KINGDOM OF ESWATINI

MINISTRY OF HEALTH

ESWATINI NATIONAL HEALTH SECTOR RESPONSE PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES, INJURIES AND MENTAL HEALTH

2024 - 2028

World Health Organization

NON COMMUNICABLE DISEASES

Eswatini National Health Sector Response Plan for the Prevention and Control of Non-Communicable Diseases, Injuries and Mental Health

(2024 – 2028)

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FOREWORD

Non-Communicable Diseases, Injuries, and mental health (NCDIMH) disorders are still the main causes of Morbidity, mortality, and disability in Eswatini: By the end of 2022, 46% of fatalities were attributable to NCDs, up from 38% in 2017. The probability of premature mortality has also increased from 25% in 2017 to 35% at the end of 2023. If this trend continues over the next 6 years, Eswatini will not be able to meet the global SDG target of one third relative reduction in overall mortality from cardiovascular diseases, cancers, or diabetes by 2030.

The likelihood of multimorbidity and disability from NCDIs and mental health disorders has increased along with life expectancy. The COVID-19 pandemic also glaringly exposed how noncommunicable diseases intersect with infectious diseases. While the effects of future pandemics are unpredictable, the majority of the NCDIs and their risk factors are preventable. Increasingly, patients, their families, and communities, health systems and the nation's economy are incurring catastrophic costs due to the high burden of these diseases. The poorest and most vulnerable in society are disproportionately affected, they bear the highest risk for NCDIs and mental health conditions, yet they face the most impediments in accessing essential health care services. This magnifies the need for a renewed effort to prevent and control NCDs and mitigate their deleterious impact on our citizens, our health systems, and our economy.

To that end it gives me great pleasure that the ministry has developed this new national health sector strategic plan to guide national efforts to prevent and control NCDs, Injuries and mental health for the period 2024-2028. This strategy builds on the achievements and lessons learned implementing the national strategy and action plan for the prevention and control of NCDs 2021-2023 as well as global frameworks, roadmaps, and strategies. It represents a departure from the previous strategy in that it not only includes the traditional four NCDs and their modifiable factors but also incorporates for the first-time injuries and mental health, thus aligning with both WHO and Africa CDC agenda and strategies as recommended by WHO.

As this is a national health response strategy, all relevant stakeholders, and partners have collectively contributed to this document demonstrating the country's political will and social inclusion to prioritise NCDIs and mental health. This strategic document, therefore, serves as a road map and when implemented will wholly contribute to ensuring Eswatini achieves progress on the 9 global NCD targets while advancing the 2030 UN Sustainable Development Goal (SDG 3.4) target to reduce premature death from NCDs by one-third by 2030.

I, together with my officials within the Ministry of Health remain committed to collaborate intensely and to ensure the implementation of this National Health response Strategic plan to mitigate the threat to national economic and human development posed by NCDIs and mental health conditions on a healthy and empowered, prosperous, and productive Eswatini free from avoidable NCDIs and mental health conditions.

Hon. Mduduzi Matsebula
Minister of Health

PREFACE

It is with great pride and commitment that I present the Non-Communicable Diseases, Injuries, and Mental Health National Health Sector Operational Plan 2024–2028. This robust and forward-looking plan is a cornerstone in our nation's ongoing efforts to safeguard and promote the health of our people. Rooted in the principles and objectives of the National Health Sector Strategic Plan 2024–2028, it serves as a vital framework for addressing the growing challenges posed by non-communicable diseases (NCDs), injuries, and mental health conditions.

The burden of NCDs continues to rise at an alarming rate, posing significant risks not only to the health and well-being of individuals but also to the socio-economic fabric of our country. Injuries and mental health conditions further compound the strain on our health systems, communities, and economy. This operational plan comes at a critical juncture, where immediate and concerted action is required to prevent and control these conditions. By focusing predominantly on prevention, we aim to reduce the incidence of NCDs, injuries, and mental health issues, thereby avoiding the complications and exorbitant costs associated with their management.

