till data saturation was achieved.^[13]

Data analysis

Data analysis was conducted manually using an inductive thematic approach. Initial transcriptions were prepared from the interview recordings using word processing software. Quality of the initial transcript (quotations, sentences, or words) was checked by all authors so that it is consistent with participants’ views. The transcripts were then translated into English and initial coding was done separately by two co-investigators. Inductive approach using constant comparative method was adopted in the coding process, where codes were identified by comparing patterns and meanings that emerged from participants’ expressed views. All the authors reviewed the codes and codes were then arranged into emerging themes using thematic approach as described by Nowell *et al.*^[14] Quotable quotes reflective of participants’ perspectives are also being presented to illustrate the thematic findings in this study.

Ethical consideration

Informed written consent was obtained from each participant before collecting data. Ethics approval was obtained from Institutional Ethics Committee of All India Institute of Hygiene and Public Health, Kolkata.

Results

Respondents in VGDs and IDIs were people diagnosed with single or several NCDs, namely diabetes mellitus, hypertension, coronary heart disease, depressive

disorder, and metastatic cancers. In addition, some PLWNCDs also worked as care provider to other PLWNCDs and thereby had multitude of experiences. Background characteristics of the participants are presented in Table 2.

Themes that emerged from inductive qualitative analysis were categorized into (a) challenges faced by PLWNCDs in accessing NCD prevention, treatment, and care services, (b) felt needs of PLWNCDs in accessing care, (c) NCD policy implementation barriers, and (d) NCD policy implementation enablers. Conceptual framework based on the findings from the qualitative interviews and discussions is illustrated in Figure 1.

Table 1: Approaches used in qualitative data collection

Data collection types	Participants	Focus of discussion/ interviews
KII	A policymaker with experience in NCD policy development and implementation process at central and state level	NCD burden in India, community awareness, NCD policy development and implementation (through NPCDCS, AB-PMJAY, etc.) at national and regional level
VGD	1 VGD with 8 PLWNCDs, caregivers	Experiences, challenges, and felt needs in accessing NCD care and support
IDIs	5 IDIs with 5 PLWNCDs	NCD care-seeking experiences, challenges, and felt needs based on four key pillars: Human rights and social justice; prevention; treatment, care and support, and meaningful involvement

KII=Key informant interview, VGD=Virtual group discussion, IDIs=In-depth interviews, NCD=Noncommunicable disease, PLWNCDs=People living with NCDs, NPCDCS=National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke, AB-PMJAY=Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana

Table 2: Background characteristics of the virtual group discussion participants (n=8), in-depth interview participants (n=5) and key informant interview participant (n=1)

Characteristics	VGD participants	IDI participants	Key-informant
Age range (years)	30-55	30-50	62
Gender			
Male	2	2	1
Female	6	3	-
Occupation			
Professionals	4	3	1*
Homemaker	1	1	-
CHWs (CSOs)	3	1	-

*Health policymaker. CHWs=Community health workers, CSOs=Civil Society Organizations, VGD=Virtual group discussion, IDI=In-depth interview

