GOVERNMENT OF LESOTHO

MINISTRY OF HEALTH

MINISTRY OF HEALTH LESOTHO

NATIONAL MULTI-SECTORAL INTEGRATED STRATEGIC PLAN FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES (NCDS): 2014-2020

FOREWORD

The Ministry of Health is charged with responsibility of policy formulation and strategies for health service delivery with the ultimate goal of ensuring that every Mosotho has the opportunity for good health and acceptable quality of life.

Over the past 3 decades Lesotho has been battling with prevention and control of communicable Diseases. In the recent years the country is facing a double burden of diseases since there is still high prevalence of communicable diseases while there is a rapid increase of Non Communicable Diseases (NCDs). The Ministry has therefore, undertaken to develop the first action plan for prevention and control of Non communicable Diseases to meet the multiple challenges faced by the country today. This document attempts to capture some radical changes that must be implemented to the health system not only responsive to the needs of Basotho, but more importantly, to guarantee sustainability of the system to carry out the sector's mandate and for other sectors to play their role in disease prevention.

This document is a product of several months of consultations with major sectors (stakeholders) and implementers. The consultations involved group discussions with all districts whereby hospital representatives, District Health Management teams, members of District Councils, representation from different government ministries in the districts, Central Government Ministries, Senior Management and Heads of Programs of Ministry of Health, United Nations and Bilateral Implementing Partners were consulted. The NCD Technical Working Group was established at central level and World Health Organisation Country Office to oversee the process.

The Consultant was engaged with support from WHO to analyse and synchronise the information into a refined strategic plan on prevention and control of Non communicable Diseases NCDs.

The Ministry is confident that wide participation in the preparation of this document guarantees ownership and commitment of all stakeholders and implementing partners of this strategic plan.

I would like to thank all those who took part in this important process and the excellent work that has been accomplished.

Honourable Dr 'Molotsi Monyamane

Minister of Health – Lesotho

Executive Summary

The Ministry of Health (MOH) through the Directorate of Disease Control decided to develop a **National Multi-Sectoral Integrated Strategic Plan for the Prevention and Control of Non-communicable Diseases (NCDs).**The development of the plan was informed through literature review and key informant interviews. Two stakeholder consultations to give the input and validate the draft, were also held. The consultant worked closely with the Technical Working Group (TWG) to refine the inputs and decide on the content of the plan.

Lesotho measures 35,000 square kilometres in area, is divided into 4 topographic zones and 10 administrative districts. The World Bank classifies Lesotho as a lower-middle income country. The road infrastructure covers a significant proportion of the country and radio ownership is estimated at 63%. Anecdotal information suggests a high cell phone ownership. The adult literacy rate is 87% (79.7% male and 93.6% females) while the Infant Mortality Rate (IMR) is 94/1000 Live births (LB). Twenty Eight Percent (28%) of the population lack access to clean water while 42% lack access to sanitation.

Lesotho adopted the Primary Health Care (PHC) strategy in 1979. The public facilities (16 hospitals and around 200 Health Centers) are almost equally divided in ownership between the Government and the Christian Health Association of Lesotho (CHAL). The 3 referral hospitals are all in the capital Maseru. The MOH has also forged partnerships with the Lesotho Red Cross (LRC) and a few Private Practitioners, mainly in the capital Maseru. The community level services are delivered through Village Health Posts and around 6000 Village Health Workers (VHWs) [CHW Inventory 2004].

According to the Annual Joint Review [AJR 2012], LDHS 2009, and Programme reports, the top ten causes of Adult and Child Morbidity and Mortality include communicable and non-communicable diseases. The major NCDs among adults, in Lesotho, are cardiovascular diseases, diabetes, and trauma (accidents/injuries). Based on the WHO Global Burden of Disease estimates, cancer accounts for 17.2% of NCDs and 4% of all deaths in Lesotho. While Lesotho does not have a cancer registry, data obtained from the records of Queen 'Mamohato Memorial Hospital (QMMH), indicates that from January to December 2012, oncology patients constituted 90% (2771/3069) of the total referrals to South Africa. At the same time the AJR reports indicates that from 2007 to 2009 and in 2012 a maximum of around 100 and a minimum of around 80 Road Traffic Accidents (RTAs) were recorded countrywide. Stunting among children Under 5 years, a risk factor for adult obesity, is reported high at 39%, with 15%of this proportion severely stunted. Blue Cross rehabilitation records indicate the clients predominantly abuse alcohol.The Lesotho STEPS Survey of Chronic Disease Risk Factors of 2012 estimates that 24.5% (48.7% male and 0.7% female) of the

population above 25-64 years currently smoke, while 30.7% (47.3 male, 14.4% female) currently take alcohol; 92.7% (93.3% male and 92.2% female) take less than 5 servings of fruits/vegetables per day.72.9% (78.7% male,67.4% female) reported a high level of activity compared with low level of activity at 11.1%, (10.4% male and 11.8% female); 41.5% (24.8% male and 58.2% female) were overweight and 19.9% (7.9% male, 31.9% female) were obese. 31% (26.3% male and 35.6% female) had an elevated blood pressure; 83.8% (91.8 male, 78.1 female) of them were not on treatment. The key risk factors for NCDs were: current smoking, less than five (%) servings of fruits/vegetables a day, low levels of physical activity, overweight, and elevated blood pressure. A significant proportion (total 26.7%; 25.2% males and 28.2% females) of the population had 3 or more of the risk factors.

The main HSS challenges are inadequate human resources and inadequate skills, shortage of financial, infrastructural and logistics resources; weak supervision, monitoring, procurement and supply systems as well as research. The already inadequate human resources have been trained vertically per programme and tend to use a vertical approach to delivery of the services. The Health Information System faces challenges in timely and complete reporting

The Vision of the National Multi-Sectoral Integrated Strategic Plan for Prevention and Control of Non-communicable Diseases is that Basotho (citizens of Lesotho) shall be a healthy nation, whose exposure to the main risk factors will be minimised and with improved access to care and rehabilitation; contributing to sustainable socio-economic development of Lesotho. The MOH, will collaborate with and coordinate all sectors and partners, integrate with other programmes in and out of the MOH, advocate for implementation of best buys, develop laws, policies and guidelines, regularly supervise and monitor the programme, and report to Government. The strategy outlines the *roles and responsibilities of the MOH* aligned to those agreed upon by African Ministers of Health and contained in the Brazzaville declaration as well as WHO guidelines for countries; the roles of other government Sectors; Civil Society and WHO and other partners as per their mandate.The *key interventions* shall be on Leadership and Governance, Health Promotion and Education, Health Services Delivery, Human Resources (For health and relevant sector professionals), Health Financing, Health infrastructure and equipment, Partnerships, Multi-sectoral Collaboration and Cooperation, Community Ownership and Participation, Health Information Systems, and Surveillance and Research. The monitoring Framework is aligned to the WHO Global Framework.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AJR	Annual Joint Review
ART	Anti- Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behaviour Change Communication
CBHC	Community Based Home Care
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
CHAL	Christian Health Association of Lesotho
CMR	Child Mortality Rate
CRD	Chronic Respiratory Disease
CSOs	Civil Society Organization
CVD	Cardio-Vascular Disease
DHP	District Health Package
DHS	Demographic Health Survey
DHT	District Health Team
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMO	District Medical Officer
DOTS	Direct Observed Treatment Short Course
DS	District Secretary
EML	Essential Medicines List
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FAO	Food and Agriculture Organization
FP	Family Planning
GFATM	Global Fund for AIDS Tuberculosis and Malaria
HC	Health Centre
HSSP	Health Sector Strategic Plan
IMCI	Integrated management of Childhood Illnesses
LDHS	Lesotho Demographic Health Survey
LRA	Lesotho Revenue Authority
LRC	Lesotho Red Cross
MCH	Maternal and Child Health
MOAFS	Ministry of Agriculture and Food Security
MOCST	Ministry of Communications Science and Technology
MODP	Ministry of Development Planning
MOE	Ministry of Energy
MOET	Ministry of Education and Training
MOF	Ministry of Finance

MOGYSR	Ministry of Gender Youth Sports and Recreation
MOH	Ministry of Health
MOL	Ministry of Law and Parliamentary Affairs
MOLGCA	Ministry of Local Government and Chieftainship Affairs
MOLPA	Ministry of Law and Parliamentary Affairs
MOPS	Ministry of Public Service
MOTEC	Ministry of Tourism Environment and Culture
MOW &T	Ministry of Works and Transport
MOP	Ministry of Police
NMDS	National Manpower Development Secretariat
PMTCT	Prevention of Mother to Child Transmission
PSA	Prostate Specific Antigen
QMMH	Queen 'Mamohato Memorial Hospital
RH	Reproductive Health
RTA	Road Traffic Accident
SACU	Southern African Customs Union
SRH	Sexual reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations AIDS Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's' Fund
U5MR	Under Five Mortality Rate
VHC	Village Health Committee
VHR	Village Health Register
VHP	Village Health Post
VHW	Village Health Worker
WHA	World Health Assembly
WFP	World Food Programme
WHO	World Health Organization
WHO - AFRO	World Health Organization Regional Office for Africa

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1.0 Introduction

1.1 Rationale/Purpose

In keeping with the emerging challenges of NCDs and recognizing that the World Health Organization has globally and regionally, since the year 2000, provided tools to both inform/make aware and assist Ministries of Health and Governments of the emerging problem of NCDs, their risk factors, the burden and socio-economic impact, the Ministry of Health decided to develop a national Multi-sectoral Integrated Strategic Plan for the Prevention and Control of Non-communicable Diseases (NCDs). The Ministry of Health and the Directorate of Disease Control would then have a tool that defines the priorities, sets targets and objectives and provide a roadmap to all sectors and partners to improve service delivery in the context of NCDs**.**

1.2Methodology

The World Health Organization (WHO) assisted the MOH through a Local Consultant to facilitate the development of as well as document the plan. Through a consultative process the key stakeholders were identified and decision reached on those for whom Key Informant Interviews (KIIs) would have to be conducted. The interviews were conducted concurrently with the review of the literature on the global, regional and country burden of NCDs and recommended interventions. Two multi-sectoral consultative workshops, first for the participants to share information and input into what should be included in the plan, and secondly to validate the draft plan were conducted. The Consultant worked with a multi-sectoral Technical Working Group (TWG) who further refined the inputs and validated the content prior to the second workshop. The Consultant compiled the inputs and documented the plan.

2. Background

2.1 Country Geography, Topography, Governance and Culture

The Kingdom of Lesotho is situated between 28 to 30 degrees latitude and 27 to 30degrees east longitude. The country area is 30,359 square Kilometres and it is completely surrounded by South Africa. It is topographically divided into 4 zonesbased on altitude above sea level: Lowlands, Foothills, Mountains and the Senqu River Valley. Thecountry lies between 1,500 and 3,500 meters above sea level in altitude. It is dividedinto ten (10) administrative districts.

Lesotho is a Monarchy with the King as Head of State and political parties form Government through a first at the goal post model. In line with the constitution, in 2012, Three (3) parties formed a coalition to obtain the requisite majority to become

Government. Ministers are the key policy makers while Principal Secretaries are the Chief Accounting Officers. The National Health Policy identifies PHC as the key strategy for reaching out to all Basotho and empowering communities to take charge of their own health. Through the decentralization, government plans to further entrench community ownership and involvement in health and other social services.

The road infrastructure covers a significant part of the country (tarmac and gravel) and the lowlands are more accessible than the mountain areas. Household radio ownership is estimated at 63%. There are up to six (6) radio (1 community) and 2 television stations. By 2002 it was estimated that there were 23,000 telephone main lines and 84,000 mobile cellular telephones (Ministry of Communications HIV/AIDS Strategic Plan 2002). Access to mass media was as follows:

Table I: Access to Mass Media

Type Mass Media	Proportion (%) of Women who Listen to the Radio, watch Television or read at least once a week	Proportion (%) of Men who Listen to the Radio, watch Television or read at least once a week
Radio	66	62
Television	25	27
Newspaper	15 – 19	
Regular Exposure to any of the mass media	9	11

Anecdotal evidence now suggests that mobile telephone usage is very high.

Lesotho is a patrilineal and patriarchal society. Despite several laws and policies e.g. Legal Capacity of Married Persons Act 2006 and Child Protection and Welfare Act 2011, to empower females and protect children, at household level the key decision makers are men who should provide for the family. Women are mandated to take care of children, the elderly and the sick; participate in agricultural activities; and take care of the welfare of the households.

2.2 Country Economy

The Population and Housing census of 2006 estimated the population of the Kingdom of Lesotho at 1.8Million (1,876,633) with an estimated annual growth rate of 1.9%. The United Nations Population Division of the Economic and Social Council estimates the current (2013) population at just over 2 Million. According to the 2006 census young people (15-24) comprised 23.5%, and Women of Child-Bearing Age (WCBA) 24%, of the total population. The Maternal Mortality Ratio (MMR) has increased from 282 in the 1990s to 939 -1152 per 100,000 LB in 2009 (UN and DHS 2009). Children below 15 years comprise 36% of the total population, 58% are 15to 64 years, and 6% 65 years and above. The age dependent ratio is estimated at 0.72;the orphan population (0-17years) is estimated at 130,245. The life expectancy at birth is 41.2 years (42.9 women and 39.7 men). The crude economic activity rate is 29.6% and the Gross National Product (GNP) per capita is estimated at US $ 5414. The adult literacy is estimated at 87% (79.7 male and 93.6 females). The Infant Mortality Rate (IMR) is estimated at 94/1000 Live births, Child Mortality Rate (CMR) 23.7/10000 Live births, and

Maternal Mortality Ratio 1152/100, 000 Live births. Agriculture contributes 7% while manufacturing contributes 17% of the GDP (BOS 2009).

According to the Lesotho Demographic Health Survey (LDHS) 2009 in which the survey population was divided into 5 wealth quintiles, 6 in 10 persons in the lowlands were in the highest quintile while more that 50% of those in the highlands were in the 2 lowest quintiles, a variation of wealth by topographic zone. Wealth was also more evenly distributed in the urban than in rural areas. Women were less likely not to have attended school than men. The level of education increased with the wealth index.

Lesotho's economy has for a long time in its history relied on the remittances of mineworkers working in South Africa complemented by receipts from the Southern African Customs Union (SACU). SACU revenues were expected to decline by over 50% between 2010 and 2012 prompting the Government to introduce austerity measures. The Government is developing the mining and tourism sectors. The sources of livelihood include subsistence farming (22% of households), cash salaries and wages (17% of households), cash crops and livestock sales (12%of households). The UNICEF Situation Analysis of Children and Women indicates increasing vulnerability of households and the threat to social protection mechanisms.

2.3 Health Sector Organization and Guiding Policy

Lesotho adopted the Primary Health Care (PHC) strategy in 1979.The services in the 10 districts are delivered through 16 general and 3 referral Hospitals and about 158 – 200 Health centres (HC). The public facilities are almost equally divided in ownership between the Government (8 hospitals and about 50% of the health centres) serving 52% of the population, and the Christian Health Association of Lesotho (CHAL), a conglomerate of facilities owned by 6 churches, serving 48% of the mainly rural population. The 3 referral hospitals (general, MDR/XDR-TB, Mental) are all in the capital Maseru.. One Military and 2 private hospitals are also located in Maseru. There are two more private hospitals in one district while a myriad of privately owned facilities providing outpatient and other services, owned by medical doctors of different cadres but primarily General Practitioners, as well as nurses, are spread across all the 10 districts with the highest density in the capital Maseru. Private Medicine outlets (Pharmacies and Chemists) are also spread across the district capitals; more are within Maseru urban area.

The Ministry of Health and Social Welfare Facilities List 2007 indicates the following distribution of health facilities by level:

Table 2: Distribution of Health Facilities by Level and Ownership

TYPE	GOL	CHAL	PRIVATE	TOTAL
Tertiary Hospital	3	0	0	3
Hospitals	9	8	2	19
Urban filter clinics	4	0	0	4
Health centers	96	75	0	171
Health posts	1	16	0	17
Doctors' Owned (Surgeries)	0	0	36	36
Total	**113**	**99**	**38**	**250**

The community level services are delivered through community owned Village Health Posts where they exist. Lesotho has around 6000 Village Health Workers (VHWs) [CHW Inventory 2004]. The term VHWs has been interchangeably used with that of Community Health Worker (CHW).Traditional Healers are not formally included in the health service structure but are integral to Basotho and the health system; the Public Health Order of 1970 indicates that their accountability and regulation is by the Minister of Health.

Lesotho is faced with a growing burden of diseases. According to reports (Annual Joint Review [AJR] 2012, LDHS 2009, and Programme reports), the country's key health indicators are worsening instead of improving. The top ten causes of Adult and Child Morbidity and mortality indicate a double burden of communicable and non-communicable diseases

According to the National Health Policy 2011, the underlying challenges faced by the Health Sector, resulting in the unsatisfactory health indicators, include the health system that needs to be strengthened, increasing pressure on human and capital resources and shortage of critical skills and expertise. The Procurement and Supply Chain Management (PSM) is also unsatisfactory while programme monitoring is inadequate despite a well-developed Health Information System (HIS). The service providers minimally undertake operations research. The health workers are overburdened and demoralized resulting in an erosion of ethical standards of behaviour and attitudes that has resulted in the diminution of trust between communities and the health system.

The National Health Policy 2011 identifies PHC as the key strategy for reaching out to all Basotho and empowering communities to take charge of their own health. Through the decentralization, government plans to further entrench community ownership and involvement in health and other social service. The overall goal is to empower District Health Management Teams to manage all district-based resources

and be accountable for results. Priorities are indicated in the Lesotho Essential Services Package (ESP). According to the Decentralization Strategy 2009, the District Health Package (DHP), a combination of the essential services and the requisite support services, for which these teams shall be accountable are as follows:

Table 3: District Health Package (DHP)

Essential Services Package Support Services / **Essential Services Package Components**	HR for Health	Health infrastructure	HMIS	Integrated Procurement System for drugs, Health Supplies & logistics	Quality Assurance System	Coordinated Planning & Policy development
Component 1:Essential Public Health Interventions						
Sub-component: Health Education & Promotion						
Sub-component: Environmental Health Services						
Component 2:Communicable Disease Control						
Component 3:Sexual & Reproductive Health						
Component 4:Essential Clinical Services						

The goal of the Health Sector Strategic Plan (HSSP) is to have a healthy nation duly ensuring equity and equality in services delivered, as well as social justice. The main strategy to attaining this goal is PHC and recognition of its key tenants as agreed upon by the African Ministers of Health in 2008 and their being signatory to the Ouagadougou Declaration on PHC. The priorities under this strategy include leadership and governance; health services delivery; human resources for health; health financing; health information system; health technology; community ownership and participation; partnerships for health development; and research for health.

2.4 Lesotho Health Sector

The gains that Lesotho had made in the late 1980's to early 1990's through its Primary Health Care (PHC) programmes have been lost. Between 1996 and 2009, the Infant Mortality Rate (IMR) increased from 72 to 91 per 1000 Live Births (LB), and the Child Mortality from 20 to 28/1000 LB. It is estimated that Twenty Seven percent (27%) of the population lack access to safe potable water, while 42% lack access to latrines. Deforestation and indoor pollution are estimated high with majority of household utilizing fossil fuels for cooking and heating (indoors).The LDHS 2004 and 2009 show stagnation in some of the indicators

Table 4: Health Indicators

Indicator	LDHS 2004	LDHS 2009
Access to safe drinking water	50.9%	73%
Access to adequate sanitation	55.8%	49.8%
Proportion using fossil fuels	67.0%	65.7%
EPI Full Coverage	68%	62%
Stunting (Height for age)	Similar 2009	39% stunted 15% severely stunted
Wasting (Weight for height) Children under 5 years	Similar 2009	4% wasted 1% severely wasted
Underweight (Weight for Age) Children under 5 years	4% severely underweight	13% underweight 2% severely underweight
Infant Mortality Rate (IMR)	72/1000 Live births	91/1000 Live births
Child Mortality Rate (CMR)	20/1000 Live births	28/1000 Live births
Under 5 Mortality Rate (u5MR)	90/1000 Live births	117/1000 Live births
Maternal Mortality Ratio (MMR)	762/100,000 Live births	1155/100,000 Live births

Lesotho is also faced with a growing burden of diseases. According to reports (AJR 2012, LDHS 2009, and Programme reports), the country's key health indicators are worsening instead of improving. The AJR 2012-13 indicates a double burden of communicable and non-communicable diseases. The top ten causes of mortality and morbidity were reported as follows:

Table 5: Proportion (Percentage) Adult (>/13 years) Admissions 2009 to 2010

Disease	Proportion (%) Males			Proportion (%) Females		
	2009	2010	011	2009	2010	2011
Trauma	12	16	11	10	13	10
HIV/AIDS	11	11	10	10	13	10
PTB	9	10	10	4	6	5
Stroke and Heart Disease	4	3	3	5	2	4
Pneumonia	4	4	4		3	
Meningitis	3	2	2		2	
Diabetes Mellitus	3	3	2	5	5	4
Diarrhoea and Gastroenteritis	2	2	2	3	2	3
Anaemia	2		1		3	
Hypertension		1		3		3
Cataracts		3			5	

Abortion				16	17	16
Others	48	45	55			

While HIV/AIDS and PTB dominate the communicable diseases, trauma, diabetes, cataracts and stroke as well as heart disease are the top NCDs; abortion is also a major source of admission for females.

Table 6: Proportionate Mortality Adults (>/ 13 years) 2009 to 2010 (Percentage)

Disease	**Proportion (%) Males**			**Proportion (%) Females**		
	2009	2010	**2011	2009	2010	**2011
HIV/AIDS	34	22	20	46	22	22
PTB	17	15	14	12	9	9
Meningitis	7	8	8	8	7	6
Pneumonia	5	7	9	9	7	8
Stroke and Heart Disease	5	5	7		9	10
Trauma	4	6	3			
Diarrhoea and Gastroenteritis	3	2				
Diabetes Mellitus (hypoglycaemia)	2	2	2	2	(1)	3
Anaemia	2	2	3			
Cancer of the Cervix					1	
Others	19	29	28		39	

HIV/AIDS, PTB and pneumonia are key causes of inpatient mortality among communicable diseases while stroke, diabetes and Cancer of the cervix contribute to adult mortality.