The implementation of this plan will require the unwavering commitment of all stakeholders. I urge everyone from policymakers and healthcare providers to civil society and international partners to rally behind this effort and ensure its effective execution. Together, we can build a healthier, more resilient nation and create a brighter future for all.

I extend my sincere gratitude to all those who contributed to the development of this operational plan. Let us now join hands to translate its vision into action.

ACKNOWLEDGEMENTS

The Ministry of Health wishes to express sincere thanks to all those who were pivotal in the elaboration of this strategy and its action plan. We acknowledge and appreciate all the stakeholders for their dedicated involvement and tireless effort in providing critique, comments and suggestions that have greatly contributed to the development of this document.

The Ministry of Health expresses sincere gratitude to the World Health Organization (WHO), World Bank, Clinton Health Access Initiative (CHAI) and other development and implementing partners for their financial and technical assistance throughout the strategic planning process.

The successful completion of this strategy was additionally made feasible by the support and commitment accorded by the Directorate within the Ministry of Health. Their contributions and feedback throughout the exercise has been exemplary.

ACRONYMS

BMI	Body Mass Index
CHAI	Clinton Health Access Initiative
CHW	Community Health wor ker
CMIS	Client Management Information System
CMS	Central Medical Store
CRD	Chronic Respiratory Diseases
CSO	Civil Society Organizations
CVD(s)	Cardiovascular disease(s)
DALYS	Disability Adjusted Life Years
DM	Diabetes Mellitus
EDCU	Epidemiology & Disease Control Unit
SNAP	Eswatini National AIDS control Program
HBA1C	Glycated Haemoglobin A1c
HCW	Healthcare worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HTN	Hypertension
M&E	Monitoring and Evaluation
MH	Mental Health
MSAP	Multi-Sectoral Action Plan
MOH	Ministry of Health
NCD(s)	Non-Communicable Disease(s)
NCDI(s)	Non-Communicable Diseases and Injuries
NCDIMH	Non-Communicable Diseases, Injuries and Mental Health
NGOS	Non-Governmental Organisations
NHSSP	National Health Sector Strategic Plan
NTCP	National Tuberculosis Control Program
OPD	Outpatient Department
PLHIV	People Living with HIV
PEN-PLUS	Package of Essential NCDs - Plus package
RHM	Rural health motivators
SRH	Sexual and Reproductive Health
TB	Tuberculosis
WHO	World Health Organization
WHO-PEN	World Health Organization -Package of Essential NCDs

EXECUTIVE SUMMARY

The Eswatini's National Health Sector Response Plan for the Prevention and Control of Non-Communicable Diseases, Injuries, and Mental Health (NCDIMH) for 2024–2028 presents a comprehensive strategy to confront the country's rising burden of NCDs, injuries, and mental health disorders. Building on the foundation laid by the 2021–2023 action plan, the new strategy draws from global best practices and aligns closely with frameworks from the World Health Organization (WHO) and the Africa Centres for Disease Control and Prevention (Africa CDC). It is also fully aligned with the National Health Sector Strategic Plan 2024–2028, ensuring a cohesive national effort across all levels of the health system.

Guided by the vision of a healthy, empowered population free from the avoidable burden of NCDs, injuries, and mental health disorders, the plan seeks to advance a mission centered on reducing this burden through evidence-based, people-centered, and sustainable interventions. The strategy goal is to attaiin a 30% reduction in premature mortality linked to NCDs, injuries, and mental health conditions by 2028.

To achieve this, the strategy outlines five strategic objectives. These include strengthening political commitment and establishing a multisectoral coordination mechanism; reinforcing health system governance, leadership, and financing; reducing key behavioral and metabolic risk factors such as tobacco use, harmful alcohol consumption, obesity, and hypertension; improving access to high-quality, evidence-based NCDIMH services; and establishing a robust monitoring and evaluation system capable of generating high-quality data from at least 80% of public and private facilities to inform policy and program decisions. Each objective is supported by measurable targets to guide implementation and track progress.