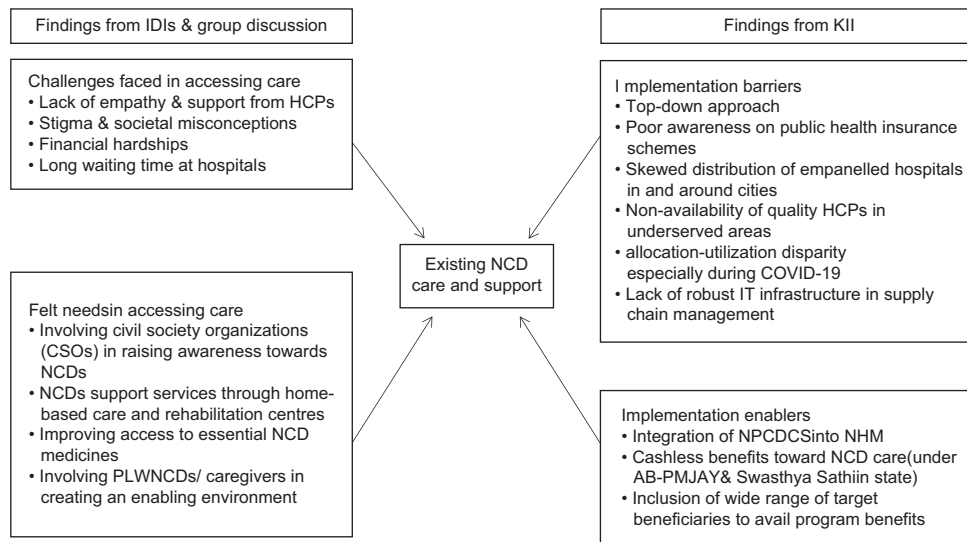


Figure 1: Conceptual framework based on the findings from the qualitative interviews and discussions

Challenges faced by people living with noncommunicable diseases/caregivers

Lack of empathy and support from health-care providers

Empathetic therapeutic relationship between PLWNCs and HCPs is critical to ensure effective communication and optimal treatment outcomes. Majority VGD (6 out of 8) and IDI (3 out of 5) participants felt that many a times their HCPs did not acknowledge their feelings, concerns, and expectations effectively during health-care consultations. In this regard, a participant stated,

“...Often it is difficult to communicate with the doctor... he (doctor) often gets irritated if we ask questions for clarifications...I know it is not always possible to clear all doubts at one go...” (VGD participant, person living with depressive disorder).

Another participant remarked, “...9 years back I was diagnosed with B-cell lymphoma. Initially I had only face swelling and was “misdiagnosed” as hypothyroidism... if I had not sought treatment from outside I would not have survived this long... the doctors here are less bothered...” (VGD participant, person living with cancer [B cell lymphoma]).

In contrast, another participant mentioned, “...I am perfectly content with the way I have received assurance and assistance from our family doctor, especially in this COVID situation...” (VGD participant, person living with coronary heart disease and diabetes mellitus).

Stigma and societal misconceptions

Perceived and experienced stigma related to NCDs, especially with mental health illness, was well evident from participants’ reflections.

One of the participants after being diagnosed with cancer was depressed initially. She remarked, “...I used to wonder why this has to happen to me?!...” Despite the challenges, her family supported her throughout. She felt, “Stigma towards cancer is well prevalent...but with the support of my family members I have been able to overcome the psychological difficulties as well...initiatives must be taken to reduce stigma especially in work-places.” (IDI, person living with cancer).

Another participant who has been living with depression for the past 3 years stated, “During initial days, I had repeated suicidal thoughts, low mood and recurrent mood swings. The symptoms had almost grappled me. It was only during my third (suicidal) attempt, that, I realized the need to seek professional psychiatric care. However, seeking care was not that easy for me.” She further iterated, “...people, including many of my (doctor) colleagues, have notion that psychiatric care is all about having “sedatives...” we (people) have failed to recognize the role of specialists for managing psychiatric illnesses...” (IDI, caregiver and person living with depression).

A participant expressed similar stigma-related concern, “...I had the insights about my depression from very early days, but was unable to share my pain, feelings and sufferings through which I was passing. As the symptoms of depression are not visible and often overlapping, our family and friends think that we are dramatizing! Even at workplace, we feel uncomfortable to talk about our mental health issues...” (VGD, person living with depression, diabetes mellitus).

Financial hardships

All the VGD and IDI participants were of views that NCDs pose a heavy financial burden and also opined about the urgency to improve financial risk protection against NCDs.

A caregiver to a person with end-stage renal disease pointed out, "... these diseases (NCDs) can make one's life miserable financially and mentally... however, with family support that we have been able to overcome all the challenges.." (VGD, person living with diabetes and caregiver to a person with end-stage renal disease).

Another participant remarked, "I also did not have to face any financial struggles in seeking cancer care but I have seen many fellow people facing extreme financial hardships ... in most cases this is due to lack of health insurance coverage... in case of serious financial distress "we" provide assistance to those in dire need of treatment (cancer care). (Cancer survivor, CSO volunteer, and NCD caregiver).

Another person living with cancer remarked, "...the main challenge was financial, the cost of chemo and radiotherapy were too high...as my treatment was out of my hometown, beside language barrier, the out-of-pocket expenses were high... Government must step forward to address the issue of financial hardship for those living with cancer..." (IDI, person living with cancer).

Voicing similar concerns, a participant stated, "Family support and financial resources were adequate, so accessing care was not a problem for me, but this is not the case for majority of us. Since, people with chronic liver disease require lifelong treatment, the cost involved is high ...it is a big issue, especially in rural and underserved areas..." (IDI, person living with chronic liver disease).

Due to lack of awareness, a VGD respondent reportedly had incurred out-of-pocket expenditure for hospitalization episodes despite being covered by public health insurance scheme. She stated, "...I was not aware about the scheme benefits...otherwise I would have used it..."

Long waiting time at hospitals

All participants had views that accessing NCD care at public health facilities was challenging owing to high patient volume, limited consultation time, and long waiting times. One participant pointed out, "... the outpatient of one of the few tertiary care centre providing specialized (hepatology) care remains overcrowded...as majority of people seek care at these public hospitals...it often pose a challenge in receiving quality healthcare..." (IDI, person with chronic liver disease).

Felt needs of people living with noncommunicable diseases/caregivers

Involving civil society organizations in raising awareness toward noncommunicable diseases

All participants agreed that the spectrum of NCDs is so broad that there is a need for specialized training and capacity building of family members and primary caregivers to understand the needs of those living with NCDs.

All participants felt that in resource-limited settings like in India, different social networks, CSOs, and patient-driven groups could serve as a facilitator in sensitizing people about NCD risks, early screening, referral, and follow-up along the care continuum pathway.

One participant stated, "... ones" journey starts before onset of symptoms...often we are unable to make decisions... involving patient support groups (CSOs) may help decrease the burden on us..." (IDI, person with NCDs and caregiver to person with diabetes).

Workshops and community engagement were seen as enablers to raise awareness on mental health. Another remarked, "... we cannot wait till the (mental health) diseases hit the community at large...we have to prepare ourselves through awareness and other preventive measures..." (VGD, person living with NCDs and caregiver to dementia patients).

Noncommunicable diseases support services through home-based care and rehabilitation centers

A participant stated, "...when my mother had cerebral stroke 13 years back, I was completely unaware about how to move forward..." The participant stressed upon the need for quality "trained NCD support services" in India and added, "...the rehabilitation centres that are available have no experience and often get into the trade without knowing what to do exactly...need of the hour is to develop specialized rehabilitation centres where we can get treatment and rehabilitative support for cerebral stroke patients..." (VGD, person living with diabetes, hypertension, caregiver to stroke patient).

Improving access to essential noncommunicable diseases medicines

All participants were of opinion that access to essential NCD medicines needs to be improved. In this context, the KI pointed that "...Public health focus is more towards communicable disease, maternal and child health and related services rather than on NCDs...in order to improve access this has to change...more resources need to be allocated towards NCDs".

The participants also put forward the challenges faced by them. One participant shared her lived experience, "...buying anti-depressants from pharmacies is not always easy...it often involves "stigma" surrounding mental health.. by and large, people still are not empathetic toward people with psychiatric illness.. this further aggravates (my) symptoms..." (VGD participant, person living with depressive disorder).

Another person living with NCD, a caregiver pointed out how difficult it has been for people

living with type 1 diabetes mellitus to get access to essential medicines like insulin, especially during this pandemic!

Involving people living with noncommunicable diseases in creating an enabling environment

The chronic nature of NCDs demands an integrated, responsive, and people-centered approach. Involving PLWNCs may act as a key component in creating a responsive health system that will enable PLWNCs to make informed decisions in the care-seeking continuum. All participants stressed on the need for family and social support to tackle NCDs on a day-to-day basis. Majority were of the opinion that most of the times, their voices were not heard and more focus was on curative care.

However, one participant expressed different views, *"...We attended several workshops on lifestyle modifications; this had helped in better adherence to treatment and adopting healthy lifestyle.. this has in a great way helped us in educating our peers and neighbours!"* (VGD participant and person living with diabetes mellitus).

A participant was of the opinion, *"...Engaging people with NCDs in the care seeking process will not only facilitate timely diagnosis, shared decision-making on treatment and continued care but will also help in tackling stigma and build a responsive health system..."* (IDI, caregiver, and person living with depression).

Noncommunicable diseases policy implementation barriers

Top-down approach

The KI pointed out that "NCD policy development and implementation processes" in the country are not "people-centered" and mostly follow a "top-down approach," often affecting peoples' participation in the screening programs. He stated, *"...public health focus is more towards communicable diseases rather than on NCDs... in spite of having several national programmes (for NCDs) peoples participation in seeking NCD care is not overwhelming mostly because of the top-down approach."*

He also highlighted the need for incorporating more number of public health professionals into public health service to counter the "strong bias" that is prevalent toward "curative care."

Poor awareness of public health insurance schemes

Community-level gaps in awareness on public health insurance schemes such as AB-PMJAY at the national level and Swasthya Sathi at the state (West Bengal) level pose a major challenge for early initiation of treatment and receiving quality of NCD care. He reiterated, "...

Enrollment level in these (public insurance) programmes is satisfactory...however gap exists in awareness about packages and benefits among those enrolled ..." He also agreed that efforts for creating awareness and increasing enrollment and utilization of these schemes were not consistent.

Skewed distribution of empanelled hospitals in and around cities

The KI was of the opinion, *"...Empanelled hospitals are skewedly distributed and are mostly concentrated in and around big cities...moreover some "big" hospitals are reluctant to join Swasthya Sathi, owing to its lower package rates... this problem is also evident in other parts of the country where AB has been implemented..."*

Nonavailability of quality health-care providers in underserved areas

The KI was of the opinion that lack of trained HCPs, especially in the underserved areas, had hindered effective implementation of NCD policies including screening, health promotion and prevention activities as envisaged in the national NCD programme. He stated, *"...Frontline health workers like Accredited social health activists are visibly overburdened by the tasks they have to accomplish...often hindering effective implementation of NCD policies!"*

He remarked, *"...given these challenges, a growing number of Quacks (unqualified HCPs) in the rural areas and slums are providing NCD care without adhering to treatment protocols!"* To his opinion, *"...as they (Quacks) are often the first point-of-contact, they can be a very good extension arm of public health...not only in NCD prevention and control... but their service can be utilized in outbreak/pandemic control as well ..."*

Aggravated allocation-utilization disparity, especially during COVID-19

The KI reported that lack of prioritization while allocation of resources, especially during the COVID-19 pandemic, has affected the effective implementation of NCD control strategies along the care continuum pathway: awareness, screening, diagnosis, treatment, and follow-up. He remarked, *"...you won't believe in some places the doctor-patient ratio is as low as 1:20,000!"*

Lack of robust information technology infrastructure in supply chain management

The KI also stressed on the need to strengthen the inventory management systems in health-care facilities using robust Information technology infrastructure so as to maximize utilization of services and minimize wastage and misuse.

Noncommunicable diseases policy implementation enablers

Integration of national program for prevention and control of cancer, diabetes, cardiovascular diseases, and stroke into national health mission

Integration of NPCDCS with the NHM and later on its integration with the flagship program AB-PMJAY facilitated a synergistic approach to address NCDs in India. KI reported that "...although there is no separate component, free diagnostics and management of NCDs are incorporated within the service packages...thereby improving access to quality NCD care..."

Cashless benefits toward noncommunicable diseases care (under Ayushman Bharat-Pradhan Mantri Jan Arogya yojana and Swasthya Sathi in state)

The KI pointed out that beneficiaries covered under the schemes can avail cashless benefits in preapproved hospitals for diagnostics, treatment, and hospital stays including that for NCDs. Both these programs were seen as an attempt to move from sectoral and segmented approach of health service delivery to a comprehensive need-based health-care service.

Inclusion of wide range of target beneficiaries to avail program benefits

KI stated, "...although the program components in 'Swasthya Sathi' are similar to AB-PMJAY, it included a larger number of target beneficiaries like artisans, folk artists, journalists who were otherwise not eligible under AB-PMJAY...thereby improving access to quality care to considerable proportion of target population..."

Discussion

Key findings

In resource-limited settings, such as India, where there is a growing burden of NCDs, understanding the journey of those living with NCDs through their lived experiences and narratives may provide critical insights to shape NCD policies that are appropriate, equitable, and context specific.^[15,16] The qualitative research based on grounded theory followed a novel approach in understanding PLWNCDs care-seeking journey through multistakeholder engagement in an eastern state of India. Insights from this study will not only support health-care professionals in appreciating patients' needs but will also help inform the policymakers to build back a responsive health system based on local evidence. Findings are summarized in four thematic areas: challenges faced in accessing care, felt needs in accessing care, NCD policy implementation barriers, and enablers. Our findings suggest that health-care system in the country is not responsive enough to mitigate the risks of NCDs in the midst of the ongoing pandemic.

What is already known and what this study adds

Similar to our study findings, evidence highlighted the need for a shift from traditional, provider-driven, disease-focused approach toward people-centered care integrating their preferences, needs, and experiences into every phase of the journey.^[16,17] Our study findings revealed that challenges revolved around poor awareness, societal misconceptions, difficulties in accessing essential NCD care, and follow-up. A review suggested that health-care interventions designed to improve the disease journey of an individual must incorporate the people-centered perspective at each touch point in the health-care system: awareness, screening, diagnosis, treatment, and adherence to build a resilient and responsive health system.^[16]

Another study also pointed out that lack of awareness about NCD prevention and control strategies is well evident in India, and without tailored behavior change communication based on peoples' perspectives, the NCD sensitization programs would never be effective.^[18] Several health promotion and health behavior theories/models should be adapted while developing tailored intervention strategies to prevent NCDs.^[19,20]

Barriers related to lack of trained workforce, inefficient logistic management that had emerged from the qualitative interviews also corroborated well with the findings from a previous study in Nepal.^[21] Another study In LMICs, similar to our findings, argued that the challenges are more in terms of allocation-utilization disparity of NCD-related resources and gaps in the supply systems.^[22] Findings suggest that care pathways in PLWNCDs are complex with multiple entries and exit points. Hence, meaningfully involving those with lived experiences along common touch points in the care pathway may help informed decision-making and improve disease care.^[23] The key informant in the current study reported that lack of prioritization while allocation of resources, especially during the COVID-19 pandemic, has affected the effective implementation of NCD control strategies along the care continuum pathway: awareness, screening, diagnosis, treatment, and follow up. Findings from a mixed method study which explored the effect of the COVID-19 pandemic on NCD care in India revealed that nearly two-third of study subjects faced challenges in their routine investigation, day-care procedures, and reaching hospital. Other challenges mentioned in the study, were difficulty in doctor appointments, emergency treatment, access to the pharmacy, and delay in health care.^[24] In order to achieve global NCD targets, integrating multifaceted people-centered approach, capacity building of the HCPs, sustaining programs (such as AB-PMJAY, Swasthya Sathi) benefits,

and building a resilient and responsive health system are necessitated.

Strengths and limitations

The study captured the perspectives of various stakeholders including PLWNCDS, policymakers and data triangulation was done using different approaches of qualitative inquiries. We used adaptive strategies to conduct interviews over virtual platform. It provided platform for the participants to share their perspectives in the midst of the COVID-19 pandemic. Although the study lacks generalizability owing to its design and purposive sampling, every effort was made to ensure its transferability using rigorous methodology so that findings can be transferred to similar settings.

Conclusion and Recommendation

In resource-constrained settings like in India, growing burden of NCDs is a major barrier toward achieving sustainable development goals and universal health coverage. To address this, both PLWNCDS and health-system related barriers should be addressed and facilitators should be strengthened at a programmatic level. Recognition of PLWNCDS as “agents of change” along with the collective role of governments, civil society, and other health-care partners will provide opportunities to achieve “Health for All” through promotion of good practices, key enablers, and experience sharing so that “no one is left behind” along the path toward the Sustainable Development.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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