Table 7: Proportionate Morbidity and Mortality Children (<13 Years) 2009 to 2010 (Percentage)

Disease	**Proportion (%) Admissions**			**Proportionate (%) Mortality**		
	2009	**2010**	**2011**	**2009**	**2010**	**2011**
Pneumonia	16	17	16	20	17	19
Diarrhoea and Gastroenteritis	13	9	9	20	12	13
Malnutrition	7	10	6	15	17	20
HIV/AIDS	9	6	3	16	14	8
URTI	2	3	4			
PTB	2			2	2	3
Convulsions	2	2	2	3	2	
Epilepsy		2	2			
Burns and Corrosions	3	3	5			
Dehydration	1	2	2		6	
Measles		5		7	2	8
Meningitis					5	
Others		41			22	

Pneumonia, diarrhoea & gastroenteritis, HIV/AIDS and measles are the dominant communicable diseases while malnutrition and burns (accidents) as well as epilepsy and convulsions are the reported NCDs for children.

Underlying challenges faced by the Health Sector, resulting in unsatisfactory health indicators, include a health system that urgently needs to be strengthened (Governance and Coordination, Procurement and Supplies Management (PSM), HR, Community System, Information System, Strategic Information), increasing pressure on human and capital resources and shortage of critical skills and expertise (National Health Policy 2011). Service providers minimally undertake operations research.

The Retention Strategy of the Ministry of Health and Social Welfare 2010, indicates that the staffing of all facilities did not meet the minimum standards and that the working conditions are poor, resulting in poor service delivery and distortion of the referral system through self-referrals, culminating in attrition and migration of health professionals. Through partner support (Irish Aid primarily) the professional staffing at health centres has been improved and reports indicate a staffing level of 3-5 Nurses and Nursing assistants at both Government and CHAL Health Centres. The Government also continues to pay incentives to the 6000 VHWs responsible for community based service delivery. The VHW supervision and support is however weak but there are plans under way to revitalize the programme and PHC in general.

Table 8: Lesotho Human Resource Health (HRH) Levels

Index	***Report 2003**		****Report 2012**	
	Nurses/1000 Population	**Doctors/1000**	**Nurses/100,000**	**Doctors/100,000**
Lesotho Actual	0.051	0.0038	0.46	0.05
Lesotho Required	0.088	0.0125		
WHO Standard	1.73	0.55	1.73	0.55

**The MOH retention strategy indicates that in 2003 the actual Nurse and Doctor Ratio per 100, 000 population was 88.5 and 12.5 respectively.*
***In 2012 there were 895 Nurses and 146 Medical Doctors for a population estimated at 1, 889,661*

The Millennium Challenge Corporation (MCC) support to Lesotho under the Millennium Challenge Account (MCA) supported the improvement of the infrastructure of health centres (MOH and CHAL) including equipment according to standards by the MOH. The Government meets the costs of all technologies and medicines as well as for a huge proportion of the costs of those supplemented through partner funding e.g. ARVs and anti-TB drugs supported by the Global Fund for AIDS Tuberculosis and Malaria (GFATM) and UNITAID.

2.5 Health Financing

Lesotho's development efforts including meeting the Millennium Development Goals (MDG) are threatened by the double burden of diseases; HIV/AIDS is recorded the main threat but the high burden of NCDs contributes. Other factors include poverty and food insecurity. Lesotho ranks 160 out of 187 countries on the UNDP Human Development Index. Unemployment is high at around 19%-29% and more than 50% of the population live below the poverty line. The Government of Lesotho in its Vision 2020 and in the National Strategic Development Plan has prioritized, among others, the improvement in the health of the population. The Strategic Plan on NCD Prevention and Control should be harmonized with the overall socio-economic development framework for Lesotho, Vision 2020 and its strategic development plans, national policies, regional, international guidelines and frameworks.

The ECSA-HC Health Care Financing Profiles of ECSA Health Community Countries 1995-2009 indicated that Lesotho's per capita expenditure on health was US $70 in 2009, more than 2 times the recommended US $34 but lower than that of its peers in East and Southern Africa (ESA) at US $74.The Government per capita expenditure on health was US $48, close to 68% of the total health expenditure and 6.2%-8.2% total expenditure as a proportion of the GDP, in 2009. The private expenditure on health represented 31.8% of the total health expenditure but out of pocket (OOP) payments constituted 70% of the total private expenditure, an indicator of poor pooling of resources and that household have to pay for health at the point of consumption; this may be a limiting factor to access to care as well as a financial burden of households. The burden of NCDs is recognized to be catastrophic to households and Lesotho is no exception. It may be advantageous for Lesotho to explore a system that protects households from impoverishment due to payments for health care through prepayment e.g. social insurance.

The ECSA-HC report further indicated an increase in total health expenditure up to 30.4% in 2009, indicating donor dependence; a factor that does not augur well for sustainability.

One of the key regional guidelines for financing of the health sector is the Abuja declaration in which Governments bund themselves to allocating at least 15% of the budget to health. A review of the MOH records indicates that the 1808 Billion Maluti (around 18 Billion US Dollars) allocated to the MOH in the financial year 2012/13 represented 13.1% of the Government budget while for the year 2013/14 the allocation was 2022 Billion representing 14% of the Government budget. In the 2 years partner/donor funding allocated directly to the MOH represented 2.5% of the total in 2012/13 and 1.2% in the year 2013/14. The report by the MOH is promising poor outcomes and deterioration of the health indicators is a concern that should be urgently addressed, including an assessment of the contribution of the unstructured and inadequate interventions for NCDs.
The Lesotho Health Sector Strategic Plan 2012/13 – 2016/17 indicates that the MOH will continue to advocate for increased government allocation of financial resources as well as donor support. The responsible officers shall be trained to strengthen the management of public finances and the ministry develop a comprehensive strategy that will facilitate the mobilization of financial resources from partners. The ministry

will also explore the establishment of social insurance; finances shall be allocated according the disease burden, demographics and location. The plan thus augurs well for NCDs including the protection of the people from financial catastrophe. The advocacy with Government should be priority in the leadership awareness and capacity building.

2.6 Lesotho Health and Related Policies Analysis

The health service in Lesotho faces several challenges that include the continued increase in morbidity and mortality as well as declining coverage of essential services. Emerging diseases such as MDR/XDR-TB and NCDs as well as consequences of trauma and RTAs are on the increase. Behaviour change, while critical in light of the emerging and high rates of communicable and non-communicable diseases, remains evasive. The high level of poverty exacerbates the already “dire” situation.

The National Health Policy 2011 bases itself on the decentralization of services and PHC as per the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. The decentralization is however yet to be effected as per policy. The MOH recently initiated a pilot PHC strengthening programme in 4 of the 10 districts with emphasis on systems strengthening.

The National Health Policy 2011 indicates that the Government accords priority to the District Health Package (DHP) and Essential Services Package (ESP) that includes:

- Essential public health interventions (Health promotion, immunization, nutrition, Integrated Management of Childhood Illnesses (IMCI), water, sanitation and hygiene)
- Communicable disease control (HIV and AIDS, STIs, and TBetc.)
- Sexual Reproductive Health and Rights/ Family Planning (Reproductive health, Safe motherhood, Maternal and infant nutrition, Adolescent health, PMTCT and ARVs)
- Essential Clinical services (Services for common illnesses, basic dental care, mental health services)
- Support Services: Human Resources, Supplies and equipment, logistics, Finance

Non-communicable diseases other than mental health and dental care, while not specified are understood to be included under health promotion as well as Essential Clinical services.

The National Strategic Development Plan 2012/13 – 2016/17states that efforts will target the improvement of the health of the nation with special focus to programmes that improve infant and child nutrition and both under-5 and maternal mortality. The strategies in addition to health systems strengthening include improving the quality and coverage of health promotion programmes and procurement and dispensing

systems for pharmaceuticals and essential supplies as well as the laboratory system. The public-private partnerships shall be strengthened and research promoted. In addition efforts to strengthen access to care shall include development of infrastructure in underserved areas, implementation of the ESP, expansion of integrated services including NCDs, and exploring options for the introduction of sustainable social/health insurance scheme. The national plan therefore provides a major government commitment for which NCD prevention and control may be tailored while aligning to the global and regional strategies

The objectives of the Health Sector Strategic Plan (HSSP) 2012/13 – 2016/17 include contributing to improved health status through equity and access to quality health care in both public and private domains guided by the principles and strategies of Primary Health Care; attaining and maintaining the deployment of right numbers and skills mix of appropriately trained and motivated HRH; ensuring availability and management of financial resources for improved access to health services and utilization of health facilities; ensuring that essential, safe, efficacious, acceptable quality and affordable medicines and other therapeutic products, medical devices and technologies are available all the times in health facilities and are accessible to all; providing timely, relevant, accurate and complete health information on a sustainable and integrated basis; improving delivery of health services by tapping into expertise and skills from the private sector, focusing on the output based partnerships and ensuring an optimal allocation of risk between the private and public sectors; and ensuring that health physical infrastructure are properly designed and constructed and that equipment are properly procured, installed and maintained in accordance with health. The key strategic objectives for the prevention and control of NCDs compare well and are aligned with this plan; NCD interventions will therefore be facilitated.

The HSSP further enunciates that priority will be accorded to the Essential Services Package; a set of cost effective, affordable and acceptable interventions that address diseases and factors associated with them. The criteria for selection of the interventions included the disease profile of Lesotho (no burden of disease study), cost effectiveness of the health interventions, affordability of the interventions and the extent to which the outcome is a public good. Under the HSSP the sector will strengthen the following components of the ESP, free of charge to the consumer at government, CHAL and LRC Health Centres:

- **Essential public health interventions:** Health Education and Promotion; Environmental Health; Child survival including immunizations and nutrition.

- **Communicable Diseases Control:** STIs, Tuberculosis and HIV.

- **Sexual and Reproductive Health:** antenatal care; management of deliveries; postnatal care; family planning; adolescent health; cancer screening (cervix and breast cancers).

- **Essential Clinical Services:** NCDs (diabetes, hypertension, cancers; and trauma); common illnesses (ear, eye and skin infections), oral health; and mental health.

The package also includes some of the intermediate risk factors for NCDs. Access to safe, effective and affordable medicines and technology are included as well. The health promotion includes healthy lifestyles, nutrition education and surveillance, supporting people that need home based and palliative care to access them, early screening and referral of people with NCDs, school health including a traumatic restorative treatment. The strategy thus covers the three levels of prevention of NCDs and the NCD strategy will be easily integrated into the sector wide strategy.

The MOH has adopted and is aligning to several policies and guidelines covering SRH, Nutrition, HIV/AIDS, and TB and on the tenets of health systems strengthening inclusive of HRH and Village Health Workers.

Lesotho is also signatory to several declarations and protocols including the Ouagadougou Declaration as a framework for health services, the Moscow Declaration on Healthy Lifestyles and Non-communicable Disease Control and has ratified the FTCT. A draft PHC Strategic Plan initiated in 2010 is yet to be completed and adopted. While there is no NCD Policy, the National Health Policy and several related policies and guidelines have been developed including the Nutrition Policy, Alcohol Policy (awaiting Cabinet approval), and guidelines for the management of Hypertension and Diabetes Mellitus at Primary Level. The recognition that NCDs need to be addressed and the fore-mentioned developments augur well for support and implementation of an NCD Strategic Plan.

In addition to Government funding of health services, the Government has entered into a purchaser-provider partnership with the Christian Health association of Lesotho (CHAL) and the Lesotho Red Cross (CRC) for provision of a defined Essential Health Package (EHP). The objective of the partnerships is to improve access to care to all Basotho and expand coverage to larger numbers of people regardless of location, through a standardized user fee structure which includes elimination of user fees at the Health Center level.

The Government has also entered into a Public Private Partnership (PPP) with a Provider (Tšepong) for the operations of the referral Hospital Queen ‘Mamohato Memorial Hospital (QMMH), operational since October 2011. The intention is to strengthen health service delivery and the PPP will run for 18 Years.

Traditional Medicine is governed through the Public Health Order 1970; the Ministry encourages collaboration with the conventional medicine but the relationship is primarily informal. Outside a publication of the Ministry of Agriculture on the plants of medicinal value there has not been any studies conducted on the efficacy nor safety of traditional medicines. Through the mass media several products are advertised purporting to cure and/or alleviate a multiplicity of ailments including NCDs.

3.0 Situation of Non-communicable Diseases (NCDs)

3.1 Global Situation

The WHO NCD Strategic Plan, Global Action Plan 2013-2020, Global Status Report on NCDs and several other documents indicate that globally NCDs are the leading cause of death accounting for 63% of the 57 Million deaths in 2008; 80% of these deaths were in low and low-middle income countries. The main causes were Cancer, Cardio-Vascular Diseases (CVD), Chronic Respiratory Diseases (CRD) and Diabetes. These diseases were also the cause of premature deaths (below 60 years of age) with the highest age-standardized death rates in low income countries (41% compared to 28% low-middle income, 25% upper and middle income, and 13% high income countries).

These diseases share the 4 main behavioural risk factors of tobacco use, physical inactivity, harmful use of alcohol, and unhealthy diets. These diseases are increasing in a majority of low to middle income countries. The intermediate risk factors are raised blood pressure, raised blood glucose, raised blood cholesterol, overweight and obesity, each associated with 13%, 9%, 6%, 6%, and 5% of the deaths, respectively. The prevalence of the risk factors differs with income and gender, higher in men compared to women.

With the World Health Assembly (WHA) endorsement of the Global Strategy for the Prevention and Control of NCDs in 2000, the need for action on NCDs was globally recognized. Several efforts were made at assisting member countries, examples of which are the WHO Framework Convention on Tobacco Control (FCTC) in 2003, WHO Global Strategy on Diet, Physical Activity and Health in 2003, WHO 2008-2013 Action Plan On the Global Strategy for the Prevention and Control of NCDs in 2004, WHO Global Strategy to Reduce the Harmful Use of Alcohol in 2008, First WHO Global Status Report on NCDs in 2009/2010, the WHO Non-communicable Diseases Country Profiles 2011and the WHO Global NCD Action Plan 2013-2020 (9 Global Targets and 25 Indicators). The high level meetings; inclusive of Meeting of the Ministers in the African Region and the Brazzaville Declaration in April 2011, First Global Ministerial Conference on Healthy Lifestyles and NCD Control and Moscow Declaration in April 2011, and the United Nations General Assembly and UN Political Declaration on NCDs in September 2011, further galvanized and put NCDs on the agendas of Governments worldwide. The World Health Assembly (WHA) Resolution WHA 66.10:Follow-up to the Political Declaration of the High Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases endorses the WHO Global Action Plan for the Prevention and Control of Non-Communicable Diseases2013–2020,which includes the 9 voluntary global targets for achievement by 2025, and the set of 25 indicators. The resolution further adopted the Comprehensive Global Monitoring Framework for the Prevention and Control of Non-communicable Diseases; it states that the framework, objectives, and targets are applicable across regional and country settings. The action plan while recognizing other NCDs mainly focuses on CVD, CRD, Diabetes, Cancer as well the main risk factors of smoking, unhealthy diets, physical inactivity, and harmful use of alcohol. The Action Plan recognizes the relationship to other WHO documents and advocates for acceleration of implementation of the WHO

Framework Convention on Tobacco Control (WHO FCTC) (resolution WHA56.1), Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17),Global Strategy To Reduce The Harmful Use of Alcohol (resolution WHA63.13), Sustainable Health Financing Structures and Universal Coverage (resolution WHA64.9), Global Strategy and Plan of Action on Public Health Innovation and Intellectual Property (resolution WHA61.21), the Outcome of the World Conference on Social Determinants of Health (resolutionWHA65.8) and the Moscow Declaration of the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease. The objectives indicated in the WHO Global NCD Action Plan 2013 – 2020 include the following:

- to raise the priority accorded to the prevention and control of Non-communicable diseases in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy ;
- to strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of Non-communicable diseases;
- to mobilize sustained resources as appropriate to national context, & in coordination with the relevant organizations and ministries, including the ministry of finance strengthen national Non-communicable diseases programmes;
- to reduce modifiable risk factors for Non-communicable diseases and underlying social determinants through creation of health-promoting environments;
- to strengthen and orient health systems to address the prevention and control of Non-communicable diseases and the underlying social determinants through people-centered primary health care and universal health coverage;
- to promote and support national capacity for high-quality research and development for the prevention and control of Non-communicable diseases; AND
- To monitor the trends and determinants of Non-Communicable Diseases and evaluate progress in their prevention and control.

The 9 Voluntary Global Targets include the following:

- 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory disease
- At least 10% relative reduction in harmful use of alcohol
- A 10% relative reduction in prevalence of insufficient physical activity
- A 30% relative reduction in mean population intake of salt/sodium
- A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years 24.6%
- A 25% relative reduction in prevalence or raised blood pressure
- Halt the rise in diabetes and obesity
- At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and stroke

- An 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities

The reaction and response of the countries has been varied in both reducing the exposure to risk factors and in control through effective management of the diseases. Improvements have been noted where countries strengthened their health systems and effectively applied population strategies. The WHO Stepwise approach for the prevention of the main NCD risk factors (AFRO Strategy) outlines the key interventions as well as their cost-effectiveness, implementation costs and feasibility for implementation. These are the recognized “best buys” interventions to reduce the exposure to the main risk factors and the NCDs, individually and together; that should be undertaken immediately for accelerated impact.

Interventions for reducing exposure to risk factors include protecting people from tobacco smoke and banning smoking in public places; Warning about the dangers of tobacco use; enforcing bans on tobacco advertising, promotion and sponsorship; raising taxes on tobacco; restricting access to retailed alcohol; enforcing bans on alcohol advertising; raising taxes on alcohol; reduce salt intake and salt content of food; replacing trans-fat in food with polyunsaturated fat; and promoting public awareness about diet and physical activity, including through mass media. Other cost-effective, low-cost population-wide interventions that can implemented to reduce the exposure to risk factors include nicotine dependence treatment; promoting adequate breastfeeding and complementary feeding; enforcing drink-driving laws; restrictions on marketing of foods and beverages high in salt, fats and sugar, especially to children; food taxes and subsidies to promote healthy diets. The impact of the diseases may be further reduced through improved health care, early detection and timely treatment of those with the diseases. Medicines, supplies, equipment and technologies are essential to facilitate this and adequate funds have to be allocated towards their procurement. The WHO has also published a list of the minimum and low-cost supplies and technologies as well as Prevention and Control of NCDs Guidelines for PHC in low-resource settings.

Experience shows that such efforts are limited and/or held back by inadequate political commitment, insufficient engagement of non-health sectors, and lack of resources, vested interests critical constituencies, and limited engagement of key stakeholders. Countries therefore have to address the limitations going forward and health promotion has to be coupled with advocacy with communities, Civil Society Organizations (CSOs), professional bodies, other sectors of government .The WHO has further provided a guide on the selected indicators to assess the country’s capacity to address and respond to NCDs and include the infrastructure, financing, surveillance, policy/strategy development, and implementation of key tobacco control measures.

3.2 Sub-Saharan Africa

The WHO Regional Office for Africa having analyzed the experience in Africa with PHC implementation, in 2008 facilitated an international conference in Ouagadougou, Burkina Faso, on PHC and Health Systems in Africa for accelerated action by all stakeholders. The Ouagadougou Declaration and the subsequent Framework for implementation, on PHC and Health Systems recognizes the strong relationships among health determinants and urges member states to update their national health policies and plans according to PHC; the emerging chronic diseases included. It further recognizes the need for inter-sectoral collaboration, use of priority interventions to strengthen health systems, measures to address human resources for health , sustainable mechanisms for increasing availability, accessibility and affordability of essential medicines, commodities appropriate technologies an infrastructure, strengthen health information and surveillance, strategic health financing and health promotion especially among the youth and adolescents. PHC is endorsed as the strategy towards improvement of the health outcomes for Africa.

The WHO Regional Office in line with the global concern and recognizing the interrelationship with health determinants also has facilitated and disseminated the guides for the African Region including the Libreville Declaration on Health and Environment in Africa, Algiers Declaration on Research for Health in the African Region Achieving Sustainable Development in The African Region, Strategic Directions for WHO 2010-2015 in 2010, and the Regional NCD Strategy 2013-2017.

The WHO Regional Office for Africa, Regional Non-communicable Diseases Strategic Plan 2013-2017 recognizes the 4 main behavioural risk factors for NCDs. Smoking was reported to increase with low education in South Africa and 23% of men were reported to smoke in Dar Es Salaam; smoking accounted for 71% lung cancer, 42% CRD, and 10% CVD. Harmful use of alcohol was reported in men more than women at 0-59% men and 0-39% women. Alcohol accounted for 4% global mortality of 320,000 young people, while the sequelae included violence, RTAs and 20-30% of oesophageal cancers. The Odds Ratio for Smoking and alcohol consumption was 7.3. In Mozambique average consumption of vegetables was 2.3 – 3.4 while fruits were 4.2-4.9; in Johannesburg salt intake higher than RDA was reported in 82% of the sampled population; while fat for energy constituted 13.1-50.7%, 4.1-25.4 % of which was saturated fats. Insufficient physical activity was reported to be 7.1% in Mozambique and 58.5% in Namibia.