The five-year plan requires an estimated budget of SZL 52,765,651.50, dedicated to critical interventions such as developing national frameworks, building the capacity of healthcare workers, scaling up integrated care, strengthening surveillance systems, and delivering public health campaigns. A comprehensive resource mobilization strategy, drawing on both domestic and external funding sources, underpins these efforts to ensure financial sustainability and effective execution.

This strategy positions Eswatini to make significant advances in preventing and controlling NCDs, injuries, and mental health disorders. Through strong governance, community engagement, strategic investment in health services, and a steadfast commitment to data-driven action, the country aims to secure long-term health and well-being for all the people of Eswatini.

CHAPTER 1 INTRODUCTION

1.1 OVERVIEW OF NON-COMMUNICABLE DISEASES, INJURIES AND MENTAL HEALTH

Eswatini has a high burden of noncommunicable diseases (NCDs), with 46% of deaths in 2019 attributable to NCDs. The country has one of the highest age-standardised mortality rates for four major NCDs (cardiovascular disease, chronic respiratory disease, cancer, and diabetes) in Africa at 1,254 per 100,000 population in males and 754 in females1. Eswatini's high prevalence of HIV can increase the risk of certain NCDs, such as cardiovascular disease. The country is facing growing challenges with hypertension, diabetes, and cancer, particularly cervical cancer. The World Health Organization and other partners are working with the government of Eswatini to improve the prevention and control of NCDs. The National Health Sector Response Plan for Prevention & Control of NCDs targets diabetes, cardiovascular diseases, cancer, chronic respiratory diseases, injuries, mental health. This Response Plan proposes to extend NCD interventions to all development sectors, including agriculture, finance, economic planning, commerce, justice, education, and others, with active participation of civil society, NGOs, local associations, and the community.

1.2 COUNTRY PROFILE

1.2.1 POPULATION AND HEALTH PROFILE

The country is divided into four administrative regions Hhohho, Manzini, Lubombo and Shiselweni, the largest regions being Manzini and Hhohho respectively. The 2017 census population projections estimate the population of Eswatini at 1 202 285, in 2024 of whom 51 per cent were women, with the country's young population having a median age of just 21.7 years.

The estimated life expectancy in Eswatini is 58.9 years for males and 63.5 for females. Eswatini is going through an epidemiological transition and is experiencing a double burden of disease. While communicable diseases remain a serious challenge, non-communicable diseases (NCDs) particularly hypertension, diabetes, and cancer are growing problems, especially cancers of the reproductive system. Mental health is increasingly acknowledged as an important public health concern in Eswatini. Mental disorders are prevalent and cause significant suffering and disease burden.

1.2.2 ECONOMIC PROFILE

Eswatini's economy is diverse, with agriculture, forestry, and mining accounting for about 13% of GDP. It is classified as a lower-middle-income country (gross domestic product per capita of US$3, 850). The 2024 financial budget allocation for health was increased by E250 million more bringing the health budget to E3 billion representing 10% of the total budget which is still below the recommended 15% of the Abuja Declaration. The health sector is one of the top three sectors in terms of Government's budgetary allocations. Currently personnel and drug expenses take up nearly two-thirds of the budget with limited expenditure on preventive and curative care, respectively about 7 percent and 0.1 percent of recurrent expenditures. NCDs and nutrition remain underfunded.

Except for the investment case on Tobacco control there have been no other studies or analyses on the socio-economic impact of NCDIMH conditions in the country. These conditions not only place a significant burden on population health, but also on economic and social development. Indeed, NCDIs and mental health conditions lead to high treatment costs, imposing a direct economic burden on health systems, households, and society. NCDIs and mental health also impose an indirect economic burden through significant productivity losses via premature mortality, early labour force exits, absenteeism, and work at lowered capacity. Thus, implementation of sustainable health financing mechanisms will be crucial for Eswatini to progress toward universal health coverage (UHC) and fulfill its socio-demographic and economic potential particularly as support from development partners continues to dwindle.

1. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.afro.who.int/sites/default/files/2023-08/ESWATINI.pdf
2. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.gov.sz/images/FinanceDocuments/Volume3.pdf,
3. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://parliament.gov.sz/media/speeches/budget/2024.pdf

1.2.3 HEALTH SYSTEM PROFILE

The health system is multi-tiered organized in five levels. Primary health care (PHC) services are provided at the Community level (Level 1), and at PHC nurse-led clinics (Level 2). Secondary care is provided by doctor-led health centers (Level 3) and Tertiary services are provided by regional hospitals (Level 4) and referral hospitals (Level 5). Access to health care facilities is generally good, with up to 85 per cent of the population living within 8 kilometres of a health facility.

Eswatini's community-based health services form an integral liaison between health care facilities and the community. A comprehensive training package for community level health providers was developed in 2018 and has enhanced standardized care. With the support of partners, improvements have also been seen in the quality of care in PHC facilities, where integration and scale up on nutrition and NCD services were supported with implementation of the World Health Organization Package of Essential NCD Interventions (WHO-PEN) for Primary Health Care in Low-Resource Settings.

Patient monitoring and management for clients living with NCDIs and mental health is documented in electronic files in the Client Management and Information System (CMIS) which enables the program to access data real time for timely action on interventions. Paper based chronic care files are kept at facilities not, yet CMIS connected and for back up of the information that is in the electronic system. Clients keep a patient card that contains a summary of their condition on each review conducted.

Generally, the health system is experiencing challenges with capacity issues and inherent structural and infrastructural limitations. Frequent disruptions in essential health service delivery have been occasioned due to resource limitations in human capital, procurement and supply chain of drugs and commodities, security controls, hospital, and fuel management. While the coverage of Client Management Information System (CMIS) has greatly improved across health facilities the connected facilities still require further connectivity in other departments. This connectivity gap negatively affects the collection of morbidity and mortality data. These challenges collectively have a negative impact on patient care and results in catastrophic healthcare costs for the patient, their families, and the health care system.

1.2.4 CONSTRAINTS TO NCDI AND MENTAL HEALTH PREVENTION AND CONTROL IN ESWATINI

There are four main constraints to the prevention and control of NCDs in Eswatini:

1. **Funding:** NCDIs and mental health generally have a constrained funding envelope and donor landscape. Budgetary allocation towards the NCDIMH is at less than 1Million Emalangeni and is below 1% of the total health budget. This has resulted in significant challenges to programmatic activity and poses a great impediment to the implementation of interventions geared towards the prevention and control of NCDs.
2. **Human Resource:** The NCDIMH programme functions with repurposed personnel thus an urgent need to deploy personnel for each unit in the establishment register. In addition, there are very few NCD-related professionals working in the public sector creating significant gaps in specialised care for NCDIs and mental health and their complications.
3. **Data quality:** NCD data is largely generated from the Client Management Information System (CMIS). However, tertiary facilities as well as private facilities are not fully CMIS connected, and this compounded by internet connectivity disruptions together with a lack of regular uptake of back-up paper-based tools contribute to under reporting. This gap greatly affects the quality of the data, especially completeness which when used, poorly informs planning, quantification, and projections.
4. **Medicines and supplies:** The Eswatini health system has experienced frequent interruptions in the supply chain of NCDIMH drugs, commodities, and supplies. NCD drugs, commodities and supplies are constantly very low in stock levels or stocked out for prolonged periods resulting in interrupted service delivery a situation needing practical urgent attention.

CHAPTER 2 DEVELOPMENT OF THE HEALTH SECTOR RESPONSE ACTION PLAN

2.1 COORDINATION

The national NCD strategic plan, 2021-2023 came to an end in December 2023, which necessitated a review to inform a new pathway for NCDs in Eswatini. The coordination of the 2024-2028 Health Sector Response Plan was through a task team comprising a core team from the NCDIMH programme, as well as technical assistance provided by CHAI and WHO.

2.2 CONDUCTING A SITUATIONAL ANALYSIS

2.2.1 REVIEW OF THE PREVIOUS STRATEGY

The NCDIMH programme alongside its stakeholders were involved in the end term strategy review which was collectively conducted with the national health sector strategic plan. The following steps were followed:

i. **Planning:** The aim of the planning phase was to consult and secure consensus among all partners and stakeholders.
ii. **End Term Program review:** It included assembling information from program reports and strategic documents. The aim of the desk review was built upon thematic review reports through national level consultations and field visits with the outcome of this process being a finalised review report.
iii. **Validation:** The aim of the validation process was to seek the stakeholder input, feedback, and perspectives on the strategic plan. This involved engaging stakeholders including MoH senior management, department heads, staff members, and external partners, to validate the findings of the review where preliminary results were presented.

2.2.2 STAKEHOLDERS AND POLICY LANDSCAPE ANALYSIS

Stakeholder mapping was done and categorised into four: High Influence-Low Stake, High Influence-High Stake, Low Influence-High Stake and Low Influence-Low Stake as depicted in the table below.

Table 1: NCDI and mental health Stakeholder and policy mapping

High Influence, Low Stake	High Influence, High Stake

• ICAP
• ASPIRE Project
• Georgetown
• NERCHA
• PEPFAR
• UNAIDS
• UNICEF
• UNFPA
• FAO
• ERS
• Transport Association
• QMP
• Ministry of Public Service
• Ministry of works and transport
• Eswatini Umbutfo Defence Force
• His Majesty correctional services
• Prime Minister's Office
• Deputy Prime Ministers Office
• Ministry of Tourism and Environmental affairs
	• Ministry of Health
	  ○ School health program
	  ○ NTCP
	  ○ NCCU
	  ○ RHM
	  ○ EDCU
	  ○ SNAP
	  ○ M&E
	  ○ RESEARCH
	  ○ HMIS
	  ○ Eswatini Health Laboratory Service
	  ○ CMS
	• CHAI
	• WHO
	• MSF
	• PSI
	• Breast and cervical cancer network
	• Taiwan ICDF
	• Cuban brigade
	• AHF
	• TLC
	• Baylor Foundation
	• Ministry of Education
	• Ministry of Finance
	• Ministry of Agriculture
	• Ministry of Sports, culture, and youth
	• Ministry of Commerce and industry
	• Academic Institutions
	• Nutrition Council
	• Royal Eswatini police services

Low Influence, Low stake	**Low Influence, High Interest**
• UNDP • Child health (EPI, IMCI) • EPR	• Diabetes Eswatini • Epilepsy Eswatini • CANGO • Hospice at Home • Hope house • Cheshire homes • SWABCHA • SRH

2.3 SITUATION ANALYSIS

2.3.1 GLOBAL BURDEN OF NCDIMH

Non communicable diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory diseases, injuries as well as mental health are the leading global cause of preventable and premature death and illness and are responsible for 41 million deaths annually, equivalent to 74% of all deaths globally. Disaggregated by disease, cardiovascular diseases (CVDs) [such as heart attacks and stroke] account for 43% of all deaths (17.9 million), followed by cancers (9.3 million), chronic respiratory diseases (CRD) (4.1 million), and diabetes (2.0 million including kidney disease deaths caused by diabetes). These four groups of diseases account for over 80% of all premature NCD deaths. Injuries and violence take the lives of 4.4 million people around the world each year and constitute nearly 8% of all deaths. For people aged 5-29 years, three of the top five causes of death are injury-related, namely road traffic injuries, homicide, and suicide. NCDIs disproportionately affect people in low- and middle-income countries, where more than three quarters of global NCD deaths (31.4 million) occur[4].

Modifiable behaviours, such as tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol, all increase the risk of NCDs. Tobacco accounts for over 8 million deaths every year; Excess salt/sodium intake accounts for 1.8 million annual deaths; Alcohol use accounts for 1.5 million deaths whilst 830 000 deaths annually can be attributed to insufficient physical activity.

Metabolic risk factors contribute to four key metabolic changes that increase the risk of NCDs including raised blood pressure, obesity, high blood glucose levels (hyperglycaemia) as well as high levels of fat in the blood (hyperlipidaemia). In terms of attributable deaths, the leading metabolic risk factor globally is elevated blood pressure (to which 19% of global deaths are attributed) followed by raised blood glucose and overweight and obesity.

NCDs also account for 63.8% of Disability Adjusted Life Years (DALYs). NCDs reduce productivity and human capital, while increasing healthcare costs from serious illness, disability, and death. In total, the five leading NCDs – cardiovascular disease, chronic respiratory disease, cancer, diabetes and mental health and neurological disorders – have been estimated to cost US$ 47 trillion between 2011-2030, an average of more than US$ 2 trillion per year.

2.3.2 CLIMATE CHANGE AND NCDIS MENTAL HEALTH ASSOCIATED RISKS

Climate change is the single biggest health threat facing humanity, and health professionals worldwide are already responding to the health harm caused by this unfolding crisis. Climate change is impacting human lives and health in a variety of ways. It threatens the essential ingredients of good health – clean air, safe drinking water, nutritious food supply and safe shelter – and has the potential to undermine decades of progress in global health.

Two major global crises of our time, climate change and the epidemic of NCDs, are intertwined. They erode gains in health and development and the quality of life, hitting poor and marginalized people the hardest. Action to manage them both should be aligned in synergistic interventions that can address both.

2.3.3 HOW CLIMATE CHANGE IMPACTS NCDIS AND MENTAL HEALTH

Climate change is already impacting health in a myriad of ways, including by leading to death and illness from increasingly frequent extreme weather events, such as heatwaves, storms and floods, the disruption of food systems, increases in zoonoses and food, water and vector-borne diseases, and mental health issues.

4WHO (2020) World Health Organization, Global Health Observatory Data Repository

Some of the impacts are:

- **Heat waves:** cardiovascular diseases, such as stroke
- **Air pollution:** stroke, heart disease, asthma, chronic obstructive pulmonary disease and lung cancer
- **Wildfires:** suffocation, burns, cardiovascular and respiratory problems, mental health, destruction of health services and housing
- **Drought:** food insecurity, malnutrition, and psychosocial stress
- **floods:** disruption to health services, displacement and shortages of safe water, mental and physiological health, food insecurity and malnutrition
- **Injuries and mortality** from extreme weather events
- **Impact on health care facilities**

2.3.4 BURDEN OF NCDIMH IN ESWATINI

As with the rest of the continent, NCDIs and mental health are a significant and growing threat to public health in Eswatini. As life expectancy has continued to increase from 47 in 2000 to 61 at the end of 2023, so too has the burden of NCDIs. The contribution of NCDs to mortality has increased significantly from 38% in 2017 to 46% at the end of 2022. It is not surprising that the absolute number of deaths from NCDs have also increased from 4,000 in 2017 to 5,400 by the end of 2022. Eswatini is off course to achieve the SDG target of reducing by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing as the probability of premature mortality from NCDs has continued to grow from 25% in 2017 to 35% at the end of 2022. It is important to note that the probability was 21% when the strategy for the period 2021-2023 was elaborated. Disability-adjusted life years (DALYs) represents the total number of years lost to an illness, disability or premature death within a given population: NCDs are the leading cause of disability in the country, accounting for 37.6% of all DALY[7].

NCDs are the result of a combination of genetic, physiological, environmental, and behavioural factors. Modifiable behavioural risk factors include harmful use of alcohol, tobacco use, physical inactivity, and an unhealthy diet. Metabolic risk factors include raised blood pressure, overweight and obesity, hyperglycaemia (high blood glucose levels), and hyperlipidaