#

# **NATIONAL STRATEGIC PLAN FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES 2021-2026**

***“Health is both a contributor to, and a beneficiary of, all of the Sustainable Development Goals (SDGs).”***

Tedros Adhanom Ghebreyesus. Director-General, World Health Organization1

***“Non-communicable diseases are widespread.  They have many dimensions, numerous causes, and countless undesirable consequences.  But, there are proven ways to prevent and manage them.”***

António Guterres. UN Secretary-General 2018.

***“We will tackle Non-Communicable diseases working with partners– we will screen and put people on treatment for diabetes, hypertension, cancer, and we will provide integrated mental health services. We will accelerate our efforts on screening and early detection of cancers to ensure that we provide timeous oncology services. We will continue to address risk factors and promote health and prevent these silent killers.”***

Dr Zweli Mkhize, Minister of Health, Budget vote 2019

***“Non communicable diseases continue to outstrip infectious diseases in South Africa according to STATS -SA. A huge chunk of the deaths are due to diabetes and cardiovascular diseases including strokes. Cancer has also been rising to epidemic levels. These developments can be attributed to urbanisation, commercial determinants of health, risk behaviour such as tobacco use, harmful use of alcohol, unhealthy diets and lack of physical activity.”***

Dr Joe Phaahla, Deputy Minister of Health, Budget vote 2019

***“The COVID-19 pandemic in South Africa underscores that living with an NCD makes us significantly vulnerable with an even greater risk of dying prematurely. The pandemic exposes NCDs inequity in the health system requiring urgent, coordinated all-of-society and all-of-government policy and implementation along with adequate resources.”***

Dr Vicki Pinkney-Atkinson, CEO South African NCDs Alliance and person living with multiple NCDs since birth 2020.

**FOREWORD**

**ACKNOWLEDGEMENT**

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**GLOSSARY OF TERMS**

A **non-communicable disease**, or **NCD**, is a health condition or disease that used to be considered non-infectious and cannot be passed from person to person. NCDs are usually chronic diseases of long duration and slow progression, or they may result in more rapid death such a sudden heart attack. In terms of the SDG
 According to thethe four main types of non-communicable diseases are cardiovascular and cerebrpvascular conditions (e.g. heart attacks and stroke), cancer, chronic respiratory diseases (e.g. COPD and asthma), diabetes and mental health. However, there is a call for the inclusion of related conditions that cause and diabetes but other non-communicable diseases include neurological diseases such as epilepsy, mental health disorders and genetic disorders.

**Best buys**: link to cost-effective interventions for modifiable risk factors. (1)

Cardiovascular and cerebrovascular disease and diabetes: (CCVDD) A group of conditions that are including metabolic and endocrine conditions. The most common group ……….

[**Continuum of NCDs care**](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211412/) **(CoNC):** A public health tool that helps to plot and understand all stages of a NCDs by 2 or more of the following dimensions: progression (when), setting of care/ level (where), what (points on the life course) and caregivers including self-care (who). Adapted for NCDs and disabilities. It is linked to the concept of integration

**Control:** Deliberate and continuous forms of treatment including rehabilitation and palliative care to reduce morbidity and mortality from condition.

**Disease prevention** for the purposes of this strategy; refers to actions that are aimed at preventing a disease from occurring and should disease occur, prevention aims to eliminate or minimise the impact of disease, including disability or death. Levels of disease prevention (i.e primordial, primary, secondary and tertiary) are defined below.

**Health in All Policies** (HiAP) an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government.(2)

**Free sugars:** all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus the sugars that are naturally present in honey, syrups and fruit juices. Monosaccharides have one sugar molecule e.g glucose, galactose and fructose. Disaccharides have two molecules .e.gs sucrose or table sugar.

**Health Promotion** is the process of enabling people to increase control over, and to improve, their health to reach a state of complete physical, mental and social well-being.

**Integrated health services:** Integrated health services: the management and delivery of health services such that people receive a continuumof health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.

**Management:** Actions and activities to achieve control of a health condition

**Multisectoral action:**Action between two or more sectors within the public sector and is generally interchangeable with “intersectoral action.

**Mutlisectoral collaboration:** A recognized relationship between part of parts of different sectors of society, such as ministries (e.g. of health or education), agencies, NGOs, private for-profit sector and community representation) which have been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.” (Source: WHO Country Cooperation Strategy)

**Modifiable risk factors** A kind of risk factors that can be reduced or controlled by intervention, reducing the probability of disease. The four major ones include; physical inactivity, tobacco use, harmful use of alcohol, and unhealthy diets (increased fat and sodium, with low fruit and vegetable intake).

**National Health Insurance (NHI**): A financing system that will ensure that all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund. NHI is the mechanism through which South Africa aims to achieve universal health coverage.

**NCDs indicators:** An indicator in NCD prevention and control is a number, proportion, percentage or rate that helps measure (“indicate”) the extent to which planned activities have been conducted (process and output indicators) and achievements have been made (outcome and impact indicators).

**Non-modifiable risk factors** are mainly biological factors which cannot be reduced or controlled by intervention; for example: age, gender, race, and genetic predisposition as a result of family history.

**NPO:** Non-profit organisation legal definition needed

**Palliative care for NCDs: An** approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual[[1]](#endnote-2). Palliative care is a crucial part of IPCHS. Thus, whether the cause of suffering is cancer or major organ failure, drug-resistant tuberculosis or severe burns, end-stage chronic illness or acute trauma, extreme birth prematurity or extreme frailty of old age, palliative care may be needed and integrated at all levels of care[[2]](#endnote-3).

**Presenteeism:** the practice of coming to work despite illness, injury, anxiety, etc., often resulting in reduced productivity

**Primary prevention**: actions that aim to protect the health of individuals by modifying risk factors for diseases through personal and communal efforts.

**Primordial prevention:** population level measures that prevent the development of modifiable risk factors and include policy, programs, education and environmental changes to support healthy ways of living.

[**Risk factor**](https://www.bhf.org.uk/~/media/files/publications/healthy-hearts-and-chest-pain-kits/session-4_risk-factors.pdf) is something that increases your chance of getting a disease and usually the more risk factors you have the greater chance you will getting the disease or condition. Risk factors are classified as either mondifiable (ones that you can do something about) and non-modifiable about which you can’t do much about. E.g, Age, ethnic background or family history.

**Secondary prevention**: heath interventions available to individuals and communities for the early detection and (screening and diagnosis) and prompt intervention9s) manage and control disease, reduce mortality and minimise disability and the burden of disease (morbidity).

**Tertiary prevention:** measures aimed at softening the impact of chronic disease and disability thereby minimising suffering and maximising years of useful life it include rehabilitation and palliative care.

[**Treatment**](https://www.lawinsider.com/dictionary/medical-treatment)**:** management and care of a person for the purpose of controlling or curing a disease, injury, or disorder, and includes both medical and surgical interventions.

**Universal health coverage**: The overarching goal of the health sdg (SDG 3) *means* that all people and communities have access to equitably available promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose them to financial hardship.

“**Whole of Government**” approach: onne in which public service agencies work across portfolio boundaries, formally and informally, to achieve a shared goal and an integrated government response to particular issues. It aims to achieve policy coherence in order to improve effectiveness and efficiency. This approach is a response to departmentalism that focuses not only on policies but also on programme and project management.” (Source: WHA A68/17, footnote 2)

**LIST OF ABBREVIATIONS**

|  |  |
| --- | --- |
| AIDS | Acquired-Immune Deficiency Syndrome corrected |
| CBOs | Community based organisations |
| CCMDD | Centralised Chronic Medicines Dispensing and Distribution  |
| CoCN | Continuum of NCDs care |
| COPD | Chronic obstructive pulmonary diseases |
| CCVDD | Cardiovascular and cerebrovascular disease and diabetes  |
| DHS | District Health Service |
| FBOs | Faith-based organisations  |
| FCTC | Framework Convention on Tobacco Control (WHO) |
| GDP | Gross Domestic Product |
| HbA1c | Glycated or glycosylated haemoglobin |
| HDL | High density lipoprotein |
| HiAP | Health-in-all-policies |
| HIV | Human Immunodeficiency Virus  |
| HMIS  | Health Management Information System  |
| HPV | Human papilloma virus |
| ICSM | Integrated Clinical Services Model  |
| IPCHS | Integrated people-centred health services (WHO) |
| ISHP | Integrated School Health Policy  |
| LMIC | Low- and middle-income countries |
| MAP | National multisectoral action plan |
| NAPHISA | National Public Health Institute of South Africa |
| NCDs | Non-communicable diseases |
| NDoH | National Department of Health  |
| NDP | National Development Plan 2030 |
| NGOs | Non-governmental organisations |
| NHI | National Health Insurance |
| NIDS | National indicator data set South Africa |
| NSP | National Strategic Plan |
| PDoH | Provincial Department of Health |
| PHC | Primary health care  |
| PHM | Public health medicine |
| PLWNCDS  | People living with NCDs |
| PPP | Public-private partnership |
| SA | South Africa |
| SADHS | South African Demographic and Health Survey  |
| SAGE | Study on Ageing and Adult Health  |
| SANHANES  | South African National Health and Nutrition Examination Survey |
| SDGs | Sustainable Development Goals |
| SDH | Social determinants of health |
| **SMART:** | Specific, measurable, achievable, realistic and timebound |
| StatsSA | Statics South Africa |
| T2DM | Type 2 diabetes mellitus |
| TB.  | Tuberculosis  |
| TC | National NCDs Technical Committee  |
| UHC | Universal health coverage |
| WGA | [Whole of government approach](https://www.who.int/global-coordination-mechanism/dialogues/glossary-whole-of-govt-multisectoral.pdf) |
| WHO | World Health Organization |
| WOS  | Whole of society approach |

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# CHAPTER 1: THE BURDEN OF NON-COMMUNICABLE DISEASES

## INTRODUCTION

Non-Communicable Diseases (NCDs), including mental disorders, currently pose one of the biggest global threats to health and development, particularly in low- and middle- income countries (LMIC)2. It is predicted that unless proven interventions are rapidly implemented in countries, in the short to medium-term, health care costs will increase exponentially and severe negative consequences will ensue not only to individuals and families but to whole societies and economies. NCDs are already a major burden in South Africa, but without dedicated and focused health and development action the consequences are likely to be catastrophic. High quality, evidence-based and focused interventions are needed immediately to promote health, prevent disease and provide equitable and more effective care and treatment for people living with NCDs (PLWNCDs). These interventions should be available throughout the health system and should cater to all PLWNCDs, across age and ethnic groups, provinces, and gender. The problem is further compounded by the rising global prevalence of multi-morbidity in which two or more chronic diseases coexist in one individual.

The significant cost, burden of disease and disability (highlighted in the chapters below) may be avoided through robust, evidence informed, context specific and comprehensive health prevention and promotion strategies15 that address the modifiable risk factors associated with NCDs, especially given that prevention and promotion interventions are understood to be more cost-effective than interventions aimed at treatment, management or cure. To achieve this, a multisectoral approach is critical. Poverty, rapid urbanization and industrialization, population ageing, the effects of globalization of marketing and trade, and other social, cultural and commercial determinants of health are among the main contributing factors to the rising incidence and prevalence of NCDs.

There is now overwhelming and broad consensus that a “health-in-all-policies” (HiAP), “whole-of-government” (WOG) and “whole-of-society”(WoS) approaches must be adopted in order to comprehensively address NCDs mortality and morbidity16. It is almost certain that without comprehensively addressing these determinants of health, Sustainable Development Goal 3.4. and the majority of the nine voluntary NCD targets set by the WHO Global Action Plan for the Prevention and Control of NCDs17 will not be reached. The WHO High level Commission on NCDs and the 2018 United Nations General Assembly Declaration stated that both the heads of state and government And the health ministers, must oversee the process of creating ownership at national level of NCDs and mental health2,8. The purpose of this NSP is therefore not only to provide a vision and guidelines for the health sectors NCD activities but a framework for non-health departments and stakeholders to utilise as they consider their own policies and activities.

In South Africa, over the past two decades a number of health sector interventions have been introduced to combat morbidity and mortality from NCDs. These include the dedicated policies aimed specifically at NCDs as well as system strengthening policies such as the Presidential Health Compact (ref) and the NHI White Paper (ref). However, additional interventions to ensure NCDs are systematically addressed. This National Strategic Plan (NSP) directs the actions to be undertaken between 2021 and 2026 across sectors to redress and to reverse the growing threat posed by NCDs. The NSP’s overarching objective is to ensure that the correct steps are defined and implemented to reach the Sustainable Development Goal (SDG) 3.4, which aims to reduce, by one-third, premature mortality from NCDs through prevention and treatment and promote mental health and well-being by 20303 and ultimately to move South Africa towards universal health coverage (UHC).

Gaining return on investment is central to this plan. The cost effectiveness of different interventions were analysed by the World Health Organization (WHO) and the “best buys” for the reduction in NCDs mortality and morbidity are a priority4[[3]](#footnote-2) and considered in the formation of this plan. Although many of these interventions focus on health promotion and primordial and primary prevention (due to the comparatively low financial and other resource inputs required to achieve critical health outcomes), the importance of secondary and tertiary preventions are also highlighted. The NSP takes an integrated people-centred approach (IPCHC Reference), within the context of UHC and implementation of National Health insurance (NHI) in South Africa.

Over the past decade South Africa has placed considerable emphasis on developing a service platform for the management of people living with HIV and TB in PHC. The significant successes of the HIV and TB programs , albeit at great financial and resources investment need to be leveraged to inform policies for other disease areas.

With the introduction of the Integrated Clinical Services Management (ICSM) model5, this platform has been extended to include an integrated basis for all chronic disease management within Primary Health Care6[[4]](#footnote-3). However, it must be recognised that both the range of diseases included under the umbrella of NCDs as well as their determinants adds another level of complexity to addressing NCDs. Despite this, noting the important focus on primordial and primary prevention within the HIV program, a cascading model (similar to 90/90/90 model for HIV) has been adopted as a part of implementation for this plan, in which, targets will be set for people’s knowledge about their status, initiation and adherence to treatment, and treatment outcomes.

## STATUS, TRENDS AND DETERMINANTS OF MAIN NCDs

Globally NCDs kill 41 million people annually, equivalent to 71% of all global deaths. Each year, 15 million people die from an NCD between the ages of 30 and 69 years with over 85% of these premature deaths occurring in low- and middle-income countries25. The WHO estimates that deaths from NCDs are likely to increase globally by 17% over the next 10 years, and the Afro Region will experience a 27% increase. This amounts to 28 million additional deaths from these conditions, which is projected to exceed deaths due to communicable, maternal, perinatal and nutritional diseases combined by 203026.

Statistics South Africa suggest that NCDs contribute 57.4% of all deaths, of which 27% are premature (under 70 years of age)[[5]](#footnote-4). https://www.uschamber.com/report/increasing-social-and-economic-benefits-globally-rates-of-return-health-investments [[6]](#footnote-5). The South African Medical Research Council publishes an annual report on mortality which highlights the probability of dying prematurely, between the ages of 30 and 70, due to selected NCDs. This has been reported as 34% for males, 24% for females, and 29% for both sexes, and there has been no significant change between 2011 and 2016. The highest single cause of death from NCDs is cardiovascular disease, followed by cancer, diabetes and chronic respiratory disease27. The leading cause of death in SA women is diabetes.



Figure 1 Mortality in South Africa (by disease category)

There is an urgent need for action on the NCDs-associated morbidity with many NCDs causing significant disability, with the associated loss of productivity, income and difficulty in accessing health care. For example, the South African Stress and Health survey found that 16.5% of adults have experienced a mood, anxiety or substance use disorder in the previous 12 months28, which led to significant morbidity. Furthermore, risk factors for NCDs tend to cluster together, particularly in people with common mental disorders, where they may have multiplicative effects. Figure 2 below highlights the conditions associated with the most disability in South Africa from 2007-201729.



Figure 2 Top ten causes of years lived with disability (YLD) in South Africa29

A substantial challenge with for NCDs management is the coexistence of NCDs with other diseases leading to multi-morbidities. All people, as they grow older, are at risk of developing one or more NCD. Additionally, coexisting communicable diseases and NCDs augment the risk or effect of the other31,32. For example, T2DM has a very high prevalence and **with estimates that** diabetes triples the risk of TB. There is also a proven increased risk of metabolic disease for those living with HIV and who take lifelong combined antiretroviral therapy.

More recently, PLWNCDs including risk factors such as obesity as well as people living with chronic communicable diseases such as tuberculosis and HIV/ AIDS have been found to be more likely to experience more serious sequelae and even death when infected with COVID-1930.

## 1.3 RISK FACTORS FOR NCDs

It is widely recognised that NCDs are the product of both non-modifiable risk factors such as genetics and age as well as modifiable factors such as social and behavioural determinants. There is increasing evidence that on the role of genetics in major non-communicable diseases including cancer, diabetes, cardiovascular diseases, mental health and asthma. Genetically predisposed individuals may develop disease, regardless of lifestyle or social factors but despite their inherent risk, they may still able to lead a healthy lifestyle so that other factors do not augment their risk for disease.

With respect to modifiable factors for NCDs, 5 five influential risk factors have been identified globally as the target of the cost-effective interventions (best buys). These risk factors are: unhealthy diet, insufficient physical activity, air pollution, tobacco and alcohol use.

Tobacco use is one of the main causes of premature deaths in the world. Smoking has negative impacts on all the major NCDs including lung and other cancers, chronic obstructive pulmonary diseases (COPD), heart disease, stroke and diabetes. Tobacco is negatively impact mental health and alcohol use. According to the SADHS, 37% of men and 8% of women currently smoke tobacco products. Of everyday smokers, the majority (75% women and 64% men) smoke between 1 and 9 cigarettes a day while 12% of women and 18% of men smoke 15 or more. The progressive decrease in smoking between 1993 (33%) and 2012 (18%) has seen a slight increase to 22% in 2016.

Alcohol is associated with all the main NCDs. A review of the relationship between alcohol and NCDs33 found alcohol to be causally linked (to varying degrees) with cardiovascular outcomes, including hypertension, haemorrhagic stroke and atrial fibrillation; eight different cancers i.e. oral, pharynx, larynx, oesophagus, liver, colon, rectum, breast (with risk linked to volume consumed); liver disease (fatty liver, hepatitis and cirrhosis); pancreatitis and diabetes. In 2018, the WHO estimated the average annual per capita consumption of alcohol for South Africa (persons over 15 years of age) as 29.9 litres (drinkers only); and the numbers of heavy episodic drinkers as 59% (drinkers only). The numbers of people abstaining from alcohol consumption in the past 12 months was estimated at 56.8% males and 80.6% female34. The significant number of alcohol drinkers that consume at heavy episodic levels requiries urgent attention.

South Africa, as with many low- and middle-income countries, suffers from the double burden of undernutrition along with overweight, obesity, or diet-related NCDs, within individuals, households and populations, and across the life-course. A systematic evaluation35 of dietary consumption patterns across 195 countries showed that the leading dietary risk factors for NCD mortality are diets high in sodium, low in whole grains, low in fruit, low in nuts and seeds, low in vegetables, and low in omega-3 fatty acids; each accounting for more than 2% of global deaths.

Low rates of exclusive breastfeeding of babies play an important role in the later development of NCDs. The 2016 SADHS found that only 32% of babies are exclusively breastfed at 6 months. Poor diet amongst young children is characterised by significant intake of sugary drinks and snacks and salty snacks. Unhealthy food environments, including access to and affordability of healthy foods, foster unhealthy diets36. This is especially true for communities with predominantly low-income, low socio-economic status. Healthier food options typically cost between 10% and 60% more when compared with unhealthier options at retail outlets. In South Africa, from 1994 to 2012, there has been an overall increase in energy intake, sugar-sweetened beverages, processed and packaged foods, animal source foods, and added caloric sweeteners, while the consumption of vegetables decreased. In particular, the consumption of processed and packaged food, such as soft (sugary) drinks, sauces, dressings and condiments, and sweet and savoury snacks had the most drastic increase (>50%). These findings show significant changes in food consumption patterns that may be due to the changing food environment37.

Among the dietary ingredients, salt, sugar and saturated fat are the biggest risk factors for NCDs and are usually present in ultra-processed foods. The association between sodium and hypertension has been well established. Moreover, high salt intake promotes gastric cancer, is associated with osteoporosis, increased asthma severity, renal stones, progression of renal disease and obesity. High intake of free sugars (particularly in the form of sugary drinks) increases overall energy intake and may threaten the nutrient quality of diets, leading to an unhealthy diet, weight gain and increased risk of NCDs38 including heart disease, stroke, diabetes and cancer. Saturated and trans-fats increase cholesterol levels and trans-fats lower HDL level, thereby increasing the risk of coronary artery disease.

Physical inactivity has been estimated to cause 6% of the global burden of disease from coronary heart disease, 7% of T2DM, 10% of breast cancer, and 10% of colon cancer. Inactivity causes 9% of premature mortality39. On the other hand, higher levels of physical activity are associated with lower mortality rates for both younger and older adults. Low levels of physical activity result in fewer calorie burned thus contributing to high prevalence of obesity. A study of SA learners aged 8 – 14 years found that 57% engaged in moderate levels of physical activity (PA)40; 31% did not meet internationally recommended amounts of moderate to vigorous physical activity and overall, males reported higher PA levels than females. Physical activity levels declined with age from 11 to 14 years by 14% and 20% in males and females, respectively. A cross-sectional survey from the Cape Town (urban) and Mount Frere (rural) found that 74% of participants engaged in moderate-to-vigorous physical activity but women were 34% less likely to engage in vigorous physical activity41.

Finally, the WHO reported that 25-33% of deaths from heart disease, stroke, lung-disease and cancers are due to air pollution42. A recent study by the Forum of International Respiratory Societies’ Environmental Committee, estimated that about 500,000 lung cancer deaths and 1.6 million chronic obstructive pulmonary diseases (COPD) deaths could be attributed to air pollution. The study further states that air pollution may also account for 19% of all cardiovascular deaths, 21% of all stroke deaths and is associated with many other NCDs including diabetes43. A 2016 report by the World Bank estimated that around 20,000 South Africans die from air pollution related causes annually44, while another study puts the number of deaths at 27,00045.

## 1.4 ECONOMIC BURDEN OF NCDS

NCDs pose an economic burden to individuals, health systems and countries at large. It is estimated that by 2030, the cumulative loss to the global economy through NCDs will be $47 trillion (baseline 2010)7. In 2015, the economic burden of diabetes alone in sub-Saharan Africa was US$19.45 billion, or 1.2% of cumulative gross domestic product (GDP) of the whole sub-Saharan African region. Unchecked, the economic burden from NCDs is projected to increase to between $35.33 billion and $59.32 billion by 20308. The accumulated losses to South Africa (SA)’s GDP between 2006 and 2015 from diabetes, stroke and coronary heart disease alone are estimated to have cost around R26 billion9.

The 2018 public sector costs of diagnosed diabetes patients in South Africa was approximately R2.7 billion and if both diagnosed and undiagnosed patients are considered, that cost would escalate to R21.8 billion 11. WHO’s global business case for NCDs shows that if low and low-middle income countries put in place the most cost-effective interventions for NCDs (including for both prevention and control), by 2030 they will see a return of $7 per person for every dollar invested12 and similar high returns on outlay would certainly be expected in South Africa. Investing in prevention and control of NCDs is thus both essential for growth and development and, when carefully planned and prioritised, is highly cost effective.

With respect to individuals, NCDs and their associated disabilities impact individuals in terms of direct and out of pocket costs related to health seeking as well as opportunity costs due to loss of productivity. In many instances, this can result in catastrophic health spend for families and households. Translated to country level costs, it has been estimated that the economic cost due to productivity losses arising from absenteeism, presenteeism and early retirement due to ill health in South Africa, largely from NCDs, equated to a total of 6.7% of GDP in 2015 and is expected to increase to 7.0% of GDP by 203010.

Despite the above social and economic burden, NCDs only attracted 1.3% of all development assistance for health in 2015 ($475 million out of $36.4 billion). This represents a steady percentage of 1-2%of global health financing, even though NCD funding has grown by 8.2% annually since 2000. This is in direct contrast to HIV, which attracts disproportionately more funding as compared to its burden.

## 1. 5 RESPONSES TO NCDs IN SOUTH AFRICA (2000-2020)

South Africa has taken a number of legislative, regulatory and policy steps to prevent NCDs. A National Health Promotion Policy and Strategy was adopted in 2015. The range of policy interventions applicable to NCDs can be found in Appendix A but specific preventive interventions by the main NCDs risk factors include:

1. Tobacco Products Control Act No 83 of 1993,(as amended)
2. Draft Control of Tobacco Products and Electronic Delivery Systems Bill (2018)
3. Liquor Bill (2016)
4. Regulations regarding warning labels on alcohol products (2017)
5. Regulation on trans-fats in foodstuffs (2011)
6. Regulations relating the labelling and advertising of foods (effective from2012)
7. Regulation on reduction of sodium in 13 categories of foodstuffs that are the most common source of sodium (2013 and amended in 2017)46
8. A levy on sugar sweetened beverages (Health promotion levy) (2018),lxxvi
9. Air Quality Act, 2004 (Act No. 39)47
10. Human Papilloma Virus (HPV) vaccination programme (2014).

The National and Provincial Departments of Health (PDoH) work closely with partners for a number of initiatives such as Salt Watch campaign (with Heart and Stroke Foundation), Annual National Nutrition Week and National Obesity Week, Annual Move for Health campaign, National Recreation Day.

In the SDG era South Africa has updated or adopted the following NCDs related policies:

1. National Cancer Strategic Framework 2017-2022 (2017)
2. Cervical cancer policy (2017)
3. Breast cancer policy (2017)
4. Updated Management of T2DM in Adults at Primary Care Level (2014)
5. Mental Health Policy Framework and Strategic Plan 2013-2020 (2013)
6. National Policy Framework and Strategy on Palliative Care 2017-2022 (2017)
7. Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020 (2015)
8. National Adolescent and Youth Health Policy, Infant and Young Child Feeding Policy
9. Guideline for the Management of Acute Asthma in Adults (2013)
10. Guidelines for Maternity Care in South Africa, 2016
11. Strategy for the Prevention and Control of Obesity in South Africa 2015-2020

In addition, a number of important health systems changes have been introduced that have included and benefitted persons with NCDs such as an Integrated Clinical Services Management Model that incorporates all chronic diseases (whether communicable or NCDs , as a part of Ideal Facility initiative), the integration of NCDs in the Primary Health Care Service Package (2015)[[7]](#footnote-6) (incorporating most common NCDs including asthma/COPD; cardiovascular disease, diabetes, mental health conditions; epilepsy, musculoskeletal disorders)48, the Essential Medicines List for PHC and Hospital Services and the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) model for distribution of medicine.

The South African Government has also decided to implement a Whole of Government approach (similar to Health in All Policies programme for World Health Organization) for improving health and its determinants.This has lead to the recently launched “Operation Sukuma Sakhe in KwaZuklu Natal, which spells out every initiative and how it links to initiatives being implemented by the different departments and the spheres of government, who are focused on delivery of services through partnership with community, stakeholders and government.

Finally, in addition to the Department of Health, different government sectors/departments at national and provincial levels have been identified as essential to addressing NCDs. These are: - Agriculture, Land Reform and Rural Development; Basic Education; Communications; Co-operative Governance and Traditional Affairs; Environment, Forestry and Fisheries; Finance/National Treasury; Higher Education, Science and Technology; Social Development; Sport, Arts and Culture; Trade and Industry and Economic Development; Transport. In addition, there are other department at local governments (such as Park, water and sanitation) which have direct influence on the management of NCDs. As such, there are policies and strategies in non-health sectors that are important to the NCD Strat Plan which provide a basis for multi-sectoral action and therefore, their utilisation must be strengthened to effect coordinated and mandated cohesive outputs. A list of these policies and strategies can be found in Appendix C..

From the above, it is evident that whilst significant strides have been made by the the South African health sector and various non-health stakeholders to address the burden of NCDs, NCDs still remain a significant and growing burden on both the South African population and the health sector at large. It is thus essential that this NSP provides a framework to guide all stakeholders in their continued efforts to curb NCDs.

# CHAPTER 2: NATIONAL STRATEGIC PLAN FOR NCDs

Developing an integrated national multi-sectoral strategy for the prevention and control of NCDs is complex and implementing it is even more difficult. This NSP focuses on the NCDs responsible for the highest morbidity, mortality and disability in South Africa and their main associated causes. These include such as hypertension, diabetes mellitus, cardiovascular diseases, obesity, cancer, respiratory diseases such as asthma, and mental health

Problems with key determinants being tobacco use, alcohol abuse, poor and lack of physical activity.

However, there are many other NCD conditions of critical public health importance, most of which have high health burden, though relatively lower mortality. These include renal, endocrine, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and oral diseases, and genetic disorders; and violence and injuries. NCDs are also associated with communicable diseases such as HIV and TB, and most recently with COVID-19 as well as with maternal and child health concerns, including hypertension and diabetes in pregnancy.

This NSP will therefore address the NCDs with the highest known morbidity and mortality, whilst simultaneously and systematically laying the groundwork for the inclusion of other NCDs in subsequent strategic plans., through the ongoing collection of evidence on the needs of people in communities. It also provides the platform and infrastructure for the development and implementation of policies and guidelines for the priority NCDs e.g. CVD & diabetes.

This chapter outlines the National Strategic Plan For The Prevention And Control Of Non-Communicable Diseases. This includes the vision and mission as well as the national NCD goals and targets, their relation to global NCD initiatives and finally the guiding principles for action.

## VISION

A long and healthy life for all through the equitable prevention and control of NCDs.

## MISSION

To provide integrated, people centred care for PLWNCDs through multisectoral collaboration and strengthened national response in order to reduce avoidable and premature morbidity, disability and mortality.

## NATIONAL NCDs GOALS AND TARGETS

The National NCD goal for South Africa, in accordance with the National Development Plan is to:

**“Significantly reduce prevalence of NCDs and disability”**

The comprehensive target for South Africa, in accordance with the SDG Goal 3.4, is to:-

**Reduce, by one-third, premature mortality from NCDs through prevention and treatment and promote mental health and well-being by 2030**

The NSP’s specific targets remain unchanged from the 2013 WHO 25 indicators including nine voluntary targets 50. The targets to be reached and indicatorsfor measuring performance are outlined in Table 1.

Table 1 WHO NCDs targets and indicators 2013-2025Indicators

|  |  |  |
| --- | --- | --- |
| WHO Framework element | Target | Indicators |
| MORTALITY & MORBIDITY |
| Premature mortality from NCD | 1 A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases | 1 Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases  |
| Additional indicator |  | 2 Cancer incidence, by type of cancer, per 100 000 population |
| BEHAVIOURAL RISK FACTORS |
| Harmful use of alcohol | 2 At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context | 3. Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context 4. Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context 5. Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context  |
| Physical inactivity | 3. A 10% relative reduction in prevalence of insufficient physical activity | 6. Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily 7. Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent) |
| Salt/sodium intake | 4. A 30% relative reduction in mean population intake of salt/sodium | 8. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years |
| Tobacco use | 5. A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years | 9. Prevalence of current tobacco use among adolescents 10. Age-standardized prevalence of current tobacco use among persons aged 18+ years |
| BIOLOGICAL RISK FACTORS |
| Raised blood pressure | 6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances | 11. Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) and mean systolic blood pressure  |
| Diabetes and obesity | 7. Halt the rise in diabetes & obesity | 12. Age-standardized prevalence of raised blood glucose/ diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose)13. Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex) 14. Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/ m² for overweight and body mass index ≥ 30 kg/m² for obesity) |
| Additional indicators | 15. Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years 16. Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day 17. Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration |
| NATIONAL SYSTEMS RESPONSE |
| Drug therapy to prevent heart attacks and strokes | 8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes | 18. Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes |
| Essential NCD medicines and basic technologies to treat major NCD | 9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCD in both public and private facilities | 19. Availability and affordability of quality, safe and efficacious essential NCD medicines, including generics, and basic technologies in both public and private facilities |
| Additional indicators |  | 20. Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer  |
|  |  | 21. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes |
|  |  | 22. Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies |
|  |  | 23. Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt |
|  |  | 24. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants |
|  |  | 25. Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies |

These indicators will be used to measure the extent to which South Africa has reached the targets and ultimately SDG 3.4. However, these parameters inform the strategic objectives outlined in Chapter 3, each of which will have their own set of indicators. These will be developed in conjunction with implementing stakeholders such as the PDoH in order to inform implementation and measure how well implementation has taken place.

## FOUNDATION FOR ACTION

Whilst the actual implementation of the National Strategic Plan lies within the remit of stakeholders beyond the NDoH, certain guiding principles will be used to ensure implementation aligned to the values of the NSP. are also identified as important principles in the WHO Global Action Plan 2013-2020. The 9 guiding principles are described below:

Whilst the actual implementation of the National Strategic Plan lies within the remit of stakeholders beyond the NDoH, certain guiding principles will be used to ensure the implementation of this NSP is underpinned by core values and principles that apply across the full burden of disease and require a robust health system. These guiding principles for action were identified as critical following a review of the Strategic plan for the prevention and Control of NCDs 2013-201 and are also identified as important principles in the WHO Global Action Plan 2013-2020. The 9 guiding principles are described below:

### Human-Rights

To assure the rights of all people with NCDs to equitable access quality and affordable health care and interventions irrespective of ethnicity, gender, language, religion, political or health condition other opinion, nationality, as enshrined in the constitution of the Republic of South Africa.

* + 1. **Equity**

To realize that the creation of inclusive, equitable and economically productive services for NCDs to cater for both the vulnerable groups and the entire society, to address the inequitable distribution of social determinants of health.

In the South African context, arguably the single greatest obstacle to UHC is inequity. This arises from the historically parallel public and private sector services as well as the significant fragmentation of stakeholders and services, even within these two systems. Whilst this inequity is perhaps most acutely demonstrated through a financial lens it is also experienced through difference health care benefit packages in the public and private sector as well in geographical terms across facilities, districts, and provinces; and across rural urban divide. This inequity is further exacerbated for PLWNCDs due to the lack of NCD specific financing available to address NCDs in South Africa.

Achieving equity in health service delivery is fundamental to attaining the target sets under the plan. This would include ensuring access to services for vulnerable populations, for example rural and disadvantaged communities and those requiring inter-provincial services as well as addressing stigma associated with diseases such as breast cancer. Doing so would require redistributing national health care resources (including human resources) between and within provinces, and increasing primary care utilization levels for currently disadvantaged groups. Furthermore, introduction of the National Health Insurance will address the inequity in historical system of health financing that has led to more than 50 percent of total health expenditure being spent on approximately 17 percent of the population. Thus, the attainment of equity requires a mechanism to realise social solidarity.

* + 1. **Universal health coverage and National Health Insurance**

To provide access; without discrimination, to nationally determined sets of comprehensive promotive, preventive, curative, rehabilitative and palliative health care services.

The South African Government committed to attainment UHC where state health system sustainably delivers defined health care benefit package that is of equitable and acceptable quality while preventing financial hardship. The values and principles articulated above form the basis of such a health system.

In South Africa, the NHI is the chosen vehicle to deliver UHC which involves restructuring of the NDoH, strengthening of oversight and regulatory bodies for the public and private sector and ultimately to incrementally align the public and private sector, and all associated stakeholders operating within and across the public and private sector.

The NSP, developed during health sector transition and the implementation of NHI, endeavours to make its objectives align with the incremental achievement of UHC. Although NHI implementation is an on-going process occurring in stages, many of which may occur after the expiration of this National Strategic Plan,

* + 1. **Efficient resource utilization**

*To ensure provision of health promotive and preventive intervention and continued primary health care and hospital care based on available resources and infrastructure.*

The health sector has a vital and dynamic role to play in a continuum starting with promotion, prevention and protection, and encompassing early identification, control, rehabilitation and palliative care at all levels within a health system. Given the breadth of the required health sector involvement in reducing NCDs, together with the number of different NCDs that require specific emphasis and that have unique objectives, appropriate resource utilisation through an efficient and effective health system is of utmost importance. This will include primary level services for NCDs, focused and specialized services for specific disease types and integration of NCD services at all levels of care. This is already occurring within the Department of Health where for example the Integrated Clinical Disease Management model and NDoH Healthcare Benefits Database complement specific and strategic documents that deal for instance with diabetes20, mental health21 and cancer22. Plans are also in place to deal with cross cutting areas such as palliative care23 and rehabilitation24

* + 1. **Integrated Health Care**

To provide integrated comprehensive approaches towards reducing common risk factors of major NCDs including policy making, capacity building, partnership, information dissemination and implementation in all aspects.

The 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases committed to strengthen and integrate, as appropriate, NCDs policies and programmes into health planning processes and the national development agenda of each Member State as a whole. This call is aligned to critical need for integration of NCDs with health programmes, in health systems, across levels and continuum of care, into service delivery platforms and care pathways, and across levels of government and with sectors and stakeholders. This is further underpinned by the Integrated People Centered Health Services model (Figure 3 below).



Figure 3: Framework for Integrated People Centered Health Services model

Taking account of the structural and governance challenges that maintain siloed approaches and whilst we await the departmental restructuring that may reduce the fragmentation of the NCD policy response, this 5-year NSP embraces the spirit of working in an integrated manner across directorates in light of the multi-sectoral nature of NCDs and their determinants. Furthermore, the national outlook of success will only be attained following a coordinated adoption and institutionalization of the interventions in here at the all levels of government. It is in this regards that a deliberate attempt has been made do highlight roles and responsibilities to different partners to ensure a coordinated and synergistic approach to the delivery of this NSP that will ensure the reduction of morbidity and pre-mature mortality from non-communicable diseases (NCDs), mitigate the impact of disabilities and promote mental health and wellbeing.

Integration occurs in various ways, which have been further detailed below.

1. *Policy Integration*

The importance and significance of policy cohesion within and between spheres of government, programmes, clusters and service Delivery platforms within the NDoH and ultimately, with other sectors across government, with the private sector, and with civil society cannot be over-emphasized. This NSP contains Strategic Objectives pertaining to sister departments and other programmes and service delivery platforms within the Department of Health. This is to highlight the commitment to achieving multisectoral, holistic and integrated prevention and control of NCDs considering that the scope of this NSP is national and not departmental and thus requiring ownership from across the entire department. Figure 4 below highlights how NCDs interact with other sectors and their associated SDGs, thereby signifying the importance of a multisectoral approach in achieving not only SDG 3.4 but all the relevant SDGs.



Figure 4 Relation between SDG target 3.4 and other SDGs18

1. *Stakeholder integration*

The global, regional, national and community level health landscape has become more complex in many respects, including the increase in the number and diversity of players who have an input in NCDs and the broader health agenda.

This NCDs NSP aligns with the broader health policy and endeavours to strengthen the NDoH’s engagement with non-state actors and stakeholders ranging from NGOs, private sector entities, philanthropic foundations, academic institutions, patient support and welfare groups, PLWNCDs including carers, CBOs, FBBs as well as individuals passionate and committed to the halting and reversing the burden of NCDS. The role of each of the stakeholders must be progressively defined and consultation enabled through an engagement mechanism.

NGOs, FBOs, CBOs and Patient Advocacy Groups have an essential role with regards to promotion and prevention of NCDs, including to some extent screening, detection and referral, as they work in and with communities.Within the private sector, there are a range of fragmented stakeholder, including key stakeholders such as funders (e.g., medical schemes, administrators), facilities (e.g., hospital networks), providers (GPs, specialists), professional societies and associations, regulators, as well as pharmaceutical and devices industry. The private sector, although serving a smaller part of the population is essential to achieving UHC in a manner that is efficient, effective, regulated and accountable. This will require strengthened coordination at a national level that focuses on alignment of the public and private sector to improve population outcomes under NHI. The non-health care related private sector that impacts on health through manufacturing and retailing of food, alcohol and tobacco is also critical in adopting and enforcing strategies to promote health and that put health before profit.

The South African National Development Plan 2030 (NDP) asserts that health is not just a medical issue and that greater inter-sectoral and inter-ministerial collaboration is central to good health. The NDP advocates that the social determinants of health (SDH) require addressing as a matter of urgency and therefore envisages to partner with state and non-state actors in view of their significant role in health delivery, empowerment of persons living with NCDs as well as in community development for the advancement and promotion of public health and to encourage non-health actors to use their own activities to advance the interventions herein and in partnership to halt and reverse the burden of NCDs.

1. *Integration Within The Department Of Health*

Multiple players, including national, province and district, influence the health care delivery system and patient care and should be integrated and in tune with each other for successful implementation of the NSP. Different spheres of government include:

|  |  |
| --- | --- |
| Sphere | Responsibilities  |
| National | * policy development
* setting national standards
* monitoring the performance of the health service across the 9 provinces and that guide service delivery in the other two spheres.
 |
| Provincial  | * manage of its health budget
* deliver all provincial health services.
* adaptation of national policy to meet provincial the needs
* run health facilities
* employ staff.
 |
| Local – health districts including municipalities | * health Districts delivery of health services at PHC facilities (clinics), district hospitals; regional hospitals; tertiary (academic) hospitals and central (academic) hospitals.
* municipal health service preventative personal health services and population based environmental health services.
 |

The links between NCDs and HIV/AIDS, TB, and child and maternal health among others mean that intervention for reducing risk factors for NCDs are implemented by various clusters within the NDoH. Besides the NCDs cluster, other clusters important to an integrated approach include Child, Youth and School Health, Health, Maternal Neonatal and Women’s Health, District Health Services, HIV/AIDS and TB, Health Promotion, Nutrition, Oral Health, Environmental Health and Food Control and Environmental Health. There is a need for strong coordination and integration of the NDC response within the Department of Health. Furthermore, the provincial governments as autonomous policy entities have a pivotal role to play in bringing to life the interventions envisaged in this NSP as they are responsible for the day to day running of NCD prevention and control interventions.

1. *Integration within the NCD disease burden*

An integrated approach aiming at all major common risk factors of NCDs is the most cost-effective way to prevent and control the most common NCDs. Such an approach responds not only to the need for scaling up interventions on major common risk factors with the aim of reducing premature mortality and morbidity of NCDs but also the need to integrate primary, secondary, and tertiary prevention, health promotion, and related programs across sectors and different disciplines.

While this NSP starts by looking at the five non-communicable disease—cardiovascular diseases, cancer, chronic respiratory diseases and diabetes mental health—which make up the largest contribution to the morbidity and mortality of NCDs and on their four shared behavioral risk factors—tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, much attention will be apportioned too to all non-communicable diseases especially those that don’t conform to the shared risk factors model to ensure progressive coverage and care is achieved for all in the spirit of leaving no one behind.

These other conditions are of utmost public health importance and are closely associated with the four major non-communicable diseases. They include but not limited to other renal, endocrine, neurological, haematological, gastroenterological, hepatic, musculoskeletal, skin and oral diseases and genetic disorders, mental disorders, disabilities, including blindness and deafness and violence and injuries and their sequelae. In the same way, attention has been apportioned to interventions meant to reduce exposure to environmental, occupational, genetic and biological risk factors.

This NSP recognizes that the conditions in which people live and work and their lifestyles influence their health and quality of life. NCDs and their risk factors also have strategic links to health systems and universal health coverage, environmental, occupational and social determinants of health, communicable diseases, maternal, child and adolescent health, reproductive health and ageing. Despite the close links, one strategic plan to address all of them in equal detail would be unwieldy and not in line with government policy and practice.

This NSP addresses the high-level issues to the major NCDs categories and their determinants in the current NDoH environment in which there are existing national strategic plans for many programmes and elements. Most of these earlier NSPs were created in the MDG era in which siloed programmes existed. This NCDs NSP strives to build a comprehensive and more comprehensively and thus reference will be made pointing some interventions to these policy documents where the substantive mandate and authority lies to create functional linkages, synergy and policy coherence. An integrated approach to the implementation of the NCD NSP is justifiable not only from a cost-effectiveness perspective but also from the equity and social justice angle. It may lead to provision of services that are coherent, uniform, and of quality, and also help enhance the motivation, skill, and competence of health care workers.

Currently, various disease entities are treated at vertically and at different levels within the health system, whereas the environment that more broadly supports health requires coordinated effort and collaborative planning at the (horizontal) level of whole people and communities. Vertical and horizontal approaches must be considered as not mutually exclusive and complementary to each other, and there is much merit to consider combining the strengths of each in the context of the health system.

1. Integration with other burdens of diseaseWith Other Burdens Of Disease

In regards to an integrated approach, the role of infectious agents in the pathogenesis of NCDs, either on their own or in combination with genetic and environmental influences, has been increasingly recognized in recent years and merits attention in this NSP.

Many NCDs, including cardiovascular disease and chronic respiratory disease, are linked to communicable diseases in either aetiology or susceptibility to severe outcomes. Increasingly cancers, such as cancer of the cervix, liver, oral cavity and stomach, have been shown to have an infectious aetiology. Several cancers of public health importance are linked to infections or infestations including herpes virus and HIV in Kaposi sarcoma, and liver flukes in cholangiocarcinoma.

Some significant disabilities such as blindness, deafness, cardiac defects and intellectual impairment can derive from preventable infectious causes requiring strong population-based for prevention, including immunization (e.g. vaccines against hepatitis B, human papillomavirus, measles, rubella, influenza, pertussis, and poliomyelitis), diagnosis and treatment.

There exists a high risk of infectious disease acquisition and susceptibility in people PLWNCDs.. Attention to this interaction would maximize the opportunities to detect and to treat both NCDs and infectious diseases through alert primary and more specialised health care services with high indices of suspicion and synergy. For example, tobacco smokers and people with diabetes, alcohol-use disorders, immunosuppression or exposure to second-hand smoke have a higher risk of developing tuberculosis while TB patients too have a risk of developing diabetes. As the diagnosis of TB is often missed in people with chronic respiratory diseases, collaboration in screening for diabetes and chronic respiratory disease in tuberculosis clinics and for tuberculosis in non-communicable disease clinics could enhance case-finding. Likewise, integrating NCDS programmes or palliative care with HIV care programmes would bring mutual benefits since both cater to long-term care and support as a part of the programme and because NCDs can be a side-effect of long-term treatment of HIV infection and AIDS.

The COVID-19 pandemic has highlighted the necessity of ensuring health system resilience in the face of public health emergencies. Emergency preparedness and response needs to ensure that NCDs are considered, thereby allowing for normal services to continue and impact on NCD patients to be minimised.

1. *Integration of health service delivery*

Integrated health services must respond to the needs of individuals and populations and deliver comprehensive good-quality services throughout the life course through multidisciplinary teams who work together across settings and use evidence and feedback loops to continuously improve performance. Integrated health services, when based on strong primary health care and essential public health functions, strengthen people-centred health systems and contribute to the best use of resources. Integrated people-centred health services strengthens self-management and enable empowered health care consumers who participate actively in their own care.

The realization of effective transformation and integrated health service delivery, needs a health-system-wide approach, which includes the participation of all of government and all of society supported by the implementation of multiple, aligned policies simultaneously applied to the different levels of the health systems within an enabling environment.

A central objective of this NSP is to facilitate the explicit inclusion of NCDs and their risk factors into the development and implementation of health systems plans and services as well as to facilitate integration with relevant programmes, policies, strategies and across levels of care. This plan takes a comprehensive and integrated approach to dealing with NCDs rather than creating a separate parallel service for NCDs. In particular, the integration of NCD care at primary care level with other health service areas is critical, predominantly with chronic communicable diseases and with maternal, youth, child health and nutrition services. There is a high proportion of people living with multiple chronic conditions (whether communicable or non-communicable or both) as well as women with pregnancy and maternal related NCDs that have both short and longer term health consequences. Hence, an approach that treats the person holistically through seamless care pathways in an integrated system is very important. As seen in Figure 5 as part of the ICSM, all chronic diseases, whether they are communicable or non-communicable, are treated equally and within the same health stream. The same applies to all users whether they have one or a number of chronic conditions. This is particularly important as people with HIV are now living longer and also developing NCDs. Within this model people are treated for all their conditions in a single session by a single health practitioner.



Figure 5 ICSM Model: services offered within the four streams of care.5

* + 1. **Engagement with and Empowerment of People and Communities:**

To enable healthy supportive environments in communities to adopt healthy lifestyle and thereby reduce modifiable NCDs risk factors through their involvement in advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

The Ottowa Charter, Alma Ata and most recently, the Integrated Person-Centered Health Services model all recognize the vital need to engage with and empowering and engaging individuals and communities. By providing these individuals and communities with opportunities, skills and resources, the means to participate actively and meaningfully in their health and health care is augmented. Furthermore, underserved and marginalized groups can be empowered to advocate and participate in priority setting and communities can be mobilized to coproduce

healthy environments, provide care services in partnership with the health sector and other

sectors, and contribute to healthy public policy.

Activities important for engagement and empowerment include health education, shared clinical decision making between individual, families and providers, self-management, patient satisfaction surveys as well as community delivered care and the development of patient and advocacy groups.

# CHAPTER 3: STRATEGIC OBJECTIVES

## STRATEGIC OBJECTIVES

1. To strengthen national capacity, leadership, accountability , multisectoral collaboration and partnerships to accelerate the country response for the prevention and control of NCDs (?within a context of the PHC and UHC OR based on the IPCHC FW )
2. To reduce risk factors associated with NCDs and disabilities addressing the social and underlying SDH as well commercial determinants of health and creating health promoting and enabling environments
3. To reduce morbidity and mortality associated with NCDs (incl through self management )
4. To strengthen and orient health systems to prevent and control of NCDs and the through people centred PHC and UHC
5. To promote and support national capacity for high-quality research and development for the prevention and control of NCDs
6. To monitor the trends and determinants of NCDs and to evaluate progress in their prevention and control

|  |  |  |
| --- | --- | --- |
|  |  | Recommended |
| **To strengthen national capacity, leadership, governance, accountability, multi-sectoral collaboration and partnerships to accelerate country response for the prevention and control of NCDs**  | * + Establish high level NCDs multi-sectoral coordination mechanisms at National, Provincial and District levels for engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on NCDs
	+ Strengthen National NCD programme through appointment of diseases specific technical expect group to provide technical advice and support to the Department on the development of diseases specific policies, guidelines, protocols, routine and periodic diseases monitoring and evaluation)
	+ In line with the PHC , Strengthen District health services…. To deliver prevention and control of NCDs . through appointment of District Clinical Dyads comprising of District based PHM specialists and nurses
	+ Strengthen governments Policy response toward prevention ……Create a National registry of all policies and regulations that might influence prevention and control of NCDs
	+ Empower communities to adopt healthy life styles and prevent NCDs
	+ Strengthen Public Private Partnerships (PPP) to enhance collaboration on NCDs prevention and control interventions
	+ Orienting other sectors and stakeholders, including civil society and the private sector, to create enabling legal, policy and regulatory environment which is conducive for the prevention and control of NCDs

(is there high level understanding of how the IPCHC FW will change the paradigm?) | 1. Promote policy cohesion and coordinate services within and across sectors
* Establish mandated multi-sectoral coordinating mechanisms, informed by the PHC at National, Provincial and District levels
* Establish a mandated coordinating mechanisms for related health programs and service providers at all 3 levels of government.
* Establish a mechanism to engage and support private and other sectors to collaborate on service delivery
1. Promote empowerment and engagement with communities and civil society organisations
* Establish mechanisms for civil society and community engagement at all 3 levels
1. Reach the underserved and marginalized
* integrate health equity goals into health sector objectives
1. Establish a mechanism for mutual accountability
 |
| **To reduce modifiable risk factors for NCDs and its co-morbidities and underlying SDH through the creation of health promoting and enabling environments**  |  | (Health Promotion and Nutrition to confirm existing content)NB: ADD query wording - Comprehensive and integrated business plans to be implemented through sustainable models using the “health promotion levy” |
| **To reduce morbidity, disability and mortality associated with NCDs** | Create an integrated approach to health care and enabling care pathways through availability of smart (a) clinical guideline (b) health technology (c) medicine (d) health work force and above all (e) patients. **A cascading effect will be implemented to manage the various NCDs.** | 1. Coordinate care for individuals in line with the “PHC”
* Develop care pathways and reflect referral and counter-referral systems, improved care transition and team-based care
* Enable and support self-management
1. Strengthen clinical governance
* Revise/update existing and develop new Clinical Guidelines
* Monitor implementation of GLs and respond to gaps in service delivery
* Dissemination of and ongoing support on GL implementation
1. Yes
2. Strengthen integrated, continuum of care
* Strengthen NCD prevention and control within the ICSMM and respond to gaps
* Support provinces and districts to plan cascades ?/?/?/? of care applicable to their respective district and provincial contexts
 |
| **To strengthen and orient health systems to address the prevention and control of NCDs** **OR** **Reorientate the model of care** | (a) Continuation of cost effective NCDs interventions into the PHC package with referral systems to all levels of care; (b) Availability of cost effective Hospital based NCDs interventions; (c) Development and dissemination of integrated clinical guidelines and treatment protocols for NCDs prevention, care and treatment for all levels of health care; (d) Building the capacity of the health workforce (including CHWs in terms of numbers and skills mix, at all levels, for the prevention and control of the NCDs; (e) Ensuring availability of essential NCDs prevention and care medicines, supplies, technologies and link this to financing mechanisms to foster access, affordability and sustainability at the national, provincial and district levels.  | 1. Define service priorities based on life course needs
* Determine local health needs assessment based on existing disease patterns
* Ensure gender, cultural and age-sensitive services
* Promote health technology assessment
1. Building strong primary care-based health systems
* Develop comprehensive packaging of services for all population groups defined by means of a participatory and transparent process with priority on PHC services
* Strengthen access to essential medicines, consumables and devices
* Strengthen availability and reorientation of human resources including development and support of community level workers.
* Promote optimal utilisation of the allocations from alternate funding models including allocation from the “health promotion levy/SSB
1. Enable outreach programmes for disadvantaged/marginalized populations, who may not receive effective coverage owing to barriers linked to factors that include income, education, residence, gender, ethnicity, working conditions or migrant status
 |
| **To promote and support national capacity for high-quality research and development for the prevention and control of NCDs** | (a) identification for priority research areas on NCDs and their risk factors; (b) strengthening capacity for NCDs research; (c) advocacy for resources for research on priority NCDs and (d) facilitation of knowledge translation on conducted operational research to guide decision making by national government  | Bilqees do you have a copy of the SUN Research Summit Report? The Report already lists priority research areas with which the Mini concurred and had asked to explore further prior to Covid-19 |
| **To monitor the trends and determinants of NCDs and to evaluate progress in their prevention and control** | (a) Strengthening capacity for NCDs surveillance; (b) Integration of key NCDs monitoring indicators into the routine Health Management Information System (HMIS) and National Indicator Data Set  (NIDS) data collection and reporting systems; (c) Conducting baseline and periodic NCDs and their risk factors surveys; (d) Establishment and maintenance of National Registries on some major NCDs (such as National Cancer Registry); (e) allocation of resources for routine and periodic surveillance of NCDs and their risk factors at all levels; and (f) dissemination of surveillance results to guide decision making by national, provincial, district and sub-district levels.  | (I support the Key Actions we agreed to during our meeting last week) |

### STRATEGIC OBJECTIVE 1

**To strengthen the capacity, leadership, accountability, multisectoral collaboration and partnerships to accelerate the country response for the prevention and control of NCDs at all levels.**

A whole-of government (WoG)and whole of society response (including HiAP) to the prevention and control of NCDs will is critical contribute to a reduced prevalence of NCDs. It requires a comprehensive mandate for multi-sectoral coordinating mechanisms and actions to develop and implement policies that must reflect the interests of different sectors. An accountability framework must, amongst other matters, set out the responsibilities of all government departments and partners to achieve shared goals.

The NDoH will ensure a multisectoral approach and the implementation of key policies Comprehensive advocacy to both government and partners is required to highlight the huge burden of NCDs in terms of morbidity, mortality and disability. Government at all levels must prioritize the prevention and control of NCDs through a WoG and multi-sectoral approach by acknowledging that investment in NCDs is a priority for social and economic development.

The strengthening the capacity of a NCDs Prevention and Control Programme at all levels is an essential first step for the successful implementation and monitoring of the national response to NCDs. The appointment of a NCDs dyad (district based public health medicine specialist and NCDs trained nurse) in line with the District Clinical Specialist teams for maternal and Child Health. The NCDs team will provide requisite skills and capacities at the grass root level and enhance the existing NCDs program structures at provincial and district levels to support implementation of planned activities and work with other sectors. In addition to multisectoral collaboration, implementation of interventions for prevention and control of NCDs will require a focus on population wide interventions. Effective implementation of all population-wide interventions requires the emphasis to shift from information and health education for individuals to legal, fiscal, and regulatory actions by governments. Active involvement of civil society organizations and advocacy groups is required to resist attempts by powerful organisations and industries with vested interests (such as the tobacco, food, and alcohol industries) to undermine the development and implementation of effective policies and laws.

## Key strategies and actions

* Establish and support a transparent high-level comprehensive NCDs multisectoral coordination mechanisms at that reaches all levels for NCDs policy, its implementation and resourcing and stakeholders. and accountability -making that have a bearing on NCDs This must include PLWNCDs
* , implement, monitor and review transparent..
	+ Strengthen National NCD programme through appointment of diseases specific technical expect group to provide technical advice and support to the DHSDepartment on the development of diseases specific policies, guidelines, protocols, routine and periodic diseases monitoring and evaluation)
* In line with the PHC , Strengthen …. To deliver prevention and control of NCDs . through appointment of District Clinical Dyads comprising of District based PHM specialist health care professionals including nurses
* Maintain and update Strengthen governments Policy response toward prevention ……a national registry and review process for all policies and regulations influencing NCDs prevention and control in the public domain.
* Empower and enable communities to adopt promote health and wellness and prevent NCDs
* Strengthen a transparent Public Private Partnerships (PPP) that enhance collaborative evidence-based interventions for NCDs+ prevention and control together with a conflict of interest policy..
	+ Develop and implement as strategy to engage non-health sectors and non-state stakeholders about the creation of an enabling legal, policy and regulatory environment which is conducive for NCDS prevention and control.

(is there high level understanding of how the IPCHC FW will change the paradigm?)**Role of government:**

* Establish and support a NCDs multi-sectoral coordination mechanism that represents a WoG and *whole-of-society* approach.
* Convene multi-stakeholder working groups, secure budgetary allocations for implementing and evaluating multi-sectoral action and monitor and act on SDH.
* Integrate the prevention and control of NCDs into planning processes with special attention to SDH, gender equity and the needs of vulnerable populations.\
* Generation of actionable evidence including HiAP and linkages between NCDs and SDGs, including other related issues such as poverty alleviation, economic development, sustainable cities, non-toxic environment, food security, climate change, disaster preparedness, peace and security and gender equality.
* Provide adequate, predictable and sustained resources for prevention and control of NCDs through UHC and NHI by an increase in annual budgetary allocations, and other finance mechanism of Government.

Provide training and appropriately allocate the workforces, and strengthen institutional capacity for implementing this NCDS NSP.

**Role of non-state stakeholders:**

* support government**:** Partners at all levels to understand and participate in evidence-based multisectoral action according to the capacity and resources.
* support the transparent mobilization of adequate, predictable, and sustained financial, human and technical resources needed for the implementation of NSP and the monitoring and evaluation of progress.
* Support the capacity-building and the sustainability of relevant NGOs at the national, provincial and district levels so that stakeholders will realize their full potential in NCDs prevention and control of NCDs.
* Hold the government at all levels to account the attainment of the NCDs NSP and the achievement of the health related SDGs..

### STRATEGIC OBJECTIVE 2

**To reduce risk factors associated with NCDs and disabilities by addressing the social determinants of health and creating health promoting and enabling environments**

The five major shared risk factors namely use of tobacco products, unhealthy diet, physical inactivity harmful use of alcohol and air pollution contribute significantly to the growing burden of NCDs. Reduction in the levels of these modifiable risk factors in the population significantly reduces the disease burden due to NCDs. Prevention and control of NCDs should target people at entire life span ranging from pre-natal life, infancy, childhood adolescence, adulthood and old age. Even though the NCDs often appear in adulthood, exposure to the risk factors starts early in life. Reducing exposure to the NCDs risk factors requires engagement of non-health sectors and non-state actors in the prevention of tobacco products use, reduction of physical inactivity, unhealthy diet, obesity, harmful use of alcohol and the protection of children from adverse impacts of marketing of unhealthy foods and beverages. This calls for strengthening the capacity of individuals and populations to adoption of healthier behaviour and lifestyle that foster health and well-being.

**Key strategy and actions:**

**:** Creation of an enabling fiscal, legal and legislative environment and provide leadershuo promotion of **healthy nutrition according to SDG 2 diet** through supporting endeavours that

.

* **Promotion of physical activity** would require a concerted WoG *and WoS strategy focusing* on

(a) Regular transparent review of existing policy and its implementation on physical activity that support the NCDs prevention and control at all levels and settings including workplace;

(b) Create and support public awareness for the health benefits of physical activity in NCDs prevention and control;

(c) Advocate across sectors for policy and regulations for urban design that is conducive for physical activity

* **Control of tobacco products** requires a coordinated WoG approach

 (a) Regular transparent review of existing national policy and its implementation on tobacco products;

(b) Raise and assess public awareness on the dangers of smoking/ tobacco products use and exposure to second hand tobacco smoke, especially through effective mass media campaigns;

(c) strengthen the implementation of tobacco control initiatives in the curriculum of schools and institutions of higher learning.

* **Reducing harmful use of alcohol**

(a) Regular transparent review of existing national policy and its implementation on alcohol;

(b) strengthening public awareness and mass media campaigns on the dangers of harmful use of alcohol;

(c) integrate alcohol abuse and substance use management and rehabilitation services at all levels including, community, health care system, and workplaces;

(d) strengthen the implementation of the component on prevention and control of alcohol use and substance abuse in the school health curriculum.

**Environmental risk reduction** (including air pollution)

(a) Assess the magnitude of environmental, biological and occupational hazards;

(b) Regular transparent review of existing national policy and its implementation for reduction of exposure to environmental, biological and occupational risk factors associated with environmental contaminants and occupational hazards that predispose to NCDs;

(c) Create and support public awareness on prevention and control of exposure to environmental, biological and occupational risk factors for NCDs

**Roles and responsibilities of Government:**

* **:** provide enabling fiscal, legal and legislative environment and has a leading role in developing, strengthening and enforcing national policies and guidelines on behavioural risk factors for NCDs.

Establish mechanisms to ensure that the effective implementation of the policies through multi-sectoral action and *whole-of-government* approach.

**Role of non-state stakeholders:**

* **F**acilitate the implementation of the *WHO Framework Convention on Tobacco Control (FCTC)*;
* **Facilitate** the global and national strategies for reduction of harmful use of alcohol, global and national strategies for nutrition , physical activity and marketing of foods and non-alcoholic beverages to children,
* **Support and participated** in capacity strengthening,
* **Shape** the research agenda,
* **D**evelopment and implementation of technical guidance,
* mobilise financial support

regular monitoring of policy an its implementation.

### STRATEGIC OBJECTIVE 3

**To reduce morbidity and mortality NCDs related conditions with integrated people-centred intervention at all levels**

The reduction of morbidity and morbidity requires an integrated people-centred approach to clinical care at all levels of care, throughout the life cycle and stages of And t.

## Key strategies and actions

Creation**:** CreationCreate an integrated approach to health care and enabling care pathways through availability of smart

(a) clinical guideline

(b) health technology

(c) medicine

(d) health work force

and above all (e) patients. **A cascading effect will be implemented to manage the various NCDs.**

## Roles and responsibilities of government

* Provide a transparent accountable enabling fiscal, legal and legislative environment that is responsive to the needs of the people..
* Strengthening existing health system for equitable access to appropriate health technology and medication.
* To establish a mechanisms for the inclusive transparent development, implementation and review of clinical guidelines at all levels of health care.

Ensure synergies among these guidelines to ensure proper management of multi-morbidities.

## Role of non-state stakeholders

* To coproduce the development and collaborate on the implementation of these guidelines

To raising awareness among population about the NCDs and support them to improve adherence.

### STRATEGIC OBJECTIVE 4

**To reorientate and strengthen the health system to provide equitable people-centred NCDs prevention and control within UHC and SDG framework.**

Implementation of the NCDs interventions needs a functioning health-care system and a stepwise approach for improvement health planning processes; health financing; capacity building of health workers; supply of essential drugs and technologies; health-information systems. This would assist in implementation of comprehensive health services delivery models for long-term patient-centred care that is universally accessible and affordable. This could require strengthening PHC as part of a service hub that provides the support needed to deliver these critical prevention and treatment services for NCDs with well-functioning referral linkages to secondary and tertiary care services. Development and implementation of a cascading model is realistic first step that need to be integrated into the PHC services.

## Key strategies and actions

 The key features of a cascading model where PHC is the focus of the delivery of care are:

(a) Person-centred focus across the lifespan rather than a disease focus

(b) Accessibility with no out-of-pocket payments

(c) Distribution of resources according to population needs rather than demand; and

(d) Availability of a broad range of services including preventive services and coordination between different levels in the health system.

This will ensure setting targets for 2025 for:

* PLWNCDs to know their NCD status;
* People diagnosed with NCDs to receive sustained therapy
* People receiving therapy to achieve control and to prevent complications

(a) Develop and implement of cost effective NCDs interventions into the PHC package with referral systems to all levels of care;

 (b) Availability of cost-effective hospital-based NCDs interventions;

(c) Develop, disseminate and evaluate transparent and evidence based integrated clinical guidelines and treatment protocols according to acceptable international standards for NCDs prevention, care and treatment for all levels of health care;

(d) Build the capacity of the health workforce (including CHWs) for numbers and skills mix, at all levels to prevention and control NCDs;

(e) Ensure equitable sustained access to essential NCDs prevention and care medicines, supplies, technologies and link this to financing mechanisms at the national, provincial and district levels.

## Roles and responsibilities of government

Exercise responsibility and accountability to assure the availability of effective and efficient NCDs services at all levels of the health system.

* Make progress towards NCDs equity within UHC by giving priority to NHI financing a combination of cost-effective range of preventive, curative and palliative care interventions at different levels of care for NCDs and disabilities.
* Identify the competencies required and invest in improving the knowledge, skills and motivation of the current health care workers.

Incorporate the NCDS prevention and control of in the training curricula of all health personnel including CHWs with an emphasis on PHC.

## Role of non-state stakeholders

* Support the mobilization of adequate, predictable and sustained financial resources to advance UHC in national health systems, especially through PHC.
* Support efforts of Government in strengthening health systems and expanding quality service coverage through development of appropriate health care infrastructure and institutional capacity for training of health personnel such as public health institutions, medical and nursing schools.

Contribute to efforts to improve access to affordable, safe, effective and quality medicines and technologies for NCDS prevention and control.

### STRATEGIC OBJECTIVE 5

**To promote and support national capacity for high-quality research and development for the prevention and control of NCDs**

The national research agenda must be collaboratively agreed so that priorities for research are set that give answers specific problems. The information and knowledge so generated will support efforts for resource mobilization and monitoring the effectiveness of interventions. Research in the NCDs field must promote the continual quest for improved NCDs prevention and control and NCDs advocates.

## Key strategies and actions

(a) Prioritize research areas transparently and inclusively based the population needs NCDs and their risk factors;

(b) strengthen capacity for NCDs research;

(c) advocacy for resources for research on priority NCDs and

(d) facilitation of knowledge translation on conducted operational research to guide decision making by national government

## Roles and responsibilities of government

Government will strengthen national, provincial, local and institutional capacity for operational research and development, through human resources, funding, research infrastructure, equipment and supplies in research institutions. In collaboration with research institutions and academia, Government will develop and implement NCDs operational research agenda and increase investment in research, innovation and development as an integral part of the national response to NCDs

It will effectively use academic institutions and multidisciplinary agencies to promote operational research, retain research workforce, incentivize innovation and encourage the establishment of networks to conduct policy-relevant operational research. It will also strengthen the scientific basis for decision making through NCD-related operational research and its translation to enhance the knowledge base for ongoing national action through platforms that promotes dialogue between government and research entities (universities, research units, relevant societies) pertaining to the combat of NCDs.

## Role of non-state stakeholders

Partners will promote investment and strengthen national capacity for quality research, development and innovation, for all aspects related to the prevention and control of NCDs in a sustainable and cost-effective manner, including through strengthening of institutional capacity and creation of research fellowships and scholarships. They will facilitate NCD-related research and its translation to enhance the knowledge base for implementation of the national action plan. In addition, partners will disseminate, as appropriate, information on affordable, cost effective, sustainable and quality interventions, best practices and lessons learnt in the field of NCDs

### STRATEGIC OBJECTIVE 6

**To monitor the trends and determinants of NCDs and to evaluate progress in their prevention and control**

For better-informed programme planning, the NCDs surveillance, monitoring and evaluation mechanisms need to be integrated in the existing routine data collection and reporting systems and tools for population-based surveys. A framework for national and global monitoring, reporting, and accountability, with agreed sets of indicators, is essential to ensure that the returns on investments in NCDs that meet the expectations of all partners. Continuous monitoring of the national progress will provide the foundation for advocacy, policy development and coordinated action, as well as to reinforce political commitment. In addition, the monitoring and evaluation framework will serve to monitor progress of national-, provincial- and district level strategies for the prevention and control of NCDs.

## key strategies and actions

(a) Strengthening capacity for NCDs surveillance;

(b) Integration of key NCDs monitoring indicators into the routine Health Management Information System (HMIS) and National Indicator Data Set (NIDS) data collection and reporting systems;

(c) Conducting baseline and periodic NCDs and their risk factors surveys;

(d) Establishment and maintenance of national registries on some major NCDs (such as National Cancer Registry);

(e) allocation of resources for routine and periodic surveillance of NCDs and their risk factors at all levels

(f) dissemination of surveillance results to guide decision making by national, provincial, district and sub-district levels.

## Roles and responsibilities of government:

Strengthen technical and institutional capacity, including appointment PHM specialists in the Districts, to manage and to implement surveillance and monitoring systems that will be integrated into existing health information systems, with a focus on capacity for data management, analysis and reporting in order to improve availability of high-quality data on NCDs and its risk factors. With the following characteristics It will also integrate monitoring systems for the prevention and control of NCDs, including prevalence of relevant key interventions into national health information systems, in order systematically to assess progress in use and impact of interventions. It will identify data sets, sources of data, integrate NCD surveillance into national health information systems and undertake periodic data collection on the behavioural and metabolic risk factors (such as harmful use of alcohol, physical inactivity, tobacco products use, unhealthy diet, overweight and obesity, raised blood pressure, raised blood glucose, and hyperlipidaemia).

* It will also take into consideration the determinants of risk exposure such as marketing of food, tobacco and alcohol products, with disaggregation of the data (where available) by key dimensions of equity, including gender, age (such as children, adolescents, adults, elderly) and socioeconomic status in order to monitor trends and measure progress in addressing inequalities.
* Develop, maintain and strengthen disease registries (such as National Cancer Registries) if feasible and sustainable, with appropriate indicators for a better understanding of needs and priorities..

Ensure the routine collection and distribution of information on trends in NCDs morbidity, mortality by cause, risk factors and other determinants, disaggregated by age, gender, disability and socioeconomic groups, as well as provide information to the WHO on progress made in the implementation of national action plans to achieve target sets around 25 indicators within the "*Global monitoring framework on NCDs*".

**Role of non-state stakeholders**

* mobilize resources, promote the investment and strengthen capacity for surveillance, monitoring and evaluation, on all aspects of prevention and control of NCDs.
* facilitate surveillance and monitoring and the translation of results to provide the basis for advocacy, policy development and coordinated action and to reinforce political commitment.

Promote the use of media to improve capacity for surveillance and monitoring and to disseminate, as appropriate, data on trends in risk factors, determinants and NCDs.

# CHAPTER 4 - IMPLEMENTATION PLAN

The NSP acknowledges that implementation of this strategy and the subsequent achievement of the related goals largely falls within the mandate of the provincial and district health services and the exact implementation plan for the provinces will have to be crafted together with the PDoH and their district counterparts.

This chapter, therefore, highlights key interventions for consideration when developing the implementation plan to meet the strategic objectives discussed in Chapter 3 as well as provides gui

dance on the establishment of the national coordination mechanism. Furthermore, it summarizes the roles and responsibilities of the relevant sectors, relevant stakeholders, and the provincial and district level inter-sectoral NCD Committees so as to streamline the individual provincial plans that will arise from this document.

Finally, it discusses monitoring and evaluation as a necessary part of the implementation plan and the elements necessary for effective monitoring and evaluation.

## 4.1 EFFECTIVE INTERVENTIONS AGAINST THE FIVE KEY RISK FACTORS FOR NCDS

WHO has identified a set of population and individual level interventions which are affordable, feasible and cost-effective and which every country can implement and significantly reduce the burden of NCDs. These high priority interventions are known as “*Best Buys*”55. There are also other important WHO recommended interventions known as “*Good Buys*” that have been shown to be effective, but for which cost-effectiveness analysis data is not readily available. Effective and efficient implementation of these interventions would require overarching health system actions, which may include:

1. Strengthen and orient the health system to address NCDs and to mitigate risk factors through people-cantered health care and UHC
2. Integrate very cost-effective NCDs interventions into the basic PHC package with referral systems to all levels of care
3. Explore viable health financing mechanisms and innovative economic tools supported by evidence to ensure universal coverage of NCDs interventions and services
4. Scale up cost-effective high-impact interventions including interventions to address behavioural risk factors and early detection and long term care of people affected by NCDs
5. Train the health workforce and strengthen the capacity of health systems, particularly at the primary care level, to address the prevention and control of NCDs
6. Improve the availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs, in both public and private facilities
7. Develop and implement a palliative care policy, including access to opioids analgesics for pain relief, together with training for health workers
8. Expand the use of digital technologies (such as electronic health records) to increase health service access according to need, efficacy for NCD prevention, and to reduce the long term costs in health care delivery
9. Strengthen human resources and institutional capacity for surveillance, monitoring, evaluation and research at the district and sub-district levels as a part of strengthening PHC services
10. Establish and/or strengthen a comprehensive NCDs surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response

## MECHANISMS TO FACILITATE THE IMPLEMENTATION OF NATIONAL STRATEGIC PLAN

### 4.2.1 COORDINATION AND IMPLEMENTATION MECHANISM

In order to effectively coordinate the national NCDs response, including the implementation of the NCDs strategy, there is a need to strengthen the current NCD programme as part of the continued commitment of the Government for the prevention and control of NCDs. It should be highlighted that strengthening of NCDs programme is required at all levels, (namely national, provincial, district, sub-district and community levels).

The efficient and effective implementation of the National multi-sectoral strategic plan for prevention and control of NCDs would require a multi-sectoral approach with effective partnership through involvement of relevant governmental Institutions, private sectors, partners, FBOs, NGOs, CBOs as well as communities through local associations. It is important to note that this multi-sectoral approach will necessitate strong harmonization and coordination among all government sectors and stakeholders. Thus, a national multi-sectoral coordination mechanism, which coordinates the actions of different sectors for the common goal of prevention and control of NCDs, is central to the success of national NCDs prevention and control efforts and the attainment of national targets. Multi-sectoral coordination mechanisms offer a synergistic response to these diseases and their risk factors. Experiences with health concerns such as HIV and AIDS indicate that ***political leadership at the supra-ministerial level is critical to drive action within any multi-sectoral coordination mechanism.*** Three levels of coordination mechanisms are suggested namely national, provincial and district levels.

**National Level**

2 levels of coordination are proposed at national level; firstly, the mechanism has the mandate of developing policies, ensuring coordination between different sectors, mobilizing and allocating resources, reviewing progress in the implementation of the agreed action plan at the national and provincial levels, addressing obstacles to progress and reporting on international commitments. The National level committee (in line with National Health Commission in many countries) will be coordinated by the Minister of Health and the secretariat would be the National Departments of Health, while Director Generals of Departments and relevant partner organizations would be members.

In order to facilitate the needed technical support at the national level, the Director General of the National Department of Health (NDoH) will form a *National NCDs Technical Committee* with representation of the different departments of the National Department of Health and. This committee will be chaired by a designated member of the Executive Management Committee and will provide technical support for the planning, implementation and monitoring of the health system response for NCDs. This committee will also create different technical working groups (TWG) for specific thematic areas (such as cardiovascular diseases, diabetes mellitus, cancer prevention and control, tobacco products control, multi-morbidities, obesity and dementia) for rendering technical support in specific areas. The NDoH will develop the terms of reference for the National NCDs Technical Committee and the different technical working groups, which will be formed under it.

**Roles and responsibilities for National Multi-sectoral Coordination Mechanism for NCDs**

* + Provide political leadership and guidance to relevant sectors for NCDs prevention and control
	+ Enhance the integration of NCDs prevention and control in the policies and programmes of relevant ministries and government agencies
	+ Provide a dynamic platform for dialogue, stocktaking and agenda-setting, and development of public policies for NCDs prevention and control
	+ Facilitate development and resourcing of the implementation of the NSP
	+ Coordinate technical assistance for mainstreaming NCDs in the work of relevant sectors at the national and provincial levels
	+ Monitor implementation of the action plan and review progress at the National, provincial, district and sub-district levels
	+ Report on inter-governmental commitments pertaining to NCDs prevention and control

**Role of the National NCDs Technical Committee (NTC)**

* + Communicate with key stakeholders, Ministries, NGOs, FBOs, CBOs on NCDs prevention and control concerns
	+ Organize meetings of the National multi-sectoral Coordination Mechanism for NCDs
	+ Develop the agenda for the meeting in consultation with the chairperson and other sectors
	+ Facilitate the development of strategic and operational plan for NCDs prevention and control
	+ Request reports on progress of work from stakeholders (such as Ministries, NGOs, FBOs, CBOs) and Provincial coordination bodies
	+ Follow-up on decisions taken by the coordination body
	+ Arrange technical assistance to other Departments
	+ Identify knowledge gaps and advance research priorities to inform policy decisions
	+ Support stakeholders in accessing resources for implementing their commitments
	+ Facilitate monitoring and evaluation of the work of the coordination mechanism against agreed national and global NCDs targets

**Provincial level**

The provincial level mechanisms are largely concerned with implementation of programmes, enforcement of relevant laws and reporting on activities. The provincial level committee will be coordinated by the Member of Provincial Executive Council (MEC) of Health and the secretariat would be the Provincial Departments of Health, while heads of Departments and relevant NGOs in the province would be members.

**Role of the Provincial Multi-sectoral Coordination Mechanisms for NCDs**

* Ensure effective implementation of the NSP on NCDs prevention and control in the province
* Coordinate with relevant sectors to mainstream NCDs prevention and control in their programme implementation at provincial levels
* Develop provincial NCD plan and identify and access resources for implementation of the plan
* Report on implementation of the plan to the National Coordination Mechanism
	+ Request reports on progress of work from stakeholders (such as Departments, NGOs, FBOs, CBOs), and District coordination bodies
	+ Follow-up on decisions taken by the coordination body

**District level**

The district level mechanisms are largely concerned with implementation of programmes, and reporting on activities. The district level committee will be coordinated by the Member of the District Mayoral Council (MMC) of Health and the secretariat would be the District Health Department, while heads of Departments and relevant NGOs in the district would be members.

**Role of the District Multi-sectoral Coordination Mechanisms for NCDs**

* Ensure effective implementation of the NSP on NCDs prevention and control in the district and its sub-districts
* Coordinate with relevant sectors to mainstream NCDs prevention and control in their programme implementation at district levels
* Integrate with four streams of PHC Re-engineering: CHWs, DCST, Integrated School Health Programmes and Private General Practitioners
* Develop district NCD plan and identify and access resources for implementation of the plan
* Report on implementation of the plan to the Provincial Coordination Mechanism
	+ Request reports on progress of work from stakeholders (such as other departments, NGOs, FBOs, CBOs),
	+ Follow-up on decisions taken by the coordination body

### A PHASED APPROACH TO IMPLEMENTATION

The detailed implementation plan using a phased approach as described in Appendix A. One of the main purpose of this plan is to create baseline data for the 25 indicators. This will require coordinated approach for the next five years. The plan also proposed a dyad structure similar to District Clinical Specialist Team (DCST) for maternal and child health to streamline implementation at the district level. In addition, yearly target for the above set of indicators are included as Appendix B.

### CAPACITY BUILDING

Successful implementation of this plan would require strengthening national and local capacity for implementing the NCD NSP including:

* Facilitating networks and partnerships to improve capacity for implementation
* Promoting human resource development to ensure staff have the appropriate knowledge and skills
* Strengthening the systems and structures through promoting institutional and infrastructural capacity building.

### CASCADING

In December 2013, the UNAIDS Programme Coordinating Board called on UNAIDS to support country- and region-led efforts to establish new targets for HIV treatment scale-up beyond 2015 which led to d a new, final ambitious, but achievable target: (a) By 2026, 90% of all people living with HIV will know their HIV status. (b) By 2026, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and (c) By 2026, 90% of all people receiving antiretroviral therapy will have viral suppression56. It is felt a similar focused target is necessary for improving management of NCDs. However, unlike HIV/ AIDS, NCDs are a compendium of many diseases and one set of targets may not suite all these diseases. Therefore, it is felt a baseline is necessary for each of these NCDs to set realistic targets. During the coming quinquennium, the focus will be to achieve (a) target sets for diabetes and hypertension and (b) to determine realistic targets for other NCDs which would be implemented in the next quinquennium.

Given very high levels of cardiovascular disease and diabetes in South Africa, the 90/60/50 model will be applied to blood pressure and blood glucose.

* 90% of all people over 18 will know whether they have hypertension and/or raised blood glucose or not;
* 60% of these people with raised blood pressure or blood glucose will receive intervention and
* Lastly, 50% of them are receiving interventions will be controlled.

Would it help if we used 2 provinces to demonstrate how these would be calculated?

## 4.3 MONITORING AND EVALUATION

The successful implementation of this NSP depends on, amongst other strategies, an effective mechanism for monitoring and evaluation to a) allow for course correction throughout the course of the NSP and b) measure whether the strategies put into place are have produced their desired impacts.

This will require the establishment of a national NCD surveillance, monitoring, and evaluation system, which will utilise a framework that will cover all the relevant processes and outputs of the NSP together with complementing policies. The NCDs program together with relevant programs within the NDoH and the individual PDoHs will formulate specific frameworks relevant to their implementations plans and will monitor the progress against these frameworks.

However, overall impact of the NSP will be evident through demonstration of NCDs risk reduction and reduction in morbidity and mortality compared to baseline (detailed below).

### REPORTING MECHANISM

The majority of the report would be submitted monthly through District Health Information System (DHIS). This would require updating National Indicator Data Set to incorporate these indicators (such as mortality and morbidity Data, Prevalence of risk factors, Epidemiological data). In addition, each sub-district and district would submit a comprehensive annual report of activities (such as information/ data from the coordination mechanisms, all outcome measures (input and process indicators, outputs/milestones, and impact and outcome indicators).

Based on the experiences from implementation of first strategic plan, first 3 years of this plan would focus on collection of data from demonstration sites selected across nine provinces. The selection of these sites will be decided after consultation with the PDoH. Subsequently from year 4, authorised or approved indicators will be included in DHIS.

### SOUTH AFRICA’S BASELINE FOR THE MONITORING AND EVALUATION OF THE 2021-2026

### NATIONAL STRATEGIC PLAN

As explained in Chapter 2, the current NSP aligns with the 9 WHO targets, thereby allowing for the monitoring and evaluation of the outcomes of the activities related to this NSP. In order for progress to be measured, baselines for the these targets are detailed in Table 4.1 below:

Table 2 NCD Baselines for South Africa

|  |  |  |
| --- | --- | --- |
| **Indicator** | **Current situation/baseline** | **M&E Plan** |
| 1. Premature mortality from NCDs27
 | 29%34% for males 24% for females | What is collected on NIDSWhat can we report on?What needs to be collected – define data sets, tools method eg survey, by whom |
| 1. Harmful use of alcohol51
 | Per capita consumption 9.14 litresAlcohol consumption.61% of men26% of women. Risky drinking total 23%20% of men5% of women |  |
| 1. Physical inactivity52
 | Total 40%28.5% men47.3% Women (< 150 of moderate/week or < 75 min of vigorous/week) |  |
| 1. Salt intake53
 | Mean population intake 7g per day |  |
| 1. Sugar intake38
 | Per capita intake 36 Kg per person annually  |  |
| 1. Tobacco use (Age 15 plus)51
 | Total 22.5%37% men8% women |  |
| 1. Hypertension51
 |  |  |
| * 1. Prevalence for raised blood pressure (Age 15 plus)
 | Total Prevalence 45%46% women 44% men  |  |
| * 1. Knowledge of hypertension status
 | 51% of people with hypertension  |  |
| * 1. Intervention provided for raised blood pressure
 | 22% of people with hypertension  |  |
| 1. Diabetes and obesity51
 |  |  |
| * 1. Prevalence for raised HBA1 (Age 18 plus)
 | 13% of women and 8% of men age 15 and older have an adjusted HbA1c level of 6.5% or above. |  |
| * 1. Knowledge of blood glucose status
 | 55% of people with raised blood glucose |  |
| * 1. User’s blood glucose levels controlled
 | 19% of people with raised blood glucose |  |
| * 1. Obesity and overweight
 | 27% of women overweight and 41% obese. |  |
| 20% of men overweight and 11% obese |  |
| 1. Drug therapy to prevent heart attacks and strokes
 | Not available. Research to be carried out |  |
| 1. Essential NCD medicines and basic technologies to treat major NCDs
 | 80% availability of essential NCD medicines |  |
| 1. Mental health screening.
 | To be determined through research |  |
| 1. National Cancer Strategic Framework
 | National Cancer Strategic Framework 2017-2022 |  |

# CHAPTER 5 – COSTING THE PLAN AND FINANCING OF NCD NSP

## COSTING ESTIMATE FOR IMPLEMENTING THE PLAN

## FINANCING NCD PREVENTION AND CONTROL

Implementation of NHI in South Africa involves a fundamental shift in the funding model for the health sector from tax-based contributions to the fiscus and membership of voluntary private medical aid schemes and insurance products, to mandatory prepaid contributions to a NHI Fund. With the reduced fragmentation in funding pools, the Fund will act a single purchaser of all services within the defined benefit package, from public and private sector providers alike, and therefore be able to realise economies of scale and scope, and improve equity of access.

NHI implementation can further be expected to include a revised regulatory environment that will have further impact on existing cost structures in the public and private sector. These include shifts that provide for greater integration and patient-centred services as well as an increasing focus on efficiency. These regulatory shifts and the incentives they are designed to create for all health stakeholder, can be expected to have a gradual effect on both the nature and level of demand and supply as well as a shift in costs structures. As a result, costing the rollout of NHI using current data – including for NCDs - is likely to generate misleading estimates.

This does not mean that costing is unimportant or unnecessary. Conversely, it highlights the need for ongoing costing exercises that track the shift in actual costs over time. It also requires a transparency in the data and methodology to conduct normative costings to ensure that as efficiency savings are pursued, it is not at the expense of quality of care. Costings should also ideally make use of a range of approaches and methodologies, and include costings from both provider perspective and patient perspective. Socio-economic costings will also be particularly important in the case of NCDs where they may reflect a higher cost than other diseases, but by ensuring that a large proportion of the population are able to remain economic active, have a net benefit at a ‘whole of government’ or whole of society’ level.

The NDoH is committed to strengthen national health management information systems to provide the data required to inform the wide range of necessary costings in the coming years. This includes foundational data on the average per patient cost to deliver each type of services; but it also data on population profile, burden of disease and level of need, which are required to calculate the total cost of service delivery for a defined population, whether a facility catchment population, or at a greater level of aggregation such as district, province or country level. Initial work has been initiated with the establishment of a National Healthcare Benefits Database on the NHI Digital platform that is grounded in the conditions and services articulated in the Standard Treatment Guidelines, and that will be developed further developed in the coming years.

While the NDoH is best placed to lead on normative costs, tracking of actual costs against these norms cannot be done without strong leadership from the provinces and districts who are responsible for service delivery, and will be best placed to identify opportunities for efficiency savings. The lessons learnt from these costings will be critical to inform context specific issues as well as highlight best practice that can be replicated and scaled in other provinces.

In the current economic and fiscal climate, identification and realization of efficiency savings must is likely to be the only strategy to increase coverage. This mean that economic evaluation, particularly cost-effectiveness analysis, must become routine analysis that is used to inform how and where the available resources are spent. This may take the form of comprehensive health technology assessments for high cost services, but also systematic reviews that may be sufficient to inform high volume services. While the WHO have recommended 88 interventions based on cost, 16 are considered the most cost-effective and feasible for implementation. These are interventions where a WHO Choice analysis found an average cost-effectiveness ratio of ≤ $ 100 per DALY averted in low- and lower middle-income countries. These will be further evaluated and aligned to the data in the Healthcare Benefits Database.

Where there is no further efficiency available at a time, the final decision must relate to priority setting. The difficult decisions that must then be made must be taken based on agreed priorities elicited through a defined and transparent priority-setting process.

“*Maximizing the impact of every dollar spent is crucial if we are to tackle one of the biggest health challenges of our time: NCDs*” (WHO 2018)57. This is important in every country, but particularly where health resources are in short supply such as in South Africa, where pressures on the public health system are impacting on access and quality of care. Return on Investment (ROI), encompasses the range of approaches that assess the value generated by an investment, compared to the resources put in. The WHO have calculated areas where countries can obtain the best return on investment. Not all of these actions are possible from within the NDoH. However, in areas that need to be implemented by other sectors, the NDoH will assist with information and support to ensure that these best buys are implemented in the country. Many of these interventions that fall outside the control of the Health sector, particularly those related to fiscal policies, have either already been proven in the real world context or projections of possible cost savings in South Africa have been calculated58.

The majority of the intervention included in this plan are routinely carried out as a part of the implementation of the first strategic plan. Therefore, the cost associated with these activities are already included in the equitable share. However, attempts will be made during this planning period to quantify these costs.

In addition, there are some activities would be carried out during the plan which would require detailed costing. This would be submitted as a supplement to this plan.

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# APPENDIX A: LIST OF RELEVANT POLICIES

| **Policy guideline** | **Year MONTH** | **Dept PROG** | **Relevance to NCDs / Comment** |
| --- | --- | --- | --- |
|  |
| **PRIMARY PREVENTION HEALTH PROMOTION GENERAL** |
| National health promotion policy & strategy 2015-2019 | 2015 | NDoH  |  |
| Strategic plan for the prevention & control of obesity in SA 2015-2020 | 2015 | NDoH  |  |
| Air Quality Act, 2004 (Act No. 39) | 2004 |  |  |
| **NUTRITION & FOOD/ BEVERAGES** |  |  |  |
| Foodstuffs, cosmetics and disinfectants Act, 1972 2007. Amended 2008 | 2008 | NDoH  |  |
| Regulations relating to health messages on container labels of alcoholic beverages. | 2008 |  |  |
| [Regulations R146:](https://www.gov.za/sites/default/files/gcis_document/201409/32975146.pdf) Labelling & advertising of foodstuffs | 2010 |  | No trans fats |
| Regulations Rxxx:  |  |  |  |
| [Draft regulations R429:](http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-09-10-23/2015-04-30-09-11-35/category/36-documents-for-comment?download=561:draft-regulations-relating-to-the-labelling-and-advertising-of-foods-r429-of-29-may-2014) labelling & advertising of foods  | 2014 | NDoH  | Comments made and no outcome |
| [Draft guidelines for Draft R429](http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-09-10-23/2015-04-30-09-11-35/category/36-documents-for-comment?download=560:draft-guidelines-applicable-to-the-draft-regulations-relating-the-labelling-and-advertising-of-foods-r429-of-29-may-2014) to explain and assist compliance | 2014 | NDoH  | Comments made and no outcome |
| Regulations R xxxx reduction of sodium in certain foodstuffs & related matters  | 2013 | NDoH  |  |
| Roadmap for nutrition in SA 2013-2017 | 2013 |  | School health  |
| National Adolescent and Youth Health Policy, Infant and Young Child Feeding Policy |  |  | From nsp draft |
| **ALCOHOL AND SUBSTANCE ABUSE**  |  |  |  |
|  |  |  |  |
| Mini drug master plan 2011/12-2013/14.  | 2011 | NDoH |  |
| **TOBACCO**  |  |  |  |
| Tobacco Products control Amendment 2007 | 2007 |  |  |
| Draft Control of Tobacco Products & Electronic Delivery Systems Bill 2018 | 2018 | NDoh  |  |
|  |  |  |  |
| **CANCER & PALLIATIVE CARE** |  |  |  |
| Regulation on the compulsory registration of cancer  | 2011 |  |  |
| National Cancer Strategic Framework 2017-2022 (2017) | 2017 |  |  |
| Cervical cancer policy (2017) | 2017 |  |  |
| Breast cancer policy (2017) | 2017 |  |  |
|  |  |  |  |
|  |  |  |  |
| National guideline on testing for prostate cancer at primary level and hospital level  | 2003 |  |  |
| National guideline: palliative care for adults – a guide for health professionals in SA | 2003 |  |  |
| National guideline: a guide for health care personnel in paediatric palliative care  | 2005 |  |  |
|  |  |  |  |
| **Diabetes cardiovascular diseases** |  |  |  |
| Updated Management of T2DM in adults at primary care level | 2017 |  | Quote nsp  |
| Management of type 2 diabetes in adults at a PHC level | 2014 |  |  |
| National guidelines on primary prevention and prophylaxis of rheumatic fever and rheumatic heart disease for health professions  | 1997 |  |  |
|  |  |  |  |
| **EYE HEALTH**  |  |  |  |
| National guideline on management and control of eye conditions at primary level  | 2000 |  |  |
| Guidelines for cataract surgery in SA  | 2001 |  |  |
| National guideline: prevention of blindness in SA  | 2002 |  |  |
| National guideline: refractive errors screening for persons 60 years and older  | 2004 |  |  |
| Refractive errors screening guideline for school children  | 2008 |  |  |
| **DISABILITY RELATED**  |  |  |  |
| National rehabilitation policy | 2000 |  |  |
| Recommended minimum criteria to improve access to health care facilities | 2002 |  |  |
| Standardisation of provision of assistive devices in SA 2003  | 2003 |  |  |
| **MENTAL HEALTH and Neurology**  |  |  |  |
| Mental health policy guidelines  | 1977 |  |  |
| Norms manual for severe psychiatric conditions | 2000 |  |  |
| Mental health care act (17) 2002 and its regulations  | 2005 |  |  |
| Child and adolescent mental health policy guidelines  | 2005 |  |  |
|  |  |  |  |
| Mental health review board orientation guideline and manual  | 2007 |  |  |
|  |  |  |  |
| Electro-convulsive therapy (ECT) guidelines.  | 2011 |  |  |
| National mental health policy framework & strategic plan 2013-2020 | 2013 |  |  |
| **ORAL HEALTH**  |  |  |  |
| National norms and standards for secondary and specialised oral health care  | 2006 | NDoH  |  |
| National norms, standards and practice guidelines for primary oral health care  | 2007 |  |  |
| National oral health strategy  |  |  |  |
|  |  |  |  |
| Guideline for themanagement of acute asthma in adults | 2013 |  |  |
|  |  |  |  |
|  |  |  |  |
| **OTHER**  |  |  |  |
| Consumer Protection Act  | 2008 |  | Return of products. |
| National Health Insurance Bill | 2019 |  |  |
| **Medicines Act & Regulation**  |  |  |  |
| Medicines and Related Substances Amendment Act 72 of 2008 | 2008 |  | Implemented June 2017 Medical devices regulated, SAHPRA |
| *Regulation*  |  |  |  |
| Medical Schemes Act 131 of 1998 | 1998 |  |  |
| Health Professions Act and Allied Health Professions Act (HPA) |  |  |  |
| Nursing Act  |  |  |  |
|  |  |  |  |
| National strategic plan for nurse education, training and practice 2012-2017 | 2013 |  |  |
| Pharmacy Act |  |  |  |
| Ideal Hospital Realisation and Maintenance Framework (ICRM) draft |  |  |  |
| [National Quality Improvement Plan (NQIP) draft](https://www.spotlightnsp.co.za/wp-content/uploads/2019/04/Draft-National-Quality-Improvement-Plan-24-August-2018.pdf)  | 2018 |  |  |
| National Infection Prevention and Control Strategic Framework 37 | March 2020 |  |  |
| South African AMR Strategy Framework |  |  |  |
| Practical manual for implementation of the national infection prevention & control strategic framework downloaded | March 2020 |  |  |
|  |  |  |  |
| Standard treatment guidelines |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Comunicable diseases  |  |  |  |
| National strategic plan for HIV, TB., STIs 2017-2022 | 2017 |  |  |
| National HIV counselling and testing policy guidelines  | 2015 |  |  |
|  |  |  |  |
|  |  |  |  |
| National guidelines on primary prevention and prophylaxis of rheumatic fever and rheumatic heart disease for health professions  | 1997 |  |  |
| National core standards for health establishments in SA  | 2011 |  |  |
| National consolidates guidelines for the prevention of mother to child transmission (PMTCT)of HIV and the management of HIV in children, adolescents and adults | 2014 |  |  |
| National adolescent and youth health policy  | 2017 |  |  |
|  |  |  |  |
| Chronic illness in school policy draft  | 2017 |  |  |
| Adherence guidelines for HIV, TB and NCDs: Policy and service delivery guidelines for linkage to care, adherence to treatment and xxxxx  | 2016 |  |  |
| National complaints management protocol for the public health sector in SA | 2014 |  |  |

1. https://www.who.int/health-topics/palliative-care [↑](#endnote-ref-2)
2. https://www.who.int/news-room/fact-sheets/detail/palliative-care [↑](#endnote-ref-3)
3. While there is concern that the studies that have influenced these “best buys” have mainly come from developed countries, there are no other current data.these [↑](#footnote-ref-2)
4. This is modelled on the HIV 90/90/90 targets. Given current baselines having a similar target for NCDs is not realistic and therefore a 90/60/50 target has been set for 2025. [↑](#footnote-ref-3)
5. This is assuming that deaths from unknown causes are equally distributed between communicable diseases, NCDs non-communicable diseases and non-natural deaths. [↑](#footnote-ref-4)
6. This is assuming that deaths from unknown causes are equally distributed between communicable diseases, non-communicable diseases and non-natural deaths. [↑](#footnote-ref-5)
7. This policy is only a training standard and not a national clinical guideline. [↑](#footnote-ref-6)