Mortality from NCDs is also high in Africa. CVD accounted for 16.6% of the mortality; while the stroke surveillance data from Mozambique indicated a crude mortality of 148.7/100,000 while the adjusted annual incidence was 260/100,000. Obesity was at 8% men and 30.5% for women in South Africa while in Mozambique 11.5% of the rural and 2.6% of the urban populations were obese and those overweight were 30.1% urban and 10.2% rural. Obesity is a high risk factor for diabetes and diabetes complications include blindness, kidney failure and macro-vascular disease (Ischaemic heart disease and stroke). Fossil fuels are the main sources of energy in Africa. Chronic Respiratory Diseases are associated with poverty and socio-economic factors as well as chronic dust and smoke inhalation from indoor and outdoor pollution. Occupational/workplace factors are the main contributory factors to

CRD together with multiple early lung infections as well as being subsequent to malnutrition and LBW. The TB rate in Africa is estimated at 340/100,000 and its chronic sequelae include CRD. Asthma in children is also common in Africa (4.0-21.5%); in a study in Mozambique it was estimated to affect 13.3% of the children aged 6 to 7 years as well as 13 to 14 years. Early weaning, passive smoking, obesity, pets and family history are contributory and the prevalence is increasing. While cancer accounts for 13% of the global mortality, 70% of these deaths are in the developing world. In Sub-Saharan Africa, Cancer of the Cervix is the leading cancer among women (31.7 new cases/100,000) along with breast cancer (92,000 new cases and 50, 000 deaths in 2008). The cancers are increasing and this is attributable to factors that include increasing tobacco and alcohol use, unhealthy diets, environmental pollution, and due to infectious agents (cervix, liver, Kaposi's sarcoma, Burkitts Lymphoma, stomach cancer) that account for 36% of cancers in Africa. For Men, the common cancers are prostate, liver, oesophageal, Kaposis Sarcoma and colorectal; in 2008 new cases were 12% prostate, 11% liver and 7% Kaposi's Sarcoma. The leading causes of mortality were liver 13%, prostate 10%, and lung and bronchus 7%. Hepatitis B is a common infection that leads to liver inflammation and subsequent cirrhosis and cancer.

The strategy for Africa further indicates that there are additional NCDs of importance for the continent; risk accumulation over the life course and exposure to multiple risk factors also play a contributory role. These additional diseases of importance include Oral Disease, Sickle Cell Disease, Violence, Injury and Disabilities, Blindness, Deafness, and Neurological and Mental Disorders.Further, NCDs affect children as evidenced by the 10 year study in Manhica Mozambique in which NCDs accounted for 13.5% of deaths while injuries and chronic diseases accounted for 3.9% and 9.5% of the deaths respectively. The high rate of 20% maternal malnutrition and foetal programming and the 14.3% Low Birth Weight (LBW) babies raises the risk of Diabetes and NCDs in adulthood, respectively.

The neuropsychiatric disorders constitute 14% of the global burden of disease, compared to the worldwide deaths distributed as follows: CVD 30%, cancer 13%, CRD 7%, Diabetes 2%, injuries 9%, and other chronic diseases maternal causes and nutrition related causes 30%.

Alcohol consumption estimated at up to 50% excluding the 50% unrecorded and non-commercial drinks, contributes to violence and Road Traffic Accidents (RTAs). Globally injuries include suicide (16.9%), violence (10.8%), RTA (22 %) poisoning (6.7%), falls (7.5%), fires (6.2%), drowning (7.3%), and wars (3.4%). The mortality from RTAs in Africa is estimated at 28.3/100,000.

The risks to oral diseases include tobacco use, harmful use of alcohol, unhealthy diets, poor oral hygiene and the ageing population. 60-80% of children are affected by tooth decay and periodontal disease while 50-60% of those with HIV and AIDS have oral lesions.

The strategy enunciates that blindness due to uncontrolled diabetes and that is age-related is globally increasing. The major causes of blindness are cataract (51%), uncorrected refractive errors (3%), glaucoma (8%), age-related macular degeneration (5%), corneal opacity (4%), diabetic retinopathy (14%), trachoma (3%), eye conditions in children (4%), and Onchocerciasis (0.7%). The main causes of blindness in Africa include cataract (41%), trachoma (3%). Trachoma is hyperendemic in many poorest and remote areas of Africa among pre-school

children (prevalence 60-90%) and women due to their close contact with children. Other causes of blindness include being born blind, ageing, eye injuries, and inflammation. Onchocerciasis, closely associated with West and Central Africa (30 countries in Africa), is another major cause of blindness in Africa. 2.55 Million preschool children in Africa are estimated to suffer from night blindness due to Vitamin A Defficiency; half of those globally affected. Blindness is also consequent to diabetic retinopathy, a complication of diabetes that is not well controlled.

Of the globally reported 278 Million with hearing impairment 80% lived in Low to Middle Income Countries. The impairment follows from infections including chronic ear infections, measles, mumps and meningitis that are common infections in Africa. The prevalence of Chronic Otitis Media (COM) in Africa is estimated 0.4-4.2%. It is estimated that 3.9 Million children in Africa have mild hearing loss while 1.2 million have severe hearing loss (studies Swaziland and Gambia).

In 2006, the United Nations adopted the Convention on the Rights of Persons with disabilities that fosters the respect for the human rights of persons with disabilities. The NCDs such injuries and malnutrition may result in disabilities; disabilities may also result from complications of diseases of CVD and diabetes (retinopathies, peripheral neuropathy, nephropathy). However, the services for people with disabilities are inadequate in coverage and scope. The WHO reports that data from four Southern African countries found that only 26-55% of people received the medical rehabilitation they needed; 17-37% received the assistive devices they needed; 5-23% received the vocational training they needed; and 5-24% received the welfare services they needed.

The WHO Africa Region recognizes that for impact on NCDs, several cross-cutting issues should be addressed that in addition to NCDs impact on the health of the people and health systems in the region. These include the lack of human, financial and infrastructure resources; and the double burden of communicable and Non-communicable diseases. An integrated approach using the existing services is encouraged for better outcomes, recognizing the interrelationships between the diseases.

3.3 Lesotho NCD Burden

According to the Annual Joint Review Report 2012 the major NCDs among adults in Lesotho are cardiovascular diseases, diabetes, and trauma (accidents/injuries)as indicated below:

Table 9: NCD Admissions 2009 to 2010

Disease	Proportion Male Admissions (%)			Proportion Female Admissions (%)		
	2009	2010	2011	2009	2010	2011
Trauma	12	16	11	10	13	10
Stroke and Heart Disease	4	3	3	5	2	4
Diabetes	3	3	2	5	5	4
Hypertension					3	3

Reports from xx GOL and CHAL facilities (out of total xxx); the other admissions were for xx, xx constituting 80% of the admissions

Table 10: Inpatient NCD Mortality 2009 -2010

	Proportionate Mortality Males (%)			Proportionate Mortality Females (%)		
	2009	2010	2011	2009	2010	2011
Trauma	4	6	3	2	3	3
Stroke	5	5	7		9	10
Diabetes	2	2	2			
Cancer Cervix					1	

Data obtained from the records of Queen 'Mamohato Memorial Hospital (QMMH) indicates that in January to December 2012, oncology patients constituted 90% (2771/3069) of the totalreferrals.The most common cancers were Breast (21.7%), cervix (21.3%), Gastrointestinal (4.6%), head neck and face (4.3%), Female reproductive system (4.1%), Chronic Leukaemia (3.8%), Gastrointestinal tract (3.8%), conjunctiva (3.7%), cerebral (3.5%), skin (3.3%), Kaposi's Sarcoma (3.2%). Others included acute Leukaemia, Non-Hodgkin's Lymphoma, Prostate, Hodgkin's Lymphoma, connective and soft tissue, malignant melanoma, and bone cancers.

There is no Cancer Registry in Lesotho and patients receive treatment in South Africa; most terminal cancer patients are discharged home for HBC but palliative treatment is erratic.

Inpatient data, based on the AJR 2012, for other NCDs were as follows:

Table 11: Mental Health Disorders seen at Outpatient Department (OPD) 2012

Condition	Proportion (%)
Organic and Symptomatic Disorders	1
Disturbance of adult Personality	1
HIV/AIDS Neuropsychiatric Disorders	3
Mental and Behavioural Disorders	6
Neurotic Stress and Psychomatic	8

Mental retardation	1
Unspecified Mental disorders	1
Epilepsy	41
Schizophrenia (schizotypal and delusional)	29

Epilepsy was the most common mental health problem reported followed by neurotic/psychosomatic and behavioural disorders.

Table12: Drug and Alcohol Abuse and Treatment (Inpatients)

Number of Patients Served at Mohlomi				**Number of Clients served at Blue Cross**	
Year	**Alcohol**	**Dagga**	**Others (cocaine, mendrax, other)**	**Number Alcohol Clients**	**Number relapsed**
2007	44	22	1	51	12
2008	56	3	3	61	12
2009	56	12	3	55	11
2010	50	35	4	60	19
2011	33	3	3	74	22
2012	41	6	4	60	54

Alcohol was the predominant substance abused; of those who went for rehabilitation to Blue Cross 20% to 90% relapsed, indicating probable lack of support and continued exposure at community level.

Through facility based screening for cataracts a total of 3013 clients were screened and 41 (1.4%) received surgical removal, indicating they were partially or fully blind.

The Road Traffic Accidents reported in the AJR 2012-13 are derived from police records and are as follows:

Table13: Trauma and Deaths form RTAs Males 2008 -2012

Year	**Number**	**Deaths**
2008	14	5
2009	11	3
2010	16	6
2011	12	3
2012	10	4

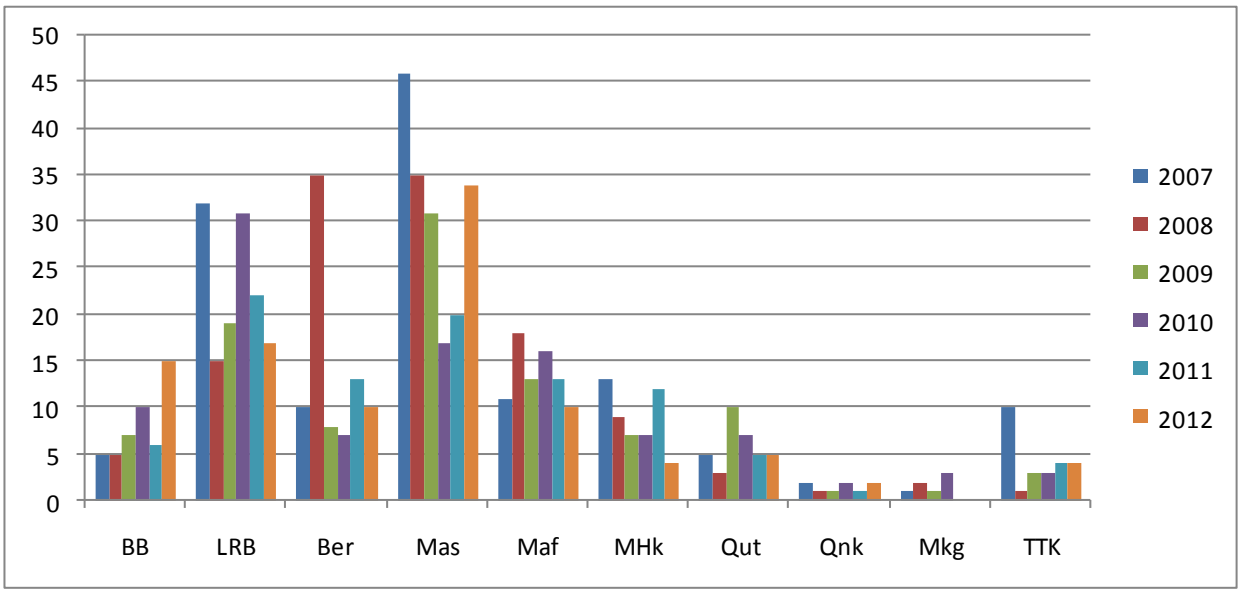
These may have been unreported due to incomplete reporting

The AJR report further reports on police data 2007 – 2009 and 2012 indicating a maximum of >100 and a minimum of >80 RTAs countrywide.

Table 14: Proportion (%) who died from RTAs in 2007 – 2012

Year	District									
	Butha Buthe	Leribe	Berea	Maseru	Mafeteng	Mohale's Hoek	Quthing	Qacha's Nek	Mokhotlong	Thaba Tseka
2007	5	32	10	46	11	13	5	2	1	10
2008	5	15	35	35	18	9	3	1	2	1
2009	7	19	8	31	13	7	10	1	1	3
2010	10	31	7	17	16	7	7	2	3	3
2011	6	22	13	20	13	12	5	1	0	4
2012	15	17	10	34	10	4	5	2	0	4

The proportion (%) of those who died varies by year within districts and between districts. The highest numbers are reported from Maseru followed by the 2 neighbouring districts of Mafeteng and Berea. While the variation between districts may have been affected by the completeness of reporting and the population size and size of traffic it is noteworthy that such accidents are highest in Maseru the capital and the closest more urbanized districts of Berea and Mafeteng.



Title: The proportion of the RTA victims who died also varies by calendar year with the highest

The NCDs reported among children are the neuropsychiatric mental disorders (epilepsy and Convulsions) and injuries due to burns (2% admissions each of 2009 to 2011) and burns and corrosives (2-3%). From 2009 to 2011 Malnutrition accounted for 6-10% admissions while the proportionate mortality was 15-20%. However the infections that may predispose children to later development of NCDs, especially pneumonia and meningitis are common causes for admission (up to 16% admissions for pneumonia and 5% meningitis) and in-patient mortality (up to 20%).

According to the LDHS 2009 stunting among children Under 5 years, a risk factor for adult obesity, is reported high at 39% and 15% are severely stunted. The UNICEF Situation Analysis of Women and Children indicates that inadequate food intake especially of protein, poor dietary diversity and quality, and reducing quantity of food to children during illness, negatively affect child nutrition and health. Unhealthy diets in Lesotho are thus a problem from childhood.

Based on the WHO Global Burden of Disease estimates, cancer accounts for 17.2% of NCDs and 4% of all deaths in Lesotho.

The following is a summary of the NCD data for Lesotho for which estimates and/or reports are available.

Table 15: NCD Data for Lesotho (WHO Global Status Report 2011)

Indicator	**Disease**			
	Total/All	**Cancer**	**Chronic Respiratory Disease**	**Cardiovascular Disease**
NCD Deaths (000's)	4.8 Males 4.5 Females			
% NCD Deaths < 70 years	57.5 Males 47.9 Females			
Age standardized Death Rate per 100,000 Males	953.5	79.2	144.4	513.1
Age Standardized Death Rate per 100,000 Females	628.8	59.3	57.7	393.4

The LDHS 2009 results show that 35% of men aged 15-49 years smoke and more than in women (xxx%). Only 26% of women had self-examined for lumps (breast cancer) while 5% had had a clinical exam in the 12 months preceding the survey. Only 31% of the women had heard of pap smear and 6% had tested. Of the 2% of women who had been diagnosed to have diabetes less than 50% were on treatment. 15% of women and 13% of men could be classified as hypertensive. Of those who were diagnosed to have hypertension, 82% took the prescribed medicines, 71% had cut down the salt intake, and 54% exercised.

The Lesotho STEPS Survey of Chronic Disease Risk Factors of 2012 estimates that 24.5% (48.7% male and 0.7% female) of the population above 25-65 years currently smoke, while 30.7% (47.3 male, 14.4% female) currently take alcohol; mean intake of an average of 2.1 servings of vegetables or/and fruits and 92.7% (93.3 male and 92.2 female) take less than 5 servings of fruits/vegetables per day while 72.9% (78.7% male,67.4% female) reported a high level of activity compared with low level of activity at 11.1%, 10.4% and 11.8% respectively; 41.5% (24.8 male and 58.2 female) were overweight and 19.9% (7.9% male, 31.9% female) were obese. 31% (26.3 male and 35.6 female) had an elevated blood pressure of which 83.8% (91.8 male, 78.1 female) were not on treatment.

Table 16: STEPS Survey Risk Factors (25 - 64 years)

Risk Factor	**Proportion (%) Population**		
	Male	**Female**	**Total**
Currently smoke	48.7	0.7	24.5
Currently take alcohol	47.3	14.1	30.7
Take <5 servings of vegetables/fruits per day	93.3	92.2	92.7
Low Level of activity	11.1	10.4	11.8
Overweight	24.8	58.2	41.5
Obese	7.9	31.9	19.9
Elevated Blood Pressure	26.3	35.6	31
Elevated Blood Pressure not on Treatment	91.8	78.1	83.8

The key risk factors were current smoking, less than?? servings of fruits/vegetables a day, low levels of physical activity, overweight, and elevated blood pressure. A significant proportion of the population had 3 or more of the factors as indicated below.

Table 17: Proportion of Population with 3 or more factors

Age Group(Years)	Total	Male	Female
25 – 44	22.1%	21.7%	22.4%
45 – 64	41.6%	40.6%	42.4%
25 – 64	26.7%	25.2%	28.2%

4. Financial and Social Impact of NCDs

4.1 Worldwide Impact

According to the Global Status Report on NCDs, briefs of the Moscow Conference, and the Regional NCD Strategy, the financial and social impact of NCDs is not only on the economy but up to household level. The illness, disability and premature deaths due to NCDs reduce productivity and result in loss of income, especially in low income countries. The high costs of care deprive families of their resources while the costs for diseases such as cancer and CVDs are catastrophic to households driving them to below the poverty line. It is the poorest members of the population that are worst affected by NCDs. Children are deprived of their education because of the depletions in income and investments; the reduction in the earning potential affects the national economies. Government expenditure is also increased through escalating cost of medicines and commodities, hospitalization and treatment of patients with NCDs.

According to the WHO Regional NCD Strategy, in 2010, the financial costs of diabetes worldwide were estimated at US $ 376 Billion and projected to rise to US$ 490 Billion by 2030. The estimates for Africa are US $ 2.4 Billion in 2010 and projected to US $ 3.6 Billion by 2030 while the International Diabetes Federation (IDF) estimated that US $111 was spent per person with diabetes in the African Region in 2010.

The reports indicate that economic analysis suggests that each 10% rise in NCDs is associated with 0.5% lower rates of annual economic growth.

4.2 Sub-Saharan Africa Impact

The Sub-Saharan countries are in the majority classified by the World Bank as low and middle income countries. The WHO Global Status Report on NCDs and the Regional NCD Strategy indicate, in these countries, deaths form NCDs occur at a younger age compared to the high income countries. In the low and middle income countries 40% of the deaths occur under the age of 60 whereas in high income countries it is only 11%. Globalization, and rapid urbanization accompanied by adoption of risk behaviours inclusive of increased smoking, unhealthy diets and lack

of physical activity contribute to the rise in disability and premature deaths from NCDs. At the same time the health systems are weak and not equipped to prevent and control NCDs. These countries are at the same time faced by the double burden of communicable diseases.

The costs of treatment, where available, are very high and unaffordable for countries. For example, based on the regional strategy it was estimated that in 2005 chronic NCDs cost the Tanzanian economy US$ 100 million. This is expected to increase to US$ 500 million by 2025 and lead to an accumulated loss of income in Tanzania over this period of US$ 2.5 billion. In 1989-1990 it was found that the average annual direct cost for diabetes care was US$ 287 in Tanzania for a patient requiring insulin and US$ 103 for a patient not requiring insulin. Purchase of insulin represented 68.2% of the total cost. The overall cost of diabetes care for this period was US$ 2,721,151, of which US$ 1,255,151 was for inpatient care, representing 8% of total government health expenditure.

The impact of NCDs at household, given the increased expenditure on care, loss of productivity and income (worst for low and middle income populations) is catastrophic; the cycle of poverty and NCDs is thus perpetuated. The level of the impact varies with the disease. It is reported that in India (Moscow Brief) a World Bank Study showed that 25% and 50%of families with a member with CVD and cancer respectively, experience catastrophic expenditures with 10% and 25% respectively driven into poverty.

NCDs also lead to social problems/costs. The sequelae of disability due to diseases such as stroke impose a heavy burden of care for households and the affected may end up with psychological problems due to their incapacitation. The cancers that affect women deprive households and children of their main caretakers and source of income (farming or otherwise). Conditions such as hearing and visual impairment are accompanied by stigma and often social isolation; in children such impairment may result in a delay in cognitive and language skills further exacerbated by limited special education facilities. Parents are less likely to send disabled children to school; at the same time such individuals are less likely to be employed. Their participation in society is restricted and they highly depend on others for their livelihood. It has been found that food insecurity, lack of access to safe water and adequate sanitation, and poor housing, are higher in households with a disabled member.

4.3 Lesotho Country Impact

The World Bank ranks Lesotho as a low-middle income country. The Lesotho Budget Survey of 2002/3 classified 57% of households as poor. The ECSA-HC profile of the member countries indicates that a decline in health expenditure per capita from US $ 38 in 1995 to US$ 23 in 2002 but an increase from $35 in 2003 to $75 in 2009, higher than the recommended $34 for providing cost-effective interventions in low-income countries. The Government per capita expenditure increased form $18 in 1995 to $48 in 2009 representing 68% of the total health expenditure. . The total

health expenditure as a percentage (%) of GDP increased from 6.2% in 2005 to 8.2% in 2009. Private health expenditure was 31.8% of the total health expenditure. Out-of-pocket payments constituted 70% of the total private expenditure indicating limited pooling of resources and that families have to pay at point of consumption, a limitation and barrier to access to the health services and a threat to financial status of households. The catastrophic expenditure on health would however be minimized by the decreased out-of-pocket expenditure as a percentage of total expenditure on health (40% 1995 and 21.9% in 2009 and projected to below 15% subsequently). During the period 1995 to 2009, Government expenditure on health as a proportion of Government expenditure was 9%, well below the Abuja Declaration of 15%. The increase of external resources form 2.3% in 1997 to 30.4% in 2009 indicated an increased dependence on donors; this does not augur well for sustainability especially given the unpredictability of donor funding.

According to the reports of the MOH this proportion increased to 13.1% in 2012/13 and 14% in 2013/14. The HSSP 2012/13 -2016/17indicatesfunding for the health sector is mainly from government and partners; Out of Packet (OOP) and contribution to private health insurance are other sources. The strategy indicates that between 2004/05 and 2007/08 the Government spent 7.7% of its GDP on health, above WHO/AFRO Region average of 5.6% in 2006; at the same time the Government spent US$54.6 per capita per annum which was also above the US$34 per capita per annum recommended by WHO for providing a minimum package of cost effective interventions in African countries.

While budgetary allocation and expenditure has not been analysed by morbidity, the double burden of communicable and non-communicable diseases imposes a financial burden on the country and households as indicated by the out-of-pocket household expenditure for health. The social impact of stigma faced for some of the conditions and the decline in social protection mechanisms impact on the outcomes. The consequent disability of some of the NCDs exacerbates the financial and social impact. At the same the rapid urbanization and inadequate education with the demonstrated high rates of risk behaviours to NCDs, exacerbated by the high prevalence of communicable diseases associated with NCDs is a proxy indicator of the social and economic impact of NCDs in Lesotho.

5. Lesotho Cross-cutting Issues

The Millennium Development Report 2011 indicates insufficient progress for Sub-Saharan Africa to reach the target if the prevailing trends persist. Lesotho like other African countries is not only faced by the challenge of the double burden of communicable and Non-communicable diseases but a weak health system. Community involvement and participation is also weak. The National Health Policy and the HSSP 2012/13 – 2016/17 emphasise on the need to revitalize PHC.

5.1 Millennium Development Goals and Lesotho Vision 2020

Lesotho is classified as a lower-income country with a Crude Economic activity of 9.6% and GNP US $5414. The risk factors to NCD are relatively high so is the

burden of NCDs and communicable diseases. The National Strategic development Plan 2012/13 – 2016/17 in reviewing trends between 2004 to date indicates either slow progress or that Lesotho is off track, with some indicators regressing, towards reaching the MDG Goals. The Infant Mortality has risen from 79/1000 LBs in 2004 to 91/1000LBs in 2009 (target 24/1000), Under 5 Mortality has similarly increased from 111/1000LB in 2004 to 119/1000 LB in 2009 (target 37/1000 LB). Maternal Mortality has more than doubled from 419/100,000 LB in 2004 to 970/100, 000 LB in 2009 (target 70/100,000). Similarly, slow progress is observed in some of the indicators of the Vision 2020 targets such as reduction of proportion of the population living below the poverty line (56.6% at baseline target 10%) and attaining a healthy developed human resource base as indicated by the slow improvement in the Human Development Index (0.43 baseline, 0.45 2012 and target 0.68). The vicious cycle of poverty, illness including NCDs is thus perpetuated. In coping with the illnesses families and patients may have to sell their possessions to pay for health care and especially women leave their jobs while older children leave school to pay for the sick. The inability of countries to reach the MDG targets is related to the burden of NCDs linked to economic factors such as spending money on tobacco and alcohol and not child health. The causes for the high maternal mortality include pre-eclampsia while the STEPS Survey indicates a high level of obesity among women; it is recognized that hypertension in pregnancy and gestational diabetes lead to adverse pregnancy outcomes. According the DHS 2009 63.2% of the men and 38.9% of the women were currently employed; this may impact on the women's capacity to seek health care.

5.2 Access to Health Services and Care

The AJR 2012 indicates a service level of 90%. While this is an improvement from the previous years, the access to early detection and to medicines for the vulnerable may be compromised by the 10% of the time when services or essential supplies are not available. The underserved areas are characterised by difficult terrain with poor or no road infrastructure demanding that clients and patients walk long distances (More than 2 Hours) to access health facilities. Failure to receive the required services may translate into late presentation for care. This situation does not augur well for early detection and treatment of diseases including NCDs.

According to the DHS 2012, 28% of the population lack access to clean water while 42% lack access to sanitation further contributing to communicable and NCDs. The causes of ill health for BASOTHO, including environmental factors, with emphasis on the most vulnerable especially women and children therefore need to be addressed integrated into strategies and policies for poverty eradication and sustainable development. Improved and equitable access to health services including equitable access to medicines, technologies and prevention will contribute to sustainable development.

5.3 Integration of Services and the Double burden of communicable and NCDs

The HIV prevalence in Lesotho is 23%, the third highest in the world. The prevalence is higher in urban (27.2% compared to rural (21.1%) areas, women (26.7%) compared to men (18%), and highest among the 30-39 year olds at 40%. The HIV co-infection among TB patients is 76%. Patients with HIV may suffer mental disorders, HIV infection is associated with increased Kaposi's sarcoma and ARV use may lead to diabetes. The high prevalence translates into increased risk of the NCDs and associated social and economic problems for households. TB contributes towards CRD. However, despite the improved coverage of HIV/AIDS and TB, the activities are vertical up to community level; a missed opportunity for NCD Prevention and control. The integration of plans and strategies for the main communicable and Non-communicable diseases, given the interrelationship, will improve on the prevention and control of both communicable and NCDs, thus improved health for the population.

Similarly the incidence of the Cancer of the cervix was estimated at 36.3% (GLOBOCAN 2008). Antenatal Care coverage for at least 1 visit is estimated at more than 90% while the Prevention of Mother to Child Transmission (PMTCT) coverage is estimated at more than 80%. The historical MCH service delivery, although it includes Family Planning (FP), does not routinely include screening women for the common cancers of the cervix and breast. EPI coverage is estimated at more than 80% and so is HPV coverage. Prevention messages to mothers, children, and the community do not however include information on the risk factors to NCDs. Linkages and integration of the MCH and NCDs activities would benefit the population.

The Government is in the process of decentralizing Government to the local level; health and social development are the first in this context. The MOH has prioritized the PHC approach for better outcomes at lower cost for service delivery and has initiated efforts at revitalization as per the Framework for the implementation of the Ouagadougou Declaration. The District Health Package and Essential services Package do not single out prevention and control of NCDs as priority; they are subsumed under basic curative services. Although Lesotho has ratified the FCTC and is party to resolutions made at the WHA there is minimal activities in the prevention of NCDs including on the key tenets of the FCTC. Established communicable disease control programmes and the MCH have not integrated NCDs other than screening for hypertension and diabetes during special campaigns and HPV vaccination which is under the EPI. At the same time the health sector is faced with inadequate human, financial, infrastructural and logistics resources; weak supervision, monitoring, procurement and supply systems as well as research. The already inadequate human resources have been trained vertically per programme while they deliver all the services, negating the efficiency and not improving on the operations of the health facilities. The Health Information System faces challenges of timely and complete reporting; the Data Quality Assessment (DQA) for EPI has however raised doubts on the accuracy of the reported data. The first mention is in the executive summary but this is in context.

5.4 Partnerships

The key partner of the MOH to health service delivery is the CHAL covering up to 48% of the health facilities mainly in the rural underserved areas. The MOH has also forged partnerships with the Lesotho Red Cross (LRC) and a few Private Practitioners. At Community Level the mainstay for health services are the community health workers. Various Community Based Organizations (CBOs), extension workers e.g. Agriculture, teachers, and civil organizations as well leaders are based at community level but are minimally if at all involved in advocacy, education and identified service delivery relevant to the health sector. Multi-sectoral and multi-disciplinary interventions including public private sector collaboration would enhance performance.

For the health system to manage NCDs and other diseases including the management, the health sector needs to be prioritized for strengthening by government and effective systems put into place. NCDs are chronic diseases that require long-term care including at the tertiary level for treatment, rehabilitation and palliative care. Efforts therefore have to be made towards a “paradigm shift” from acute to chronic care; the WHO developed the Innovative Care for Chronic Conditions Framework (ICCCF) and the elements of this model describe the modes for the effective management of NCDs. A basis has been set with the ART and management of Diabetes and hypertension although the latter may not be as comprehensive nor as patient focussed and empowered as required as well weak on community based actions. The revitalization of PHC also needs to be accelerated; this requires a change in laws and policies such as fiduciary and human resources quota and cadres (the country is under structural adjustment) as well as financial resources allocation Guidelines for all areas of management of district level services including at community level need to be urgently developed and a clear hierarchy of accountability and functions disseminated. The pilot in the 4 districts will hopefully provide the key information for the future organization of services. First mention in executive summary but now in context

6. Common and Recommended Prevention Strategies for NCDs (“Best Buys”)

The common and recommended strategies include those that address the NCDs and the key risk factors. According to the WHO the key NCDs are cancer, diabetes, cardiovascular diseases and chronic respiratory diseases whose key risk factors are tobacco use, harmful use of alcohol, lack of physical activity and unhealthy diets. in The Lancet 2011, 377: 1438-37, Priority Actions for the Non-Communicable Diseases Crisis, recommendations on the best buys interventions are based on their documented significant public health impact in reducing premature deaths and disability, are highly cost-effective and inexpensive, and are politically as well as financially feasible for implementation. The feasibility of the scale up of these interventions is reported dependent on factors that include the political situation, resource availability, health system capacity, community support, the power of commercial interests, experiences of other countries, and international commitments and support. A set of priority actions that are pre-requisite to delivery are sustained political leadership at the highest level nationally and internationally, support for strengthening of health systems especially PHC, international cooperation,

monitoring systems and accountability mechanisms for measurement and reporting progress. Thebest buys are as indicated below:

(a) **Primary Prevention**

Risk Factor	**Interventions**
Tobacco Use	• Raise taxes on tobacco • Protect people from tobacco smoke • Warn about the dangers of tobacco • Enforce bans on tobacco advertising
Harmful Use of Alcohol	• Raise taxes on alcohol • Restrict access to retailed alcohol • Enforce bans on alcohol advertising
Unhealthy diet and physical inactivity	• Reduce salt intake food • Replace trans fats with polyunsaturated fats • Promote public awareness about diet and physical activity (mass media) = a good buy??
Cancer and Chronic Respiratory Disease	• Reduction of indoor air pollution
**Cancer	• HPV Vaccination to prevent Cervical cancer • Hepatitis B vaccination to prevent liver cancer

These interventions are cross cutting for the 4 main NCDs of cancer, CVD, CRD, and diabetes.

Table 18: Common Risk Factors NCDs

Risk Factor	**Non-Communicable Disease**			
	CVD	**Diabetes**	**CRD**	**Cancer**
Tobacco Use	X	X	X	X
Harmful use of alcohol	X			X
Unhealthy Diet	X	X	X	X
Physical inactivity	X	X		X

(b) SecondaryPrevention

Disease	Intervention
Cancer	• Screening and treatment of pre-cancerous lesions to prevent cervical cancer • Screening through examination for lumps and mammography for breast cancer*** • Screening at age 50 and treatment for colorectal cancer • Early detection and treatment of oral cancer
Diabetes	Counselling and drug therapy (blood sugar control)
CVD	• Counselling and multi-drug therapy for people with medium-high risk of heart attack • Treating heart attacks with aspirin
CRD	Treatment of persistent asthma with inhaled corticosteroids and beta-2 agonists

© Tertiary Prevention

This is the stage at which there will have been complications resulting in disability (reduced DALYs) and at which efforts are directed at delaying the disease progression, relieving the pain and palliative treatment, especially considering the human rights of such individuals. It is indicated further research is needed to inform the best buys at this level and the interventions may be as follows:

Disease	Intervention
Stroke and Heart Failure	• Multi-Drug therapy • Counselling • Physiotherapy and occupational therapy
Diabetes	• Supportive therapy, drug therapy • Counselling
CRD	• Supportive therapy, drug therapy • Counselling
Cancer	• Pain relief and palliative care • Chemo and radiotherapy

7. Existing Measures for NCDs in Lesotho

7.1 Measures by level

7.1.1 Primary Prevention

Lesotho is faced with a huge problem of exposure to the main risk factors of NCDs with 25% of the population current smokers, mainly males; Current Alcohol consumption is at 31%, 93% people haveless than 5 Servings vegetables/fruits per day, and 44% are not engaged in rigorous activity, The rate of the intermediate risk factors is also high with 42%Overweight, 20% Obese, 31% with raised Blood Pressure (BP), 84% of whom are not on treatment, 6% with raised fasting blood glucose, and 5% with raised cholesterol. 26.7% of the population 25-64 years (22.1% 25-44 and 41.6% 45-64) has at least 3 of the risk factors. At the same time 39% of the children are stunted (later obesity). The inpatient proportionate morbidity and mortality are relatively high for the reported main NCDs: Stroke and heart disease 2% and diabetes 5% and 3% of the admissions and hospital deaths, respectively. The extent of the cancer burden is difficult to obtain in the absence of the cancer registry; however at the only referral hospital QMMH, in 2012 cancers accounted for 90% (2771/3069) of the patients referred to South Africa; 21.7% of these were with cancer of the breast while 21.3% had cancer of the cervix (late reporting and inadequate screening facilities).

Despite the problem of NCDs, interventions have not been well organized or coordinated and have mainly involved the MOH. A few other Government sectors have been involved due to their felt need (e.g. Ministry of Tourism and alcohol policy, Ministry of Sports and sport activities).

The Primary Prevention interventions have mainly been health promotion on NCDs and risk factors – campaigns, use of media, IEC materials and HPV Vaccination which was initially in the context of reproductive health and later incorporated into the EPI programme. There however is neither a tobacco, physical activity, nor dietary policy. An alcohol policy is awaiting Cabinet approval while a nutrition policy involving all relevant stakeholders has been approved but has been minimally disseminated. Collaboration with the private sector and NGOs, except CHAL and LRC is minimal and there is yet no policy on such collaboration. There is no approved topic-specific, integrated programme or plan, for NCDs.

7.1.2 Secondary Prevention

Screening for NCDs is mainly ad hoc, there is no health care provider initiated testing or counselling for most NCDs except screening for raised blood pressure and glucose, mainly during HIV campaigns. There is a cervical cancer (and breast) screening and treatment of pre-cancerous lesions facility in the capital Maseru; access is limited for most of the population. The treatment of hypertension and diabetes has been on-going through hospitals and health centres for a long time and medicines availed for treatment but the quality of services varies. The MOH developed Guidelines for the management of hypertension and diabetes at primary care level but they are minimally distributed nor in use in most facilities. The Government continues to procure drugs and technologies but the procurement

system is uncoordinated leading to inefficiencies and artificial shortages (weak Procurement and supplies management [PSM]).

7.1.3Tertiary prevention

Strokes and heart failure, CRD and complicated diabetes are managed directly or referred to the referral hospital QMMH. The Government also funds referrals to South Africa for patients that require high level care e.g. Cancer patients are referred to RSA for chemotherapy and radiotherapy at a total (all cancer patients) cost of around Twenty Million Maluti [M 20 000 000] (about US $ 2 Million) annually. There is limited counselling and rehabilitation therapy for such patients and the limited number of therapists and facilities are based in Maseru. Terminal stage patients are sent back for home based care but access to pain relief and palliative care are limited.

7.2 SWOT Analysis NCDs Prevention and Control in Lesotho

Strengths	Weaknesses

• Increase in leadership awareness following
  ○ UN High Level Meeting
  ○ Brazzaville Declaration
  ○ In-country developments
• Existing initiatives by sectors and NGOs in areas of their mandate such as the MOH draft alcohol policy whose development involved all key stakeholders, involvement of communities throughout the country in sports by theMinistry of Gender, youth, Sports and Recreation (MOGYSR), and raising awareness on the risk factors through print and electronic media
• Government funding of drugs and equipment including for people with NCDs,
• Government concern on the high cost of referral of patients for tertiary care
• Existence of guidelines and policies for some of the conditions e.g. Management of hypertension and diabetes at primary level, guidelines for screening for cervical cancer, Infant and young Child feeding Guidelines, National nutrition Policy
• Tobacco and RTA Bills have been submitted for
	• Inadequate/ Lack of data on:
	  • Burden
	  • Interventions that work for the other priorities of the African continent as well as in the African context
	• Weak health systems
	  ▪ Service delivery not integrated
	  ▪ Health workforce: capacity and shortage in numbers and types of required professionals
	  ▪ Lack of surveillance systems for NCDs
	  ▪ Inadequate logistics and infrastructure
	  ▪ Uncoordinated Procurement and Supplies Management (PSM)
	  ▪ Financing: donor dependence
	  ▪ PHC approach and decentralization
	• Leadership and governance: low capacity for implementation in line with guidance (e.g. FCTC)
	• Lack of/inadequate multi-sectoral approach and collaboration
	• Lack of risk pooling mechanism and high household expenditures for health beyond health centre level
	• Weak regulation of pharmaceuticals and professionals

promulgation; policy on alcohol awaiting Cabinet approval
• Quality Improvement Policy and Strategic Plan in place
• Existence of guidance
  ○ FCTC
  ○ Action Plan for the Global Strategy for the Prevention and Control of Non-communicable diseases
  ○ WHO Global Strategy to Reduce the Harmful Use of Alcohol
  ○ WHO Global Strategy on Diet, Physical Activity and Health
  ○ WHO Package of Essential NCDs interventions at PHC
• Abolition of user fees at health centre level for Government, CHAL and LRC	

Opportunities	**Threats**

• Potential partnerships
  • Other Government Sectors
  • NGOs
  • Private Sector
  • International??
• Existence of training programmes for other diseases and programmes especially reproductive health, child health and nutrition, TB, and HIV and AIDS
• Existence of training materials for NCDs
• Coordination and cooperation with other disease programmes, e.g. HIV/AIDS, TB, Reproductive Health, Child Health, Nutrition
• Existence of Vision 2020 and Prevention of Blindness programme
• Existence of facilities for specific programmes such as Mental Health and screening for cancer of the cervix
• Addressing the main risk factors also addresses the main NCDs
• Cost-effective proven interventions exist
• Existence of Oral Health and Mental Health Services in the district hospitals.
• National Health Training Centre
	• Double Burden of NCDs and Communicable diseases
	• Increasing risk factors
	• Increasing poverty and urbanisation
	• Lack of policies and legislation in support of interventions for risk factors
	• Inadequate multi-sectoral approach and conflicting priorities between government sectors
	• Limitation of resources and the financial impact of organised and increasing programmes of the MOH as well as increased number of people diagnosed and treated leading to higher costs
	• High number of people not diagnosed/accessing services concurrent with scarcity/inadequate human resources
	• Sustainability of programmes and projects developed outside partner support
	• High attrition of trained Human Resources for Health (HRH)
	• Weak regulation of alternative medicine including TAM

(NHTC) has now established a curriculum of Dental Therapists • NHTC also trains Laboratory Technicians • NHTC and other Nursing training colleges in the country (total 5) • NMDS support for out of country training • The opening of the Medical School in Lesotho and improvement MD availability	

8. National Strategic Plan for the prevention and control of NCDs

8.1 Vision

Basotho shall be a healthy nation, living with minimal NCDs and living a productive life. Their exposure to the main risk factors will be minimised and there will be improved access to care and rehabilitation for people affected by NCDs thus contributing to sustainable socio-economic development of Lesotho.

8.2 Mission

The MOH, through the NCD Unit, will collaborate and coordinate all sectors and partners, integrate with other programmes in and out of the MOH, advocate for implementation of best buys, develop laws, policies and guidelines, regularly supervise and monitor the programme, and report to Government.

8.3 Core Principles

The NCDs shall be mapped, health care for people with NCD strengthened, inter-sectoral collaboration fostered, partnerships and networking assured. The PHC approach to service delivery ensuring delivery of better health outcomes at lower cost, shall be the mainstay for services. The Strategic Plan shall be aligned to the following core principles:

- **Equity**: Disparities in quality basic health services shall be addressed ensuring equal access to services and in accordance with the Constitution of Lesotho.
- **Universal Health Coverage**: All people living in Lesotho shall have access to prevention and control of NCD risk factors and diseases. Underserved areas shall be mapped out and innovative approaches to improved access implemented. e.g. special days NCDs
- **Accessibility and availability:** All public and NGO facilities as well as high volume private sector health facilities shall be appropriately equipped and provided with technology for NCDs (efficiency); safe and effective medicines shall

be available differentiated by level, and health workers as well as VHWs and CSOs trained and supervised to deliver the services at community level. NCD services shall be offered at all times at all levels of care only differentiated by the level of prevention. In line with HSSP this shall be extended to underserved areas; innovative mechanisms shall also explored.

- **Affordability**: NCDs shall be integral to the Essential Services Package that shall be free of charge at health centre (GOL, CHAL and LRC) level, and subsidized at other levels including for the private sector.
- **Acceptability:** The services shall use a human rights approach respecting the dignity of everyone. The services shall be provided by trained Human Resources in a conducive environment. The culture of the people shall respected unless it contravenes prevention principles; in such a case adequate counselling and support will be provided.
- **Integrated approach:** The prevention and control of NCDs shall be integrated into the on-going key programmes interventions. The reduction of exposure to risk factors shall be integrated with the control of the diseases.
- **Multi-Sectoral Collaboration and Partnership**: Government and non-Government sectors will be consulted and will be involved in the planning, implementation, monitoring and evaluation of health services delivery using effective collaborative mechanisms. Local and international Partners shall be included.
- **Scientific Basis and Cost-Effectiveness:** The programme shall utilize scientifically proven and cost effective interventions adapted to the local context,
- **Leadership and Coordination:** The country leadership shall be sensitized and intensive advocacy conducted to ensure country ownership. Each sector shall identify their area of comparative advantage that they shall lead including coordination of the actors and be accountable for specific outcomes. The activities shall be in line with the Paris Declaration and the Accra Agenda for Action.

8.3 Guiding principles

The Guiding Principles for this strategy, closely related and complimentary to the core principles, as well as aligned to the National Strategic Development and the Health Sector Strategic Plan include the following:

Political Commitment: Commitment to this plan will be required from all Government sectors and partners (NGOs, Donors, Civil Society, Private Sector). Due recognition should be given to that the prevention and control of NCDs will contribute to poverty reduction and economic growth, leading to NCDs being prioritized and allocated resources.

PHC Approach: In line with the Ouagadougou Declaration and the Framework for Implementation, the PHC approach shall be fostered for better outcomes at low cost. Through this approach, equity shall be attained through ensuring access, affordable quality health services (multi-sectoral response), and an evidence based approach shall ensure interventions of high standard and that are cost effective

Decentralization: A decentralized approach accompanied by community empowerment and involvement shall be reinforced in line with the Local Government Act.

Community Participation: Communities shall be actively encouraged and supported to participate in decision-making and planning for health services. Through ownership of community projects, communities will be masters of sustainable Primary Health Care programmes in their own areas.

Integrated Approach: The delivery of NCD services shall be integrated with other established health services in Lesotho.

Sustainability: Innovative mechanisms for sustaining services shall be explored in line with the National Strategic Development Plan and evidence based mechanisms as outlined in the WHO World Health Report, Health Systems Financing. These shall include reducing reliance on direct payments, contributions by people who can afford to pay, and through taxation (especially levies on tobacco and alcohol).

Quality: NCD standards shall be integrated into the national Quality Improvement systems and guidelines. The Standard Operating Procedures for outpatient departments and health centres shall also cater for NCDs.

Gender Sensitivity and Responsiveness: NCDs and the exposure to risk factors vary by gender and are affected by cultural and societal norms and values as well as economic status of households. The planning, implementation and monitoring of the services shall recognize these differentials.

Ethical consideration: A human rights approach shall be fostered for NCDs (and all health services). The capacity of health workers shall be built and reinforced through supervisory support.

Research: Research on NCDs shall be encouraged and supported. The priority shall be accorded to studies that assess the level of risk and disease, defining cost-effective interventions and best practices, in line with international standards.

8.5Strategic Objectives

Lesotho has decided to adopt the 6 Strategic Objectives as defined by WHO, and defined the strategies to attaining these objectives as follows:

8.5.1. To raise the priority accorded to the prevention and control of NCDs in national agendas and internationally agreed development goals, through strengthened multi-sectoral cooperation and advocacy

8.5.2. To strengthen national capacity, leadership, governance, multi-sectoralaction and partnerships to accelerate country response for the prevention and control of NCDs

8.5.3. To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environment.

8.5.4. To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centered primary health care and universal health coverage

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

8.5.6. To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

8.6. Areas of Intervention

In line with the Framework for implementation of the Ouagadougou Declaration, the Lesotho PHC Plan, and the Health Sector Strategic Plan 2012/13 – 2016/17, Lesotho has prioritized the interventions indicated below.

8.6.1. Leadership and Governance

Advocacy is required to ensure that NCDs are prioritised including for their socio-economic impact that negate the plans and outcomes envisioned in the Lesotho Vision 2020 as well as the National Strategic Development Plan 2012/13 2016/17. Budgetary allocations for NCDs and health have to be improved. Leaders at all levels have to be provided with tools to facilitate decision making and social mobilization. The Policies, regulations and laws have to be put in place in support of reduction of exposure to risk factors and regulate services, especially the promotion and availability of quality, safe and effective medicines; advertisement of unproven concoctions disguised under traditional medicine for the treatment of intermediate risk factors and cure of NCDs has to be halted. The following actions will therefore be under taken

- Development of a tool kit for leaders and high level government officials for their own education and reference in social mobilization. The improved knowledge, and through leaders interactions with their communities, will among others contribute to reduction of the stigma and fear of NCDs, increase intolerance for behavioural risk factors and therefore support for interventions to reduce exposure, and promote involvement in screening programmes and seeking care early.
- Meetings and roundtable with Cabinet Members, Principal Chiefs (Senate), Members of the National assembly, District Administrators, District Council Members, the Private Sector through their associations and the Chamber of Commerce, NGOs and CSOs, Private Practitioners, Professional Associations, and People Living with NCDs.
- Policies, regulations and legislation will be developed; with the cabinet and parliamentarians knowledgeable, such legislation would hopefully be approved. These will include, among others, implementation of the FCTC, levies on tobacco and alcohol, strict road traffic regulations and laws, tax exemption of vegetables and fruits as well as main foodstuffs.
- Medicines regulation and control will be strengthened and the Medicines Law passed to ensure availability of quality, safe and effective medicines
- The budget to health and specific line item in all government sectors will be allocated towards each sector input into NCD Prevention and Control.

- Advocacy will also be made with Partners that include the UN agencies, Bilateral and Multilaterals and international organizations, to be allies and assist in the mobilization of resources.

8.6.2 Health Promotion and Education

Health promotion is recognized as the best tool for NCD prevention and control. Individuals, families and communities have to be made aware and knowledgeable of the risk factors and the need for early identification of diseases through screening. Following from rapid assessments of community knowledge, messages shall be developed and transmitted through print materials, electronic media, and verbal communication.

- The messages shall encompass the relationship of the risk factors to many of the NCDs, noting the lag time between exposure and disease. HIV and AIDS has provided a good model and communication can build on the analogy for educating on NCD and risk factors as communities are aware that HIV infection precedes (risk factor) AIDS.
- The MOH has already initiated efforts in reducing tobacco use including smoke free schools and a relative ban on smoking in public buildings. Government ratified the FCTC in 2005 and education will target complying with FCTC in the context of the people's lives and socio-economic advancement (profit tobacco compared to household expenditure on health) and exposing others to the risk. Through support of the Ministry of Trade and Industry (MOTI), the Lesotho Revenue Authority (LRA) of the Ministry of Finance (MOF), and consumer groups, access to cigarettes shall be reduced.
- Alcohol is a recognized underlying factor to violence and RTAs, maiming or killing heads/members of households and loved ones. Stricter traffic rules will be reinforced through education on alcohol as a risk factor for many diseases such as cirrhosis and cancer that are relatively known conditions that lead to death, as well as cause of misery and poverty.
- The vegetables and fruits are pricy for most households. In the mountain areas cold resistant strains and/or preservation are needed for year- long access. In conjunction with Ministry of Agriculture and Food security (MOAFS), food preservation and household gardens will be re-invigorated. Through support of the MOTI the MOF will exempt critical food stuffs from taxation to bring down their costs. The community consumption of saturated fats and the conflict of interest with commercial food outlets will require carefully prepared messages, especially for the youth. Basotho consume a lot of salt and hardly spice their food (anecdotal); education messages will address the risk of high salt intake, and provide alternatives (explored through research). While there is little information on maternal malnutrition, the high rate of 39% children under 5 years and foetal programming in cases of maternal malnutrition, demand that education during the antenatal and other MCH activities, also integrate nutrition.
- The STEPS Survey indicates a high level of physical inactivity even in the rural areas; physical activity may also vary with seasons. The Ministry of Gender and Youth Sports and Recreation (MOGYSR) is already encouraging sports (including traditional). School children should be educated to continue

beyond the compulsory school years and the efforts of the MOGYSR positively reinforced through the mass media.

- The education will also cover the risk accumulation and exposure to multiple risk factors and their relationship to NCDs.
- The health promotion will also cover the relationship of the risk factors to the intermediate or biological risks (diabetes and raised blood pressure widely known in Lesotho) and the progression to disease(s).

8.6.3 Health Services Delivery

The MOH has embarked on PHC revitalization; the prevention and control of NCD risk factors and diseases will be integral to this effort through:

- NCDs have to be included and specified in the Essential Services Package (ESP) and the model of delivery of services, prioritising on the best buys, integrated with other programmes.
- Referral models that enhance efficiency and equity shall be explored. All levels of NCD prevention shall have SOPs that facilitate the integrated services. Systems and mechanisms for improving services at community level, including palliative care especially for terminal cancers, and rehabilitation for those with disabilities consequent to NCDs shall be explored.
- The continuum of care shall be ensured through involvement of NGOs, and Private Providers.
- Availability of essential medicines and technologies shall be reinforced through integration into the PSM plan that the MOH has initiated and is assuring availability of anti-TB drugs and ARVs at all times. The Medicines and supplies shall include for screening of diabetes, pre-cancer of the cervix and treatment of the biological risk factors of raised blood pressure (hypertension) and Diabetes, before complications such as stroke, retinopathies (leading to visual impairment) and nephropathies; and CVD and CRD. The medicines such as Glibenclamide, Metformin, Actraphane and Actrapid (insulin), Salbutamol, Beclometasone, Aspirin, Simvastatin, Hydrochlorothiazide, Atenolol, Tamoxifen are already in use in Lesotho but there are no guidelines to ensure equity of access; such guidelines will be developed and disseminated widely. Technologies for screening for precervical cancer (Visual Inspection Acetic Acid [VIA] and Pap smear), cancer of the prostate (PSA),colorectal cancer (occult blood), including appropriate laboratory choice of technology shall also be prioritized and access ensured for all districts, at least at hospital level. Appropriate prescribing and dispensing practices will be promoted. Advocacy and support shall be made for a national Formulary that includes medicines for palliative care.

8.6.4 Human Resources (For health and relevant sector professionals)

- Through advocacy and support for strengthening of health, agriculture and other sectors the training of health and other relevant professionals e.g. nutritionists, Therapists, Agriculture Extension Workers, shall be augmented
- Pre-service training for scarce but essential professionals for NCD prevention and control shall be advocated for and National Manpower Development Secretariat (NMDS) assisted in mobilizing the requisite financial resources as well as placement in academic institutions in and out of Lesotho
- In-service training on NCDs and risk factors will be instituted at all levels of care including at community level (VHWs and CSOs).
- The MOH shall regularly update and effect the retention strategy.

8.6.5 Health Financing

- Mechanisms for improved financing for health, especially reducing dependence on OOP expenditure such as social insurance shall be explored.
- Advocacy shall be made for imposing levies on tobacco and alcohol and utilizing resources so obtained to augment health sector resource allocations.

8.6.6 Health infrastructure and equipment

- The health infrastructure and equipment shall be assessed for NCD service delivery and appropriate modifications and additions advocated for.
- A Cancer Treatment Centre shall be built and relevant staff trained with partner support (Plan already in place)

8.6.7 Partnerships, Multi-Sectoral Collaboration and Cooperation

Interventions for NCDs may only be effectively implemented with multi-sectoral input.

- Partnerships, including PPPs, will be reinforced in both service delivery and for complementing the government resources. Partnerships with NGOs and with CSOs at community level shall be explored and expanded.
- The MOH will develop MOUs for specific or a set of interventions and institute committees to reinforce collaboration and coordination.
- The strategy shall be costed and bilateral, and multilateral partners approached for support and in mobilizing the requisite resources

8.6.8 Community Ownership and Participation

- Guidelines that include all key target groups, including adolescents shall be developed and health promotion shall address the determinants of health and NCDs. VHWs and CSOs shall be supported for primary prevention of NCDs. Collaboration and coordination with Community based Organizations (CBOs and NGOs) shall be strengthened and continuously reinforced.

8.6.9 Health Information Systems

- NCDs shall be specified and included among the key performance indicators of the MOH.
- Community based reporting, especially on the primary prevention interventions shall be instituted and regular discussion forums with community leaders encouraged at district, area/HC and community level.

8.6.10 Surveillance and Research

- The STEPS Survey shall be conducted every 5 years and efforts made at including NCD prevention in the nationwide health surveys e.g. DHS.
- Tertiary institutions shall be encouraged and awarded incentives e.g. sponsorship to international meetings, finance, provided for them, to undertake research that informs NCD interventions.

8.7. Outputs

The following will be the outputs of the plan:

1. 100% Cabinet, Parliamentarians, (Senate and National Assembly, etc.) sensitized and capacity at all levels of service built on situation of NCDs in Lesotho. Parliamentarians understand the cost of risk factors and NCDs and ratify international conventions as well as promulgate laws.
2. 50% District leadership (Chiefs, Councillors, District Administrators, District Council Secretary, Religious Leaders, Traditional Healers) sensitised about and capacity built on situation of NCDs in Lesotho
3. NCD prevention and control included in the National Health Policy, Health Sector Strategic Plan, and National Strategic Development Plan
4. Legislation relevant to priority NCD risk factors and diseases in place
5. NCDs mainstreamed in all sectors' activities
6. Multi-stakeholder working group on NCDs in place and functional
7. Established budget for NCDs; Improved efficiency of resource utilization
8. Monitoring and Evaluation (M&E) plan for NCDs developed; NCDs risk factors (behavioural and metabolic) and diseases monitored
9. Empowered communities and people affected by risk factors and NCDs; Increased awareness on 4 major NCDs risk factors
10. Increased capacity of healthcare services to deliver prevention and treatment interventions for NCD risk factors and diseases
11. Developed National policy on physical activity for Health
12. NCDs risk factors included in Food and Nutrition policies
13. Development and dissemination of toolkits on NCDs risk factors.
14. Increased access to healthy food (tax exemption)
15. Multi-sectoral collaboration to develop a national research policy and plan on NCD related research including community based research and evaluation on the impact of interventions and policies
16. National institutional capacity building (research infrastructure, equipment & supplies) and competences of researchers to conduct quality research
17. Effective use of academic institutions & multi-disciplinary agencies to promote research, retain research workforce, incentivize innovation &

encourage establishment of National Reference Centre & networks to conduct policy-relevant research.

18. Improve the scientific basis for decision-making through NCD related research & its translation to enhance the knowledge base for ongoing national action.
19. Accountability through preparation and submission of regular progress reports
20. Integrate NCD monitoring system including prevalence into HIS to systematically assess progress
21. Institute, maintain and improve on a Cancer Registry to assess needs
22. Ensure surveillance of NCDs and risk factors including periodic data collection of behavioural and metabolic risk factors, to assess progress and determine trends, especially in inequities; Surveillance and Monitoring of NCD and risk factors allocated identifiable budget annually
23. Build the capacity (institutional and technical) for the management, analysis and reporting on NCD data
24. Disseminate report on NCD morbidity and mortality and risk factors (disaggregated by socioeconomic status, gender, age, level of education, disability)
25. Report to WHO

SEE ANNEX I: LOGICAL FRAMEWORK

9. Roles and Responsibilities

9.1 Ministry of Health

The roles and responsibilities are aligned to those agreed upon by African Ministers of Health and contained in the Brazzaville declaration as well as WHO guidelines for countries. They are as follows:

- Strengthen health information systems to generate disaggregated data on NCDs, their risk factors and determinants. The trends, magnitude and impact should be monitored.
- Share information on NCDs through all appropriate means including Information and communication technologies (ICT)
- Develop and implement NCD prevention and control strategies, guidelines, policies, legislation, and regulatory frameworks in support of NCD prevention and control
- Strengthen public health systems: training health workforce; retention health workforce; procurement, distribution and management of medicines, vaccines, technologies, medical supplies, equipment; health infrastructure; effective evidence-based service delivery
- Accord priority to NCDs, keeping them on government agenda, and integrate NCD-related services into PHC (Identify opportunities with established programmes such as of control of communicable diseases to accelerate prevention and control of NCDs, in the context of PHC and HSS)
- Establish partnerships, alliances and networks, including the civil society, the private sector, and academia
- Translateand disseminateresearch to identify effective approaches for NCD prevention and control, and strategies appropriate to Lesotho

- Strengthen the HIS and establish surveillance as well as monitoring systems for NCDs and risk factors as well as monitoring mortality and morbidity attributable to NCDs, and the level of exposure to risk factors and their determinants in the population.
- Foster and promote community-based interventions and initiatives for prevention of NCDs.
- Institute school health programmes that integrate health promotion strategies
- Advocacy with leaders
- Strengthen health promotion and social mobilization for all levels of NCD prevention

9.2 Other Government Sectors

Based on their mandate and comparative advantage the other government sectors' role will include the following:

- Develop and implement policies, strategies, regulatory frameworks and legislation that relate to prevention and control of NCDs and risk factors
- Training and support of officers in health promotion and prevention of NCDs
- Membership and active participation in committees and working groups on prevention and control of NCDs
- Mainstream Budgetary allocations for NCD interventions

9.3 WHO

The roles and responsibilities of WHO are defined in the WHO global and regional action plans as per the mandate of WHO and are as follows:

9.3.1 The WHO Country office

- Adaptation of generic training modules, tools and guidelines
- Provide technical assistance to countries in the adaptation of, training modules, tools and guidelines, development of country plans and capacity building
- Monitor the burden of NCDs in the country and monitoring implementation of NCD workplans.
- Support research
- Resource mobilisation
- Forge partnerships at the country level

9.3.2 WHO Regional Office

- Provide generic, training modules, tools and guidelines
- Prove technical assistance to countries in the adaptation of, training modules, tools and guidelines, development of country plans and capacity building
- Monitoring the burden of NCDs in the region and monitoring implementation of the NCD strategy.
- Support research

- Resource mobilisation
- Forge partnerships at the regional level

9.3.3 Inter-country Support Team (IST):

- Provide technical assistance to countries in the adaptation of, training modules, tools and guidelines, development of country plans and capacity building in consultation with WHO AFRO
- Monitoring the burden of NCDs in the sub-region
- Resource mobilisation
- Forge partnerships at the sub regional level in consultation with WHO AFRO

10. Standards with Respect to Availability of Resources

The World Bank classifies Lesotho as low-middle income country. More than 50% of the people are reported living below the poverty line and there is a high rate of unemployment. The reliance on OOP for health care is high, malnutrition rates (acute and chronic children under 5 years of age) are high and the country faces the double burden of communicable and Non-communicable diseases. There is a shortage of human resources for health and other related cadres. While health facility infrastructure is acceptable, the road infrastructure in parts of the country is lacking while there is shortage of transport in the districts. While the Government provides funding for most medicines, technologies and equipment, the procurement supply system is weak. Supervisory support is inadequate and the HIS also faces several challenges including of human resources. Minimal research is being conducted primarily due to paucity of skills. The declining indicators and the near collapse of the PHC system are a cause of concern but the MOH has initiated steps at revitalizing PHC. Appropriate standards therefore have to be developed with due consideration to the following:

- Regular supervisory support to implement the plan
- Health Information System and utilization of data
- Technology including Information and Communication Technology (ICT)
- Improvement of the Procurement and Supply Management System
- Human Resources deployment and retention
- Financial resources for the double burden of diseases and access as well as affordability of services
- Infrastructure Development
- PHC revitalization and approach to service delivery

11. Implementation Plan

The National Multi-Sectoral Integrated Strategic Plan for the Prevention and Control of Non-communicable Diseases covers a period of 6 years (2014-2020). Most of the activities will be implemented throughout the period except for infrastructure developments.

Lesotho recognizes the limitations of resources including that it is a poor country but with a high reliance on out of pocket expenses in financing health care. The country is faced with a double burden of communicable and Non-communicable diseases as

well as high rates of malnutrition among children. The country's capacity is further limited by shortage of human resources, logistics and transport, weak PSM and HIS challenges, weak supervision, weak research capacity, and a weak PHC system. The resultant decline in health indicators is of concern to the country. The planned NCD prevention and control activities start with advocacy as well as capacity building of leaders through meetings and roundtables, providing a tool kit as both an advocacy tool as well as reference for the leaders, and holding the leaders accountable for outcomes through mechanisms such as performance appraisals for NCDs. The staff of the relevant sectors and NGOs shall be trained as is relevant in technical and managerial skills; this includes academic training of required but scarce or/and unavailable professionals (health and other). Infrastructure improvements shall be sought, especially for rehabilitation at district hospitals; the establishment of the cancer treatment facility and research reference centre included. The PSM system shall be strengthened and adequacy as well as reliability of medicines, technologies, and equipment ensured. Health Promotion, the mainstay for positive outcomes, shall be improved upon and partnerships established with Civil Society Organizations (CSOs) and the private sector. Effective referral mechanisms shall be put in place.

SEE ANNEX II: IMPLENTATION PLAN

12. Monitoring and Evaluation

The plan seeks to reduce by 25% the morbidity and mortality form NCDs and by a minimum of 10% the risk factors, especially in the age groups below 60 Years of age; and contribute to socioeconomic development of Lesotho. Priority shall be accorded to Cancer, Diabetes, Cardiovascular Diseases, and Chronic Respiratory Diseases; efforts shall also be addressed to Injuries especially due to RTAs, Oral Diseases, visual impairment including Blindness and Deafness, Neurological and Mental Disorders.

The NCDs shall be mapped, and priority accorded to reduction of exposure to the common modifiable risk factors of tobacco use, harmful use of alcohol, unhealthy diet and inadequate physical activity. The screening and early treatment of the biological risk factors of raised blood pressure, raised blood glucose, raised blood cholesterol, overweight and obesity shall also be addressed.

The programme is aligned to the 25 Global Monitoring Indicators as per the interventions outlined in the Logical Framework (Annex I) according to risk factors (behavioural and biological) and the diseases.

Strategic Plan	Target (by 2020)	Indicator
Mortality and Morbidity		
Premature mortality from NCDs (Start with mapping of the diseases and establish baseline)	25% relative reduction in mortality due to Cancer, Diabetes, CVD, CRD	1.Reduced probability of people under 60 years dying from cancer, Diabetes, CVD and CRD 2.Prevalence/Incidence of Cancer by type per 100,000 population
Behavioural Risk Factors		
Current tobacco use	A 15% relative reduction in prevalence of current tobacco use in persons aged 10+ years (reduction from 10.1% - adolescents; Reduction from 24.5% - adults)	3. Prevalence of current tobacco use among adolescents. 4.Age-standardized prevalence of current tobacco use Among persons aged 18+ years. 5.tobacco-related morbidity and mortality among adolescents and adults 6.Implement FCTC
Harmful use of alcohol	At least 5 % relative reduction in the harmful use of alcohol from 30.7%	7.Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in Litres of pure alcohol. 8.Age-standardized prevalence of heavy episodic drinking among adolescents and adults in Lesotho 9. Alcohol-related morbidity and mortality among adolescents and adults
Insufficient Physical activity	A 10% relative reduction in prevalence of	10.Prevalence of physical inactivity (< 60

Strategic Plan	Target (by 2020)	Indicator
	insufficient physical activity	minutes/day of moderate to vigorous activity) in adolescents daily. 11.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
High intake salt	A 30% relative reduction in mean population intake of salt/sodium	12.Prevalence of physical inactivity (< 60 minutes/day of moderate to vigorous activity) in adolescents daily. 13.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
Biological Risk Factors		
Raised Blood Pressure	A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure	14.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). 15.Antihypertensive and cholesterol lowering drugs available
Diabetes	At least 80% of diabetic clients receive their drugs	16.Reduction in the age standardized prevalence

Strategic Plan	Target (by 2020)	Indicator
	and screened and treated for retinopathies& neuropathies	of raised blood glucose/**diabetes** among persons aged 18+ years (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose. 17.Availability at all times of Diabetic drugs
Obesity	Reducing by 50% in rate of increase in & obesity	18.Reduction in the Prevalence of overweight and obesity in adolescents 19.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).
National Systems Response		
Drug Therapy to Prevent Heart attacks and Strokes	At least 80% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.	20.Proportion of eligible persons (defined as aged 40 years and over 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 Non-communicable Diseases Medicines and Basic Technologies to Treat major Non-communicable Diseases	An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities.	21.Proportion of eligible persons (defined as aged 40 years and over 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

Strategic Plan	Target (by 2020)	Indicator
		strokes 22.Technology available in 80% of facilities Drugs (safe, efficacious, of good quality) available in all licensed facilities for NCDs.
Cancer of the Cervix	Increased Proportion: women of between the ages of 30–49 screened for **cervical cancer;** **increased number of people screened for ca breast, cancer of the prostate and colorectal cancer**	23.HPV vaccination coverage sustained at >90% 24.Increased number of women screened ca cervix Increased number of people screened for breast, colorectal, prostate cancer 25.Cancer Treatment centre established in Lesotho by 2020
Injuries due to Road Traffic Accidents	Reduce the number of people killed and /or seriously injured in a road traffic accidents by 50%	26.Improved data capture, analysis and reporting at least annually on RTAs 27. Reduced number of people with traffic offences. 28. Increased number of RTA offenders prosecuted.
Mental Health	Increase in the number of people screened and treated for Mental Disorders by 10%	29.Increased demand for mental health services and reduction in the number of people with neglected mental disorders and those untreated roaming the streets 30.Increased epilepsy patients receiving treatment
Blindness	Increase number of people screened and treated for blindness by 10%	31. Increased demand for eye disorders screening (at community, school and PHC level) and increased numbers of people receiving cataract surgeryeye glasses provision, and adequate treatments for any potentially disabling eye

Strategic Plan	Target (by 2020)	Indicator
		condition
Oral Health	Increase the number of people screened and treated for oral disease 10%	33. Increased demand for screening 34. Increased numbers of people receiving oral health services

15. Budget

The following is the estimated budget for the National Multi-Sectoral Integrated Strategic Plan for the Prevention and Control of Non-communicable Diseases in Lesotho:

Objective	Estimated Budget (Maluti)
To raise the priority accorded to the prevention and control NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy	6, 747, 000
To strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of NCDs	139, 117, 200
To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments	624, 073, 600
To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centered primary health care and universal health coverage	231, 697, 800
To promote and support national capacity for high-quality research and development for the prevention and control NCDs	9, 982, 800
To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control	466, 500
Total	**659, 074, 600**

For Details See Annex III

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ANNEX I:LOGICAL FRAMEWORK NATIONAL STRATEGY FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Vision	To minimise the exposure to the main NCD risk factors and improve access to care and rehabilitation for people affected by NCDs thus contributing to a sustainable socioeconomic development of Lesotho.	At least 5 % relative reduction in the harmful use of alcohol from 30.7%	Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol.	WB Analysis STEPS survey,	MOH MOH	MOF MOTI MOET MODP Police LRA MOCST MOTEC Cellphone Companies Milling Companies Utilities Companies
			Age-standardized prevalence of heavy episodic drinking among adolescents and adults in Lesotho	STEPS survey	MOH	MOH MOCST ADAAL, Blue cross MOET, Academia Cellphone Companies Utilities Companies
		A 15% relative reduction in prevalence of current tobacco use in persons aged 10+ years (reduction from 10.1% - adolescents; Reduction from 24.5% - adults)	Alcohol-related morbidity and mortality among adolescents and adults Prevalence of current tobacco use among adolescents.	Lesotho GTYS	MOH	MOH ADAAL, MOTI Blue cross, CARP MOET, MOCST Academia Cellphone, Utilities and Milling Companies
			• Age-standardized prevalence of current tobacco use Among persons aged 18+ years. tobacco-related morbidity and mortality among adolescents and adults Implement FCTC	STEPS survey	MOH	
		A 10% relative reduction in prevalence of insufficient physical activity	Prevalence of physical inactivity (< 60 minutes/day of moderate to vigorous	STEPS Surveys	MOH	MOGYSR MOAFS MOET MOCST Cellphone, Utilities and

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			activity) in adolescents daily. • 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	STEPS Survey STEPS survey	MOH MOH	milling Companies MOAFS, FNCO,
		A 30% relative reduction in mean population intake of salt/sodium	Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years	STEPS Survey	MOH	MOET, MOTI, MOCST
		A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure	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). Antihypertensive and cholesterol lowering drugs available	Pharmacy records Facility Surveys	MOH MOH	MOF MOF
		At least 80% of diabetic clients receive their drugs and screened and treated for retinopathies& neuropathies	Reduction in the age standardized prevalence of raised blood glucose/**diabetes** among persons aged 18+ years (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/dl) or	STEPS Survey	MOH	MOF

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		Reducing by 50% in rate of increase in & obesity	on medication for raised blood glucose. Availability at all times of Diabetic drugs		MOH	MOF
			Reduction in the Prevalence of overweight and **obesity** in adolescents • 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).	STEPS Survey	MOH	
		At least 80% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.	Proportion of eligible persons (defined as aged 40 years and over 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	Pharmacy records	MOH	MOF
		An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities.	Technology available in 80% of facilities Drugs (safe, efficacious, of good quality) available in all licensed facilities for NCDs.	Laboratory records	MOH	MOF
		Increased Proportion: women of between	HPV vaccination	HPV Vaccination Coverage Survey	MOH	MOF

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		the ages of 25-49 screened for **cervical cancer; increased number of people screened for ca breast and colorectal cancer**	coverage sustained at >90% Increased number of women screened ca cervix Increased number of people screened and breast, colorectal, prostate cancer			
		An 80% Access topalliative care medicines like morphine and strong opioid analgesics	Cancer Treatment centre established in Lesotho by 2020	Physical Infrastructure in place and appropriately staffed Pharmacy Records reviews	MOH	MOF Police
		Reduced number of people killed and /or seriously injured in a road traffic accidents by 50%	Amount of morphine-equivalent and strong opioid analgesics per cancer death Improved data capture, analysis and reporting at least annually on RTAs Increased number of RTA offenders prosecuted.	VHW Records review Record reviews(police and Hospitals for hospitalized	Police	MOL MOJ
		Increase in the number of people screened and treated for Mental Disorders by 10%	Reduced number of people with traffic offences. Increased demand for mental health services and reduction in the number of people with untreated roaming neglected mental disorders	Review Mental Health records	MOH	MOLGCA

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			Increased epilepsy patients receiving treatment		MOH	MOLGCA MOF
		Increase in number of people screened and treated for blindness by 10%	Increased demand for screening and increased numbers of people receiving cataract surgery.	Review records Ophthalmology	MOH	MOF
		Increase the number of people screened and treated for oral disease 10%	Increased demand for screening and Increased numbers of people receiving oral health services	Review records Oral Health	MOH	MOF
Purpose	The Ministry of Health and the Directorate of Disease Control have a tool that defines the priorities, sets targets and objectives and provide a roadmap to all sectors and partners to improve service delivery in the context of NCDs**.**	All stakeholders understand the risk factors and non-communicable diseases	Number of stakeholders involved in NCD prevention and control	Interviews Review of records	MOH	MODP, MOF
		All sectors and partners identify their roles in the prevention and control of NCDs	Number of Sectors and partners that have aligned their interventions to the defined roles	Interviews	MOH	MODP, MOF
		All stakeholders develop their own plans and contribute to the prevention and control of NCDs	Number of plans available	Review of records	MOH	MODP
		All stakeholders improve their service delivery for NCDs	Number of stakeholders who have defined and are implementing their activities in the prevention and control of NCDs		MOH	ALL

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Strategic Objective 1	To raise the priority accorded to the prevention and control of NCDs and risk factors in Lesotho	100% cabinet, parliamentarians, (senate and national assembly, etc.) sensitized and capacity at all levels of service built on situation of NCDs in Lesotho.	Number and frequency of meetings as well as numbers who participated	Reports Participant lists	MOH	MOCST MOET MOLGC MOAFS MOGYSR
		50% District leadership (councillors, district administrators) sensitised about and capacity built on situation of NCDs in Lesotho	Number and frequency of meetings as well as numbers who participated	Reports Participant lists	MOLGCA	MOH MOCS&T MOET MOAFS MOGYSR
		NCD prevention and control included in the National Health Policy and National Strategic Development Plan	Comprehensive inclusion of NCDs in the Health Policy and National Development plan	Review of documents Review of available laws	MOH MOJ MOL	MODP
		Legislation relevant to priority NCD risk factors and diseases in place	Laws relevant to NCDs gazetted	Review of print materials and		MOH MoCS&T MoET MoLGC MOAFS MOGYSR

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
				programmes for electronic media	MOH	MOETC
		NCDs materials for Mass media and individuals available	Number, types, frequency of programmes as well as level of distribution	Review of the tool kit and		MOCST MOET MOLGC MOAFS MOGYSR MOETC
		A tool kit with correct information for leaders on NCDs available	Availability of toolkit with leaders and at Parliament	Spot checks relevant places, Inventory Supervisory visits	MOH	MOCST MOAFS MOET
		Integrated SOPs, guidelines, monitoring tools developed and disseminated	Availability and extent of distribution of the SOPs	Spot checks in relevant places Inventory	MOH	CHAL LRC
		Structures that include other government sectors, NGOs, Civil society , private sector, people affected by the NCDs(clubs) and international organizations and Agencies in place and functional	Membership and frequency of meetings/forums	Review of records; List of Participants Site visits; Review Hansard	MOH	MoCS&T MoET MoLGC MoAFS MoGYSR MoETC International Partners (UN Bi& Multi, NGO) Civil society, NGOs
Activities Central Level	1. Workshop/round table Parliamentarians : venue, meals, trainer, materials	2 workshops	Reports of workshops	Review records	MOH	MOLPA
	2. Toolkit development and distribution: Consultant	1 Toolkit	Toolkit available with Parliamentarians and at Parliament	Review laws Site visit Record review	MOH	MOLPA
	3. Review of HSSP and NSDP Worksop: venue, meals, materials	1 Plan each	Revised policy and plans available	Review of records	MOH	MODP
	4.Draft Bill : Consultant	1 policy		Review records		
	5.Submit to		Draft bill	Review	MOH	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	Parliament: Presentation		available	records		MOL
		1 Draft Bill	Law promulgated		MOL	
	4. Workshop SOPs, guidelines, monitoring tools	1 presentation		Review records		MOH
			SOPs, guidelines an monitoring tools available	Site visit	MOH	
	6. Develop TOR Structures	1 set each SOPs, guidelines and monitoring tools		Record review		CHAL, LRC, LPPA
	7. Hold meetings: tea, lunch		TOR available Minutes available	Records review	MOH	
		2 TOR Coordination and TWG	Workshop report available		MOH	All Sectors NGOs Partners
	1.Workshop District: venue, meals, materials, Trainer	At least 1 Quarterly (4)				All Sectors NGOs Partners
Activities District	2.Toolkit distribution		Toolkit available		MOH	MOH
		Toolkit at all levels	Toolkit at HC and with members of HC Committee		MOH	MOET, MOGYSR, MOAFS, Police, MOLGCA
Activities HC	1. Toolkit Distribution	10 workshops			MOH	
	2..Workshops on toolkit (1 per district)		Toolkit available			
	Nil	Toolkit at different levels of care	Reports available			MOLGCA, MOET, MOAFS, MOGYSR, Police
Activities Community		Toolkit at HC and with HC Committee				

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Strategic Objective 2	To strengthen National capacity, Leadership, Governance, Multi-sectoral Action and Partnerships to accelerate country response for prevention and control of NCDs	NCDs prevention and control included in the Health Sector strategic Plan	Updated Health Sector Strategic Plan	Review of the national Health strategy	MOH	MOF MOCS&T MOET MOLGC MOAFS MOGYSR MOETC MOEL International Partners (UN Bi& Multi, NGO)
		Parliamentarians understand the cost of risk factors and NCDs and ratify international conventions.	Conventions ratified	Relevant laws gazetted Review documents	MOL	MOH NGOs
		NCDs included in the Health Planning processes,		Review M&E Framework and reports MOH	MOH	MOH All sectors
		Mainstream NCDs in all sectors' activities	All Sector plans include NCDs	Review sector plans Minutes and records	MODP	All sectors Partners
		Multi-stakeholder working group on NCDs in place and functional	Multi-sector Meetings held	Review of budgets Review MOH Plan (s)	MOH	All sectors Partners
		Established budget for NCDs	Budget for NCDs identified	Review of materials	MOF	MODP Partners
		Develop M&E plan for NCDs	NCD implementation regularly monitored	Review of budget allocations	MOH	MOF MODP
		Empowered communities and people affected by risk factors and NCDs	Communities and individuals reduce exposure to risk factors	Site visits Minutes		MOCST NGOs Cellphone, Utilities and

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
						Milling Companies
	Activities Central level	1.Annual budget preparation (5)	Improve efficiency of resource utilization	Records review Records review	MOH	MOF
		2.Quarterly (4) Advocacy meeting Parliament	Quarterly meetings held (4 per annum)		MOH	MOCST
		3.Annual Meetings with HPS (6)	Meetings held	Minutes	MOH	
		4.Annual Meetings all ministries	meetings held	Minutes Minutes Review of materials	MOH	MODP MOF All Sectors NGOs Partners
		5.Quarterly meeting TWG (4x6)	Meetings held		MOH	MODP MOCST MOAFS
		6.Annual meetings Districts (10x6)	Meetings held1 per annum		MOH	MOET FNCO MOGYSR
		7.Quarterly meetings M&E (4x6)	20 (4x6) meetings held meetings (1 per district per annum) held	Reports	MOH	MOCST MOAFS, MOET, MOGYSR, Police, MOTI
		8.Development and review Health Promotion materials: rapid assessment interviews, design, distribute/broadcast materials (air time radio and TV and newspaper fees)	Quarterly visits conducted	Reports	MOH	MOCST MOLGCA, MOAFS MOTI Police
		9.Quarterly supervisory support visits (4x5): allowance		Reports	MOH	MOLGCA, MOAFS, Police
	Activities District Level	1. Training and refresher courses Managers and NGOs	1. Number and cadre trained	Reports Reports	MOH	MOLGCA, MOTI, MOAFS,MOET, Police

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		2. Training and refresher courses service Providers	2. Number, location and cadres trained	Reports	MOH,	MOAFS, MOLGCA, MOTI
	Activities HC Level	3. Quarterly Supervisory Support Visits	3. Number, location and cadres trained	Reports	MOH,	MOAFS, MOLGCA, MOTI
		1. Training and refresher courses VHWs and CSOs	1. Number, location of VHWs and CSOs trained	Reports	MOH	MOAFS, MOTI, MOLGCA
	Activities Community level	2. Supervisory support VHWs and CSOs	2. Number, location and cadre Supervised	Reports	MOH	MOAFS, MOTI, MOLGCA
		1. Hold public gatherings	1. Number and location of public gatherings held		MOH	MOLGCA
		2. House to house and business to business visits	2. Number of households and businesses visited			MOTI

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
3.Strategic Objective 3	.To strengthen and orient health systems to address the prevention and control of Non-communicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage	A 15% relative reduction in prevalence of current tobacco use in persons aged 10+ years(reduction from 10.1% - adolescents; Reduction from 24.5% - adults)	Level of reduction in Prevalence of tobacco use	STEPS Survey	MOH	MOCST MOET MOAFS MOLGCA ADAAL Cellphone, Utilities and Milling Companies
		10% reduction in harmful use of alcohol, Increased capacity of healthcare services to deliver prevention and treatment interventions for hazardous use of alcohol use disorders.	Level of reduction in Prevalence of harmful use of alcohol	STEPS Survey	MOH	MOCST MOET MOAFS MOLGCA ADAAL Cellphone, Utilities and Milling Companies
		10% relative reduction in prevalence of insufficient physical activity	Level of reduction in Prevalence of physical inactivity	STEPS Survey	MOH	MOCST MOET MOAFS MOLGCA ADAAL Cellphone, Utilities and Milling Companies
		Developed National policy on physical activity for Health	Policy in place	Records review	MOGYSR	MOH
		A 30% relative reduction in mean population intake of salt/sodium	Level of reduction in Mean population intake of salt	STEPS Survey	MOH	MOCST MOET MOAFS MOLGCA Cellphone, Utilities and Milling Companies
		25% reduction in prevalence of raised blood pressure in people affected by	Level of reduction in prevalence of raised blood pressure	STEPS Survey	MOH	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Activities Central Level	1. Advocacy for NCDs (meetings as obj 2)	NCDs risk factors and NCDs Increased awareness on 4 major NCDs risk factors	Level of increase in awareness	STEPS Survey	MOH	MOCST MOET MOAFS MOLGCA Cellphone, Utilities and Milling Companies
	2. Health promotion mass media	Regular use of print articles and through radio (5 stations)	Frequency of transmission and content of mass media broadcasts	Media Survey Policy review	MOCST	MOH MOET MOAFS MOLGCA Cellphone, Utilities and Milling Companies
	3. NCDs included in Nutrition Policy	NCDs risk factors included in Food and Nutrition policies	Content of food and nutrition policies include NCD risk factors	Site visits	MOH	
	4. Toolkits for advocacy with and reference for leaders developed	Development and dissemination of toolkits on NCDs risk factors.	Toolkits with leaders and at facilities Policy in place Records review	Records review	MOH MOGYSR	MOAFS MOTI MOET MOH
	5. Development of policies (NCDs, Physical activity, HHF vegetables and fruits)	Guidance on physical activity available	Food stuffs exempted from taxation	Review of legislation Spot checks at shops Interview Leaders	MOAFS MOLGCA	MOH
	6. Development of a law on tax exemption of key foodstuffs, promulgation of laws on FCTC, alcohol, RTA,	Increased access to healthy food	Level of involvement of leaders in NCDs	Records review;	MOH	CHAL, LRC
	7. TOT and refresher (6)	Skills of workers improved in NCDs	Frequency of transmission	media survey Record review	MOCST	MOTI

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		Guidelines in line with control of NCDs	and content of mass media broadcasts	Records review		MOF-LRA
	8. Development/review guidelines and Formulary medicines and technologies (Referrals, Formulary, EML, Protocols Lab etc.)		Number of policies developed	Review of laws, spot checks shops	MOGYSR	
		Guidelines followed Skills of staff reinforced,	Number and type of foodstuffs exempted from taxation	Report, participants list	MOTI MOF-LRA	MOH
	9. Quarterly supervisory support visits (4x5) as in obj2		Number and cadres trained	Record reviews	MOH MOAFS MOGYSR	MOH
		NGOs mobilized for NCDs				
	10. NGO mobilization (meetings: tea)		Number of guidelines developed		MOH	MOH
		Programme monitored		Reports Record reviews		
Activities Districts	11. Community surveys: consultant fees, training interviewers, per diems, fuel costs, car hire	Leaders aware and supportive of prevention and control of NCDs	Number of NGOs active in NCD prevention and control	Record review; interviews NGO leaders	MOH	MOCST MOET MOAFS MOLGCA Cellphone, Utilities and Milling Companies
	1.Advocacy district leaders and Health promotion	Guidelines followed, skills reinforced	Number and frequency of supervisory visits	Reports	MOH	MOAFS MOET MOGYSR
	2.Quarterly Supervisory support HCs	Skills updated	Number and cadres participated	Record reviews, interview leaders	MOH	MOAFS MOET MOGYSR
			Availability of medicines and technologies	Reports, record reviews	MOH	
	3..District level trainings and refresher courses(10x5)	Adequate safe medicines and technologies available	Number CSOs active in NCD prevention and control	Reports, participant list Pharmacy records review, exit interviews	MOH	MOLGCA
	4.Procurement and Distribution medicines and	CSOs mobilized for NCDs	Number and frequency of community surveys;	Reports, interview CSO leaders	MOH	MOAFS MOLGCA MOGYSR

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	technologies	Programme monitored, staff capacity built	number and topics addressed in operations research studies	Reports, participants list	MOH	CHAL
	5.Mobilization CSOs (meetings: lunch)			Record reviews		LRC
	5. Participate in community surveys and conduct own Operations Research (10 annually): data capture and analysis fees	Care accessible to all	Number of meetings held; number of leaders using the toolkit	Record reviews Records review,	MOH	CHAL
Activities HC Level		Effective systems in place for managing complicated patients	Number and frequency of supervisory visits Number VHWs trained and content of training	Records review Supervisory support	MOH	CHAL LRC
	7.Patient management at hospital level	Community based services available	Number of committee members that use the toolkit	Records review	MOH	MOLGCA
	8.Referrals	Leaders active in NCD prevention	Number of facilities that follow the guidelines	Records review	MOH	
	1. Training VHWs: transport, lunch, pens, exercise books	Care accessible to all	Number, content and location VHWs trained	VHW Records, rapid assessment	MOH	MOLGCA CHAL LRC
	2. Advocacy HC Committee and Health promotion	Skills reinforced	Number and reasons for referrals		MOH	CHAL LRC
Activities Community	3. Management of clients/patients	Effective systems in place for managing patients	Number and frequency of gatherings held;	VHW and CSO Records,	MOH	MOAFS MOLGCA
	4. Supervision VHWs: transport	Communities educated on NCDs and change behaviour	Frequency of house to house visits	VHW Register, VHW reports		
	5. Referrals		Frequency and location of spot checks	VHW Records	MOH	MOTI MOF-LRA
	1. Social Mobilization: public gatherings,	Laws and regulations complied with	Number and reasons for referrals		MOH	CHAL LRC

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	house to house 2. Business spot checks comply law/regulations 3. Identification clients/patients and referrals	Appropriate Care available/availed				
Strategic Objective 4	To strengthen and orient health systems to address the prevention and control of Non-communicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage	Effective Leadership and governance	NCD prevention and control part of the outcomes that leaders are accountable for In the context of PHC NCDs prevention in all government policies NCDs integrated into Health sector reforms/plans targeting improved outcomes and aligned to the 'best buys'. Implementation of evidence based interventions which address social determinants of health	Review records Review policies Review HSR programme Review of type of interventions instituted	MODP MODP MOH MOH	MOH All Sectors MOH MOET MOAFS FNCO MOLGCA MOAFS MOET MOGYSR

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			(poverty, level of education, house hold resources)	Community surveys Records review		
		Improved financing and less reliance on out-of-pocket payments for NCD	NCD integrated into community based structures and activities	Review budget documents	MOH	MOF
			Budget for Health increased to at least 15% of National budget with NCDs a with line budget.	Budget speech Levy instituted	MOH MOH	MOF
			Levy on tobacco and alcohol allocated to Prevention& Control of NCDs	Social insurance functional	MOH	MOH MOTI
			Social insurance established	IGAs instituted	MOH	MOF
			Establishment of community based income generating projects for sustainability of financing at community level.	HR in place	MOLGCA	MOF, MOTI
			HRH at all levels knowledgeable	Equipment in place	MOPS	MOH
		Integrated expanded quality services provided at all levels of care including for cardiovascular Diseases, Cancer, respiratory diseases, Diabetes	Facilities adequately equipped for NCDs	Medicines and technologies available	MOH	CHAL LRC MOLG MOF
			Quality, safe and adequate	PHC approach used in all districts	MOH	MODP MOF

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			drugs available			MOLGC
				Referral system in place		
			Revitalization of service delivery,		MOH	MOLGCA
			Referral systems that are people centred established among all networks of primary health care and fully integrated with secondary and tertiary care level of health care delivery including quality rehabilitation, comprehensive palliative care and specialised ambulatory and inpatient care facilities.	HR available	MOH	CHAL LRC
		Human resources developed for prevention and control of NCDs	Availability of trained human resources for health and allied health professionals for prevention and control of NCDs	HR retained Services available	MOPS	MOH MODP-NMDS
			Retained trained human resources for health and allied health professionals	Services available	MOPS	MOLGCA CHAL MOF MOFA&IR WHO Development partners
		Improved equitable access to prevention and control of NCDs	Screening for: Diabetes: blood glucose levels and glycaemic control	Increased Coverage HPV vaccine	MOH	CHAL LRC
			Screening for	Services	MOH	CHAL LRC

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			cancers: Cervical cancer- VIA for 85% of women aged 25-49yrs ,	available		MOF
		Access to Prevention strategies ensured	Access to HPV vaccination increased.	Services available	MOH	MOF
				Services available		
			Breast: biannual clinical breast examination	Services available	MOH	CHAL, LRC
			Prostate: PSA after 55yrs of age	Medicines available	MOH	CHAL
			Colorectal: faecal occult blood testing)		MOH	
			Availability of 1.CVD – blood pressure & cholesterol lowering drugs available. 2.Diabetes-glycaemic control drugs 3.Asthma and COPD – corticosteroids, bronchodilators and exacerbation drugs available	Therapy available	MOH	CHAL, LRC
		Essential Medicines 80% availability, Affordable medicines for :	Oral Health Availability of 1.Pit and fissure sealant 2. Glass Ionomer Cement for Atraumatic Restorative Treatment 3. Oral Health Education	Medicines available Services expanded	MOH	MOF
			Psychoactive drugs psychosocial therapies available for Mental	Medicines available	MOH	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
			disorders and epilepsy	Records review		
			Pain relief drug therapy and urgent oral treatment		MOH	
			Antibiotic treatment for oral, eye and ear health	Review plan	MOH	
Activities central Level	1. Define and submit performance appraisal indicators 6 (1 annually)	1 submission annually	Indicators included in performance review	Review report	MOH, CHAL, LRC	
		Leaders held accountable		Report		
	2.Review and include NCDs in PHC revitalization plans :1		Facilitated access to preventive measures, treatment and		MOH	MOLGCA
	3.Assess NCD prevention and control implementation 2 times: Midterm and end	NCD integrated and delivered per PHC approach		Record review	MOH	CHAL
		Progress assessed; corrective measures taken	NCDs included in plan	Minutes		
	4.Conduct STEPS Survey at least 2 times		Programme evaluated; Survey undertaken	Record review	MOH	
		Trends in risk factors determined				
	5.Meeting NMDS pre-service training emergency surgery and neglected professionals (Radiology; therapists; other) HWs : 5 (1x5)	Critical HR capacity built	Number and type of trained or in training	Report	NMDS	MOH
	6.Training HWs screening and management NCDs: workshops		Number and cadres trained	Facility survey	MOH	CHAL, LRC
	7.Training Police and Traffic Officers RTAs: workshops	Competent HWs in screening for and management of diseases	Number trained		Police	MOH
	8.Review and update traffic laws: meetings	Competency data collection and handling of RTAs	Number of laws updated	Review Gazettes	MOW&T	Police

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	9.Explore, define and develop guidelines, regulations and laws financing mechanisms: meetings	Serious punitive measures for offenders especially drunken driving	Financing mechanism in place	Review gazettes	MOL	MOH
	10.Review and update trade laws risk substances	Catastrophic health costs for households avoided; poverty mitigated	Law promulgated	Record review Minutes	MOL	MOTI
	12. Institute levies: LRA laws	Laws authorising Levies imposed on cigarettes and fast food promulgated	Levies imposed	Record review Physical count	MOF	MOTI, MOH
	12.Meetings committees quarterly for 5 years (20)	Access reduced; funding for prevention of NCDs enhanced Multi-sectoral involvement and accountability	Frequency of and Meetings held on schedule	Reports	MOH	MOLGCA, MOTI, MOAFS, Police, MOGYSR
	13.Regular update retention strategy: consultancy	fostered Multi-sectoral interventions ensured	Staffing of health facilities by cadre	Records review Records review	MOH	MOPS
	14.Monitor programme and supervisory support	HRH available for the burden of diseases	Visits conducted; information analysed	Report Report	MOH	
	15.Quarterly and annual reports	Progress regularly determined and corrective measures taken	Reports available	Pharmacy and Lab records	MOH	
Activities District Level	1.Participate in STEPS survey	Regular performance and self-assessment	Report available	Exit interviews	MOH	
	2.Training HWs, Police and traffic officers	Trends in risk factors determined	Number and cadre trained	Records review Exit interviews	MOH	
	3.HPV vaccination girls 5 (annually) campaigns	Competent officers in primary and secondary NCD prevention	HPV Coverage	Minutes	MOH	
	4.Procurement and distribution medicines, technologies for screening, treatment and palliation of NCDs	Prevalence of cancer of cervix reduced at later age	Medicines and technologies available	Supervisory visits	MOH	
	5.Manage and Monitor financing mechanisms	Medicines and technologies available and				

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		accessible to all In need	Mechanism in place	Record review	MOF	
	6. Meetings committees (4x6)					MOH
		OOPs minimized; accountability and transparency ensured	Regular meetings conducted	Reports	MOH	MOLGCA
	7. Screening for NCDs	Multi-sectoral approach enforced				MOAFS MOGYSR MOTI
	8.Management of patients		Services available	Record review	MOH	MOET Police NGOS
		Timely intervention and reduced complications of the diseases	Services available		MOH	
	9.Monitor programme and supervisory support	Patients with NCD receiving quality care				
			Regular visits conducted	Report Record review	MOH	
	10.Quarterly and annual reports	Quality and extent of services determined; appropriate interventions put in place	Reports available	Record review Exit interviews	MOH	MOAFS MOGYSR MOTI MOET Police NGOS
		Accountability and self-assessment of performance ensured		Site visits Record review Record review		MOAFS MOGYSR MOTI MOET Police NGOS
Activities HC	1.Training VHWs		Number and location of VHW trained	VHW Log Book Reports	MOH	
	2.Manage and monitor financing mechanisms		Mechanism in place	Record review	MOF	
	3.Screening for NCDs	VHWs skills in NCD prevention improved		Community consultative forums		MOH
	4.Management of uncomplicated patients	Access to care assured; accountability fostered	Screening available	Record review	MOH, CHAL, LRC	
	4. Supervision VHWs	Timely identification and referral of NCD	Services and supplies available Regular visits	Community Records VHW records	MOH, CHAL, LRC	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Activities Community	5.Monthly reports 1.Manage and monitor financing scheme 2.Monitor risk factors and diseases 3.Monthly reports	Access to care improved VHW performance enhanced Programmes performance regularly assessed Community ownership and involvement reinforced Community participation and taking responsibility for their own health Regular assessment of performance	conducted Reports available Communities actively involved Communities actively monitoring risk factors and engaged in prevention Communities contribute to report	Community Records Interviews leaders	MOH, CHAL, LRC MOH, CHAL, LRC MOF MOH MOH	MOLGCA MOH

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Strategic Objective 5	To promote and support national capacity for high-quality research and development for the prevention and control of NCDs	promote relevant research to fill gaps around NCD interventions	Budget allocated for NCD related research	Financial record review	MOH	MOF MODP MOET MOLGCA
		Multi-sectoral collaboration to develop a national research policy and plan on NCD related research including community based research and evaluation on the impact of interventions and policies	Availability of Multi-sectoral Technical Working Group Availability of the research policy & plan on NCD related research Availability of research infrastructure, equipment & supplies in research institutions.	Records (minutes) review Review of the policy & plan reports Review of the research reports. Spot checks Review of Records	MOH	MOF MODP (BOS) MOET MOLGC LRA MOCST WHO CHAL LRCS NGOs Development Partners
		National institutional capacity building (research infrastructure, equipment & supplies) and competences of researchers to conduct quality research	Availability of competent researchers Number of academic institutions & multi-disciplinary agencies engaged in NCD related research.	Spot checks Review of reports that reflect quality research conducted	MOH MOH	MOCST
		Effective use of academic institutions & multi-disciplinary agencies to promote research, retain research workforce, incentivize innovation & encourage establishment of National Reference Centre & networks to conduct policy-relevant research.	Number of research studies conducted by academic institutions Availability of incentive package for researchers	Review records Studies reports available Record review	MOH	MOF MODP (BoS) MOET MOLGC
		Improve the				

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
		scientific basis for decision-making through NCD related research & its translation to enhance the knowledge base for ongoing national action. Accountability for progress NCD research part of agenda by year 1	Availability of National Reference Centre & networks to conduct policy-relevant research. Accountability for progress	Review Curriculum academic institutions Review of multi-sectoral meeting reports Reports; Records review	MOH Academic Institutions	LRA MOCST WHO CHAL LRCS NGOs Development Partners WHO CHAL LRCS NGOs Development Partners MFF MODP MOET WHO CHAL LRCS NGOs Development Partners MOF MODP MOET
Activities Central	1. Decide on NCD research agenda and integrate into national/MOH plan	At least 2 each district	NCDs included in research agenda	Reports	MOH	MOCST MOAFS MOGYSR MOET FNCO
	2. In collaboration with the Research Unit, train HWs on research in NCDs: 1 workshop per annum (5)	At least 2 trained annually	Number and cadre trained	Records review	MOH	CHAL, LRC
	3. Train and support tertiary institutions to undertake quality research in NCDs: Workshops; research grants	At least 1 tertiary institution capacitated Finances availed for infrastructure and staffing of institution	Type of institution capacitated	Reports; Site Visit	MOH	MOCST MOF
	4. Include NCDs in the Health		Number and types of topics included in	Reports	MOH	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	Research Policy	NCD included by end of year 1,	research agenda MOH			
		Minimum 1 topic per best buy		Budget		
	5. Advocate for establishment of research Reference Centre: lobbying	interventions Quality of research assured	Type of centre established and amount of resources allocated	Reports	MOH	MOCST
Activities District Level	1. Train staff on health research		1. Number and cadres trained	Record review	MOH	CHAL
	2. Allocate resources for research	Capacity of HWs in research built	2. Amount reflected in budget	Records review	MOF	MOH
	3. Conduct research	Resources for research available	3. Research reports available		MOH	MOAFS MOLGCA Police
Activities at HC Level		Information available to inform operations	1. Research reports available	Records review	MOH	MOAFS
	1. Conduct research	Information available to inform operations	2. Reports on the research conducted		MOH	MOAFS
	2. Review research results with HC Committee	HC committee members informed and aware of their situation	Minutes Meetings			
					MOH	MOAFS MOLGCA
	3. Disseminate results in communities	Communities aware of their situation	Reports of studies; Reports on modes of community information			

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Strategic Objective 6	To monitor the trends and determinants of Non-communicable diseases and evaluate progress in their prevention and control	Integrate NCD monitoring system including prevalence into HIS to systematically assess progress	NCD Indicators included in HIS	Review HIS and tools	MOH	MODP
		Institute, maintain and improve on a Cancer Registry to assess needs	Cancer registry in place	Review tools hospitals and MOH Reports	MOH	CHAL Partners
		Ensure surveillance of NCDs and risk factors including periodic data collection of behavioural and metabolic risk factors, to assess progress and determine trends, especially in inequities	Surveillance system in place	Spot check equipment	MOH	CHAL Partners MOET MOGSR MOAFS
		Build the capacity (institutional and technical) for the management, analysis and reporting on NCD data	Competent HR and appropriately equipped HIS Unit	Records capacity of staff Quality of reports produced	MOH	Tertiary Institutions WHO
		Disseminate report on NCD morbidity and mortality and risk factors (disaggregated by Socioeconomic status, gender, age, level of education, disability)	Trends and impact of NCDs and risk factors assessed	Review reports	MOH	WHO
		Report to WHO	The effectiveness of policies and strategies determined	Review reports	MOH	
		Surveillance and Monitoring of NCD and risk factors allocated identifiable budget annually	Surveillance and Monitoring of NCDs reliable and regular	Review Budget	MOH	BOS
Activities central	1. Meetings with HIS Unit and integrate NCDs	A 1 month consultancy	NCD integrated into HIS	Review HIS tools Review HIS tools	MOH	

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
	2. Develop and disseminate cancer registry (Consultant)	building on experience other African countries At least every 2 years	Cancer Registry instituted	Report	MOH	
	3. Conduct community based data collection (STEPS)	Analysis complete within 1 month date of submitted data	Information on social determinants, behavioural and metabolic factors available	Review reports	MOH	MODP (BOS)
	4. Monthly analysis regular facility data	Routine data report quarterly and at least annually	Report on Progress , and interventions made available	Review reports; Minutes; Participant List	MOH	All sectors
	5. Institute a Multi-sectoral committee to analyse and report on NCDs	Multi-sectoral collaboration and cooperation fostered	Regular meetings of committee	Review reports	MOH	MOAFS MOGYSR Police MOTI MOET
	6. Prepare and disseminate regular reports on studies/surveys	At least every 2 years	Report available	Communication from WHO	MOH	
	7. Report to WHO	Effectiveness of interventions assessed	Report sent to WHO		MOH	
Activities District Level	1. Institute a multi-sectoral monitoring committee; meet on a quarterly basis	Programme performance regularly assessed	1. Frequency of meetings, membership and participants list		MOH	WHO IARC
	2. Collect, collate and analyse data on NCD risk factors and diseases	Information on NCDs available	2. Report available		MOH	MOAFS Police
	3. Assess district performance and prepare a report	Performance assessed and corrective measures taken	3. Report available		MOH	MOF
	4. Submit the report and data to Central level	Central level informed and provide support to districts			MOH	MOAFS Police

	Description	Target/Output	OVI`1	MOV	Lead Responsibility	Support Responsibility
Activities HC Level	5. Conduct regular supervision of HC, Resource centres etc.	Performance enhanced	4. Report submitted		MOH	MOAFS MOGYSR MOLGCA Police
		Performance assessed	5. Report available		MOH	MOAFS MOGYSR MOLGCA Police
	1. Collect data on risk factors and diseases, analyse and prepare a report	Committee members informed	Report available		MOH	MOAFS MOGYSR MOLGCA Police
	2. Discuss report with HC committee	District informed	Committee members aware of their situation		MOH	MOAFS MOGYSR MOLGCA Police
	3. Submit the report to the district					
Activities Community Level	1. Collect data on risk factors and suspect cases	NCD situation monitored	Report available at district level		MOF	MOH
	2. Collect data on Businesses compliance with the trade laws	Compliance to the levies and other laws assessed	Data available		MOH	MOAFS MOLGCA Police
	3. Discuss data at HC Committee meetings	Committee members informed District informed	Data available		MOH	
	4. Submit report to the district		Report available Minutes Report available			

ANNEX II: IMPLEMENTATION PLAN NATIONAL STRATEGY FOR PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
1.To raise the priority accorded to the prevention and control of Non-communicable diseases in national agendas and internationally agreed development goals, through strengthened national cooperation and advocacy	**Activities Central** 1. 1 Workshop/round table for Parliamentarians 2. 1 Toolkit development, review and distribution 3. Review of Health Policy, HSSP and NSDP through a Workshop 4. Submit bills to Parliament; Promulgate laws Tobacco and RTA, as amended; promulgate Public Health Law; Cabinet approval Alcohol Policy,	Primary	1. Number of workshops conducted 2. Number of toolkits developed, reviewed and distributed 3. NCDs included in Health Policy, HSSP andNDSP 4. Number and content of laws, alcohol policy approved Number of laws promulgated	MOH MOH MOH and MODP MOH and MOL MOL	X X X X	X	X X X	X	X	X	**6,747,000**
	Activities District 1. 10 Workshops District leaderships 2. Toolkit distribution	All levels	1. Number of workshops and districts covered 2. Extent of distribution of toolkit	MOH and MOLGCA MOH and MOLGCA	X	X X	 X				
	Activities HC 1. Toolkit Distribution	Primary	1. Extent of	MOH and MOLGCA	X	X	X				

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
	2. 10 Workshops by district		distribution of toolkits 2. Number and location of HC staff and Extension Workers trained	MOH, MOAFS, MOLGCA, MOGYSR, Police	X	X	X				
Activities community Nil											
2. To strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of Non-communicable diseases	**Activities Central** 1. Annual budget preparation (6)	All Levels	1.NCDs included and identifiable in budget	MOH	X	X	X	X	X	X	**139,117,200**
	2. Quarterly (4) Advocacy meetings Parliament	All levels	2.Number and content of meetings held	MOH	X	X	X	X	X	X	
	3. Annual Meetings with Health Planning & Statistics (6)	All levels	3.Number and content of meetings held	MOH	X	X	X	X	X	X	
	4. Annual Meetings all ministries (6)	All levels	4.Number and content of meetings held	MOH and MODP	X	X	X	X	X	X	
	5. Quarterly meeting TWG (4x6)	All levels	5.Number and content of meetings held	MOH	X	X	X	X	X	X	
	6. Annual meetings Districts (10x6)	All levels	6.Number and content of meetings held	MOH and MOLGCA	X	X	X	X	X	X	
	7. Quarterly meetings M&E (4x6)	All levels	7.Number and content of meetings held	MOH	X	X	X	X	X	X	

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
	8. Train NCD Managers in leadership and managerial skills	All levels	8.Number of Managers trained	MOH	X	X	X	X	X	X	
	9. Development and dissemination of Health Promotion materials: rapid assessment interviews, design, distribute/broadcast materials (air time radio and TV and newspaper fees)	All levels	9. Types and mode of dissemination of health promotion materials	MOCST and MOH	X	X	X	X	X	X	
	10. Quarterly supervisory support visits (4x6)	All levels	10. Number and frequency of supervisory support	MOH	X	X	X	X	X	X	
	Activities District Level										
	4. Training and refresher courses Managers and NGOs	All Levels	4. Number and cadre trained	MOH, MOLGCA, MOAFS, Police, MOTI,	X	X	X	X	X	X	
	5. Training and refresher courses service Providers	All levels	5. Number, location and cadres trained	MOH, MOLGCA, MOAFS, Police	X	X	X	X	X	X	
	6. Quarterly Supervisory Support Visits	All levels	6. Number, location and cadres Supervised	MOH, MOLGCA, MOTI, Police	X	X	X	X	X	X	
	Activities HC Level										
	3. Training and refresher courses	Primary and tertiary	3. Number, location of VHWs and	MOH, MOAFS, MOLGCA, MOTI	X	X	X	X	X	X	

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
	VHWs and CSOs		CSOs trained								
	4. Supervisory support VHWs and CSOs	Primary and tertiary	4. Number, location and cadre trained	MOH, MOAFS, MOLGCA, MOTI	X	X	X	X	X	X	
	Activities Community level										
	3. Hold public gatherings	Primary	3. Number and location of public gatherings held	MOH, MOAFS, MOTI	X	X	X	X	X	X	
	4. House to house and business to business visits	Primary Secondary	4. Number of households and businesses visited	MOH, MOAFS, MOTI	X	X	X	X	X	X	
	Activities central										
3.To reduce modifiable risk factors for Non-communicable diseases and underlying social determinants through creation of health-promoting environments	13. Advocacy for NCDs (meetings as obj 2)	All levels	1. Number of advocacy meetings held	MOCST, MOH, MOAFS	X	X	X	X	X	X	**541,708,000**
	14. Health promotion through mass media	All levels	2. Frequency and content of health promotion through mass media	MOCST, MOH, MOAFS, MOGYSR	X	X	X	X	X	X	
	15. MOUs with cellular phone companies for regular transmission of massages through their networks	All levels	3. Frequency and regularity of messaging	MOH, MOCST	X	X	X	X	X	X	
	16. MOUs with utility companies for regular transmission of messages through their billing systems	All levels	4. Frequency and regularity of messaging	MOH, MOCST	X	X	X	X	X	X	
	17. MOUs with milling and food (staple foods) distribution companies	All levels	5. Frequency and regularity of	MOH, MOTI							

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
	for including messages in the packaging		messaging								
	18. Development of guidelines (NCDs, Physical activity, HHF vegetables and fruits)	Primary	6. Number and type of guidelines developed	MOH, MOAFS, MOGYSR,MOET, MOTI, MOF	X	X	X	X	X	X	
	19. School health revitalisation	All levels	7. Number and frequency of visits to schools	MOH, MOET, MOAFS, MOGYSR, MOLGCA	X	X	X	X	X	X	
	20. Development of Bills on waiving taxation key foods, adoption of FCTC, promulgation of laws on alcohol, RTA and Public Health (as obj 1): Consultant	Tertiary	8. Number of laws promulgated	MOL, MOH, Police, MOAFS, MOTI	X	X					
	21. Establish the cancer treatment centre	Tertiary	9. Centre established	MOH			X	X	X	X	
	22. TOT and refresher (6)	All levels	10. Number of TOTs and refresher courses conducted	MOH, MOAFS, MOLGC, MOTI	X	X	X	X	X	X	
	23. Development/review guidelines and Formulary medicines and technologies (Referrals, Formulary, EML, Protocols Lab, Waste management etc.)	All levels	11. Number of guidelines developed	MOH	X	X					
	24. Quarterly supervisory support visits (4x5) as in obj2	All levels	12. Number, frequency and location of supervisory visits	MOH, CHAL,	X	X	X	X	X	X	

Objective	Activities	Level of prevention	Indicator	Responsibility	Time Frame						Budget (Maluti)
					15	16	17	18	19	20	
	25. NGO mobilization	All levels	13. Number of NGOs active in NCD prevention and control	MOH, MOLGCA	X	X	X	X	X	X	
	26. Community surveys: consultant fees, training interviewers, per diems, fuel costs, car hire	All levels	14. Number, content and frequency of community surveys	MOH, MODP (BOS)	X		X				
	27. Commemorate a National day for NCD prevention and control	All levels	15. NCD maintained on the national agenda	MOH, MOAFS, MOLGC, MOTI, MOET	X	X	X	X	X	X	
	Activities districts 1. Advocacy district leaders and Health promotion	Primary and secondary	1. Number of meetings held; number of leaders using the toolkit	MOLGCA, MOH, MOCST MOH, CHAL	X X	X X	X X	X X	X X	X X	
	2. Quarterly Supervisory support HCs	All levels	2. Number and frequency of supervisory visits	MOH, MOAFS, MOET, Police, MOTI	X	X	X	X	X	X	
	3. District level trainings and refresher courses(10x5)	Primary and secondary	3. Number and content of training; cadre trained	MOH	X	X	X	X	X	X	
	4. Procurement and Distribution	Secondary									

	of medicines and technologies 5. Mobilization CSOs (meetings: lunch) 6. Participate in community surveys and conduct own Operations Research (10 annually): data capture and analysis fees 7. Patient management at hospital level 8. Referrals	Primary Cross cutting Secondary and tertiary Tertiary	4. Availability of medicines and technologies 5. Number CSOs active in NCD prevention and control 6. Number and frequency of community surveys; number and topics addressed in operations research studies 7. Number of facilities that follow the 8.Number and reasons for referrals	MOLGCA, MOH MOH, MOLGCA, MOAFS, MOET, MOTI Police MOH, CHAL MOH, CHAL	X X X X	X X X X	X X X X	X X X X	X X X X	X X X X	
	Activities HC 6. Training VHWs: transport, lunch, pens, exercise books 7. Advocacy HC Committee and Health promotion	Primary and secondary Primary	1. Number of VHWs trained; content of trainings 2. Number of committee members that use	MOH, CHAL, LRC MOH, CHAL, LRC, MOLGCA	X X	X X	X X	X X	X X	X X	

	8. Management of clients/patients 9. Supervision VHWs and CSOs: transport 10. Referrals	Secondary Primary and Secondary Secondary	the toolkit 3. Number of HCs that follow the guidelines 4. Number of VHWS and frequency of supervision 5. Number and reasons for referrals	MOH, CHAL, LRC MOH, CHAL, LRC, MOLGCA MOH, CHAL LRC	X X X	X X X	X X X	X X X	X X X	X X X	
	Activities Community Social Mobilization: public gatherings, house to house Business spot checks comply law/regulations Identification clients/patients and referrals	Primary Primary Secondary	Number and frequency of gatherings held; Frequency of house to house visits Frequency and location of spot checks Number and reasons for referrals	MOLGCA, MOH MOLGCA, MOTI, MOF MOH, CHAL, LRC	X X X	X X X	X X X	X X X	X X X	X X X	
4.To strengthen and	**Activities central** 1. Define and submit performance	All levels	1. NCD Included	All Ministries	X	X	X	X	X	X	99,697,800

orient health systems to address the prevention and control of Non-communicable diseases and the underlying social determinants through people-centered primary health care and universal health coverage	appraisal indicators (1 annually) 2. Review and include NCDs in PHC revitalization plans 3. Assess NCD prevention and control implementation 2 times: Midterm and end 4. Conduct STEPS Survey 5. Advocate with MOF (NMDS) pre-service training emergency surgery, Specialized Medical Doctors, Dentists, Pharmacists, Nurses and neglected professionals (Radiotherapy; Therapists; Cytologists, Technologists, Dieticians, paramedics other) HWs : 5 (1x5) 6. In-service training and refresher courses HWs in screening and management of NCDs: workshops 7. Assess and upgrade infrastructure for management of	All levels All levels Primary All levels All levels tertiary Tertiary All levels	in Performance appraisal for Ministers 2. NCDs included in PHC Revitalization Plan 3. Implementation of NCD Prevention and Control assessed 4. STEPS Survey Report available 5. Number and cadres per professionals trained 6. Number per cadre trained 7. Number of hospitals with rehabilitati	MOH MOH MOH MOH, MOAFS, MOF MOH MOH, MOF Police, MOH, WHO	X X X X X X X X	X X X X X X X X	X X X X X X X X	X X X X X X X X	X X X X X X X X	X X X X X X X X	

	NCDs (rehabilitation)	Primary	on units	MOL, Police	X						
	8. Training Police and Traffic Officers on RTAs: workshops and field experience	All levels	8. Number and ranks trained	MOH, MOF	X	X	X	X	X	X	
	9. Review and update traffic laws		9. Laws updated and gazetted								
	10. Explore, define, develop and disseminate guidelines, regulations and laws on financing mechanisms	Primary Primary	10. Number and type of mechanisms in place	MOL, MOTI MOTI, MOF, MOH	X X	X X	 X	 X	 X	 X	
	11. Review and update trade laws in relation to risk factors	All levels	11. Number and content of updated trade laws	MOH	X	X	X	X	X	X	
	12. Institute levies on tobacco and alcohol: LRA laws	All levels	12. Levies imposed	MOH, MOPS, MOF	X		X		X		
	13. Meetings Multi-sectoral committees quarterly for 5 years (20)	All levels	13. Number and participants in meetings	MOH	X	X	X	X	X	X	
	14. Regular update retention strategy: consultancy	All levels	14. Updated retention strategy available	MOH	X	X	X	X	X	X	
	15. Monitor programme and supervisory support		15. Progress reports available								
	16.Prepare quarterly and annual reports		16. Reports available								

	Activities District										
	1. Participate in STEPS survey	All levels	1. Report available	MOH			X				
	2.Training HWs, Police and traffic officers	All levels	2. Number and cadres trained	MOH, Police, MOW&T	X	X	X	X	X	X	
	3.HPV vaccination girls 9 – 13 years (annually) campaigns	Primary	3. HPV Coverage	MOH	X	X	X	X	X	X	
	4.Procurement and distribution medicines, technologies for screening, treatment and palliation of NCDs	Secondary and tertiary	4. Medicines and technologies available	MOH	X	X	X	X	X	X	
	5.Manage and Monitor financing mechanisms	Primary	5. Mechanism	MOH, MOF	X	X	X	X	X	X	
	6. Meetings committees (4x5)	Primary and Secondary	6. Number and frequency of meetings; participants	MOH	X	X	X	X	X	X	
	7. Screening for NCDs	Secondary	7. Number of people screened and diseases for which screened	MOH	X	X	X	X	X	X	
	8.Management of patients	Secondary	8. Number of patients managed;	MOH	X	X	X	X	X	X	
	9.Monitor programme and supervisory support	Primary and secondary									

			guidelines followed								
	10.Quarterly and annual reports	Primary and secondary	9. Number and frequency of visits, reports available 10. Reports available	MOH	X	X	X	X	X	X	
	Activities HC										
	1.Training VHWs	Primary	1. Number VHWs trained	MOH	X	X	X	X	X	X	
	2.Manage and monitor financing mechanisms	Primary	2. Mechanism functional	MOH, MOLGCA	X	X	X	X	X	X	
	3.Screening for NCDs	Secondary	3. Number and diseases for which people were screened	MOH, CHAL, LRC, LPPA	X	X	X	X	X	X	
	4.Management of patients	Secondary	4. Number treated; diseases for which they were treated; guidelines followed	MOH, CHAL, LRC	X	X	X	X	X	X	
	5. Supervision VHWs	Primary		MOH, CHAL, LRC	X	X	X	X	X	X	
	6. Monthly reports	Primary and secondary	5. Number, location and frequency of supervision 6. Reports available	MOH, CHAL, LRC	X	X	X	X	X	X	

	Activities Community											
	1. Manage and monitor financing scheme	Primary	1. Mechanism functional	MOLGCA, MOH	X	X	X	X	X	X		
	2. Monitor risk factors and diseases	All levels	2. Data and reports available	MOLGCA, MOH	X	X	X	X	X	X		
	3. Community Home Based Care including palliative	Primary and tertiary	3. Medicines available	MOH	X	X	X	X	X	X		
	4. Monthly reports	Primary	4. Reports available	MOH	X	X	X	X	X	X		
5.To promote and support national capacity for high-quality research and development for the prevention and control of NCDs	**Activities Central**											**111,697,800**
	6. Decide on NCD research agenda and integrate into national/MOH plan	All levels	1. Research agenda available	MOH	X	X	X	X	X	X		
	7. In collaboration with the Research Unit, train HWs on research in NCDs: 1 workshop per annum (6)	All levels	2. Reports of studies available	MOH	X	X	X	X	X	X		
	8. Train and support tertiary institutions to undertake quality research in NCDs: Workshops; research grants	All levels	3. Number of institutions supported	MOH, MOCST	X	X	X	X	X	X		
	9. Include NCDs in the Health Research Policy	All levels	4. Updated research policy available	MOH	X							
	10. Advocate for establishment of research Reference Centre: lobbying	All levels	5. Research Reference Centre operational	MOH	X	X	X					
	11. Allocate resources for research	All levels	6. Amount reflected in annual budgets	MOH	X	X	X	X	X	X		

	Activities at District Level											
	4. Train staff on health research	Primary and secondary	4. Number and cadres trained	MOH	X	X	X	X	X	X		
	5. Allocate resources for research	Primary and secondary	5. Amount reflected in budget	MOH	X	X	X	X	X	X		
	6. Conduct research	Primary and secondary	6. Research reports available	MOH	X	X	X	X	X	X		
	Activities at HC Level											
	4. Conduct research	Primary and secondary	3. Research reports available	MOH	X	X	X	X	X	X		
	5. Review research results with HC Committee	Primary and secondary	4. Members HC committee aware of results	MOH	X	X	X	X	X	X		
	6. Disseminate results in communities	Primary	5. Communities aware of results	MOH	X	X	X	X	X	X		
6. To monitor the trends and determinants of Non-communicable diseases and evaluate progress in their prevention and control	**Activities central**											
	8. Meetings with HIS Unit and integrate NCDs	All levels	Number and frequency of meetings	MOH	X	X	X	X	X	X	**885,678,400**	
	9. Develop and disseminate cancer registry (Consultant); training for staff procuring software	Secondary and tertiary	Registry in place	MOH, WHO, IARC	X							
	10. Develop and disseminate the community based data collection tool	Primary and secondary	Tool in place	MOH	X	X						
	11. Monthly analysis regular facility data	All levels	Facility data report available	MOH, MOAFS, Police MOTI, MOF	X	X	X	X	X	X		

	12. Institute a Multi-sectoral committee to analyse and report on NCDs	All levels	Frequency of meetings, membership of committee and participants list	MOH	X	X	X	X	X	X	
	13. Prepare and disseminate regular reports	All levels	Report available	MOH	X	X	X	X	X	X	
	14. Report to WHO	All levels	Report submitted to WHO	MOH	X	X	X	X	X	X	
	Activities District										
	6. Institute a multi-sectoral monitoring committee; meet on a quarterly basis	Primary and secondary	Frequency of meetings, membership and participants list	MOH	X	X	X	X	X	X	
	7. Collect, collate and analyse data on NCD risk factors and diseases	Primary and secondary	Report available	MOH, MOAFS, Police, MOTI, MOF	X	X	X	X	X	X	
	8. Assess district performance and prepare a report	Primary and secondary	Report available	MOH, MOAFS, Police, MOTI, MOF	X	X	X	X	X	X	
	9. Submit the report and data to Central level	Primary and secondary	Report submitted	MOH, MOAFS, MOTI, MOF, Police	X	X	X	X	X	X	
	10. Conduct regular supervision of HC, Resource centres etc.	Primary and secondary	Report available	MOH, MOAFS, MOTI, MOF, Police	X	X	X	X	X	X	
	Activities HC										
	4. Collect data on risk factors and diseases, analyse and prepare a report	Primary and secondary	Report available	MOH, MOAFS	X	X	X	X	X	X	
	5. Discuss report	Primary and		MOH	X	X	X	X	X	X	

	with HC committee 6. Submit the report to the district	secondary Primary and secondary	Members aware of situation in their locality Report available at district level	MOH	X	X	X	X	X	X	

ANNEX III: BUDGET NATIONAL STRATEGIC PLAN FOR PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASE

Objective	Activity	Unit cost (MALUTI)	Total units	Duration (DAYS)	TOTAL COST (MALUTI)
1. To raise the priority accorded to the prevention and control of Non-communicable diseases in national agendas and internationally agreed development goals, through strengthened national cooperation and advocacy	**Central level**				
	1 Workshop Parliamentarians: venue, meals, stationery, teas	320	200	5	320000
	1 Toolkit development and distribution: Consultant	10000	1	20	200000
	2 Review of Health Policy,HSSP and NSDP:Worksop:venue,meals,materials	200	20	2	8000
	1 Draft and review Bills : Consultant	10000	2	30	600000
	1 Submit to Parliament: Presentation				
	Subtotal				**1128000**
	District Level				
	10 Workshop District: venue, meals, materials,	880	300	2	528000
	Accommodation	1200	300	3	1080000
	Consultant	7000	1	30	210000
	1 Toolkit distribution				
	Subtotal				**1818000**
	Health Center Level				
	1 Toolkit Distribution				
	10 Workshop: venue, meals, materials, accommodation	180	7000	3	3780000
	Accommodation	700	300	3	630000
	Consultant	7000	1	3	21000
	Subtotal				**3801000**
	Total				**6747000**
2.To strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of Non-communicable Diseases	Activities Central				
	1. Annual budget preparation (6)				
	2. Quarterly (6x4) Advocacy meeting Parliament	320	200	6	384000
	3. Annual Meetings with HPS (6)	140	20	6	16800
	4. Annual Meetings all ministries (6) and partners	200	120	6	144000
	5. Quarterly meeting TWG (4x6)	200	20	24	96000

	6. Annual meetings Districts (10x6)	880	300	60	15840000
	7. Quarterly meetings M&E (4x6)	880	20	24	422400
	8. Development Health Promotion materials- rapid asses	300	5	60	90000
	Print materials	500	3000	1	1500000
	broadcast fee	600	60	4	144000
	9. Quarterly supervisory support visits (4x6)	2000	5	24	240000
	Subtotal				**18877200**
	Activities District Level				
	1. Training and refresher courses Managers and NGOs	1200	50	60	3600000
	2. Training and refresher courses service Providers	1200	200	60	14400000
	3. Quarterly Supervisory Support Visits	1200	200	240	57600000
	Subtotal				75600000
	Activities HC Level				
	1. Training and refresher courses VHWs and CSOs	300	6000	24	43200000
	2. Supervisory support VHWs and CSOs	300	200	24	1440000
	Subtotal				44640000
	Activities Community level				
	1. Hold public gatherings				
	2. House to house and business to business visits				
	Subtotal				
	Total				**139117200**
3.To reduce modifiable risk factors for Non-communicable diseases and underlying social determinants through Environments	**Activities central** 1. Advocacy for NCDs (meetings as obj 2) 2. Health promotion mass media 3. MOUs with cellular phone companies for regular transmission of messages through their networks 4. MOUs with utility companies for regular transmission of messages through their billing systems 5. MOUs with milling and food (staple foods) distribution companies for including messages in their packaging 6. Development of guidelines (NCDs, Physical activity, HHF vegetables	11000 10000	12 3	60 30	7920000 900000

and fruits)				
7. School Health Revitalization	100000	10	6	6000000
8. Development of Bills on waiving taxation key foods, adoption of FCTC, promulgation of laws on alcohol, RTA and Public Health: Consultant	10000	2	20	400000
9. Establish the cancer treatment centre				500,000,000
10. TOT and Refresher (6)	12000	20	30	7200000
10. Development/review guidelines and Formulary medicines and technologies (Referrals, Formulary, EML, Protocols, Laboratory, waste management)	100000	6	30	18000000
11.. TOT and refresher (6)	1200	20	60	1440000
12. Quarterly Supervisory Visits	1200	5	24	144000
13. NGO Mobilization	1200	20	60	1440000
14. Community Surveys: Per diem, Consultant, car hire, fuel)	1200	50	20	1200000
	10000	1	30	300000
	4000	10	20	800000
	1000	10	20	200000
15. Commemmorate a National Day for NCD Prevention and Control	180	300	6	324000
(Dignitaries and Public)	80	3000	6	1440000
Subtotal				**547708000**
Activities District Level				
1. Advocacy district leaders and Health promotion	700	30	60	1260000
2. Quarterly Supervisory support HCs	500	24	40	480000
3. District level trainings and refresher courses(10x5)	880	30	50	1320000
4. Procurement and Distribution medicines and technologies				0
5. Mobilization CSOs (meetings: lunch)	180	20	6	21600
6. Participate in community surveys and conduct own operations research	1200	50	20	1200000
7. Patient management at hospital level				
8. Referrals				
Subtotal				**3021600**
Activities HC				
1. Training VHWs: transport, lunch, pens, exercise books (4x10)	300	6000	40	72000000

	2. Advocacy HC Committee and Health promotion (6x20) for 1 day	300	120	24	864000
	3. Management of clients/patients				
	4. Supervision VHWs: transport (4x1x6)	100	200	24	480000
	5. Referrals				
	Subtotal				**73344000**
	Activities Community				
	1. Social Mobilization: public gatherings, house to house				
	2. Business spot checks comply law/regulations				
	3. Identification clients/patients and referrals				
	Subtotal				**0**
	Total				624073600
4.To strengthen and orient health systems to address the prevention and control of Non-communicable diseases and the underlying social determinants through people-centered primary health care and universal health coverage	**Activities central**				
	1.Define and submit performance appraisal indicators 5 (1 annually)				
	2.Review and include NCDs in PHC revitalization plans :1	10000	1	10	100000
	3.Assess NCD prevention and control implementation 2 times:	1200	20	10	240000
	4.Conduct STEPS Survey at least 2 times				20000000
	5.Meeting NMDS pre-service training	180	10	6	10800
	6.Training HWs screening and management NCDs: workshops	1200	300	30	10800000
	7. Upgrading Infrastructure for rehabilitation				12000000
	8.Training Police and Traffic Officers RTAs: workshops	1200	20	30	720000
	9.Review and update traffic laws:	10000	1	30	300000
	10.Explore, define and develop financing mechanisms	180	30	5	27000
	11.Review and update trade laws risk substances	10000	1	20	200000
	12.Institute levies: LRA laws	10000	1	20	200000
	13.Meetings committees quarterly for 5 years (20)	200	20	20	80000

14.Regular update retention strategy: consultancy	10000	1	40	400000
15.Monitor programme and supervisory support	1200	5	60	360000
16.Quarterly and annual reports				
Subtotal				45437800
Activities District				
1.Participate in STEPS survey	1200	40	40	1920000
2.Training HWs, Police and traffic officers	1200	30	6	216000
3.HPV vaccination girls 5 (annually) campaigns				2000000
4.Procurement and distribution medicines, technologies for screening,	2000000	10	6	120000000
treatment and palliation of NCDs				
5.Manage and Monitor financing mechanisms				
6. Meetings committees (4x5)	180	30	60	324000
7. Screening for NCDs				
8.Management of patients				
9.Monitor programme and supervisory support (200x1)	700	30	200	4200000
10.Quarterly and annual reports				
Subtotal				**128660000**
Activities HC				
1.Training VHWs	300	6000	24	43200000
2.Manage and monitor financing mechanisms				
3.Screening for NCDs				
4.Management of patients				
5. Supervision VHWs	100	6000	24	14400000
5. Monthly reports				
Subtotal				**57600000**
Activities Community 1. Manage and monitor financing scheme 2. Monitor risk factors and diseases 3. Monthly reports Subtotal				

Total					**231697800**
5.To promote and support national capacity for high-quality research and development for the prevention and control of Non-communicable diseases	**Activities central**				
	1. Decide on NCD research agenda and integrate into national/MOH plan	140	20	1	2800
	2. In collaboration with the Research Unit, train HWs on research in NCDs: 1 workshop per annum (5)	7000	30	30	6300000
	3. Train and support tertiary institutions to undertake quality research in NCDs: Workshops; research grants	10000	50	6	3000000
	4. Include NCDs in the Health Research Policy	7000	1	2	14000
	5. Advocate for establishment of research Reference Center: lobbying				
	Subtotal				**9316800**
	Activities at District Level				
	1. Train staff on health research	**300**	**200**	**3**	180000
	2. Allocate resources for research				
	3. Conduct research Operations research)	**300**	**10**	**6**	18000
	Subtotal				**198000**
	Activities at HC Level				
	1. Conduct research (operations research)	**300**	200	**6**	360000
	2. Review research results with HC Committee	**100**	**180**	**6**	108000
	Disseminate results in communities				
	Subtotal				**468000**
	Total				**9982800**
6.To monitor the trends and determinants of Non-communicable diseases and evaluate progress in their prevention and control	**Activities central**				
	1. Meetings with HIS Unit and integrate NCDs				
	2. Develop and disseminate cancer registry (Consultant)	10000	1	20	200000
	3. Conduct community based data collection (STEPS)				
	(covered above)				
	4. Monthly analysis regular facility data				
	5. Institute a Multi-sectoral committee to analyze and report	200	30	24	144000
	on NCDs				
	6. Prepare and disseminate regular reports				

	7. Report to WHO **Subtotal**				**344000**
	Activities District 1. Institute a multi-sectoral monitoring committee; meet on a quarterly basis 2. Collect, collate and analyze data on NCD risk factors and diseases 3. Assess district performance and prepare a report 4. Submit the report and data to Central level 5. Conduct regular supervision of HC, Resource centersetc. **Subtotal**	200 250	30 5	20 50	120000 62500 **182500**
	Activities HC 1. Collect data on risk factors and diseases, analyze and prepare a report 2. Discuss report with HC committee 3. Submit the report to the district **Subtotal**	100	30	20	60000 **60000**
	Activities Community 1. Collect data on risk factors and suspect cases 2. Collect data on Businesses compliance with the trade laws 3. Discuss data at HC Committee meetings 4. Submit report to the district **Subtotal**	100	30	20	60000 **60000**
	Total				**466500**
GRANT TOTAL					**659074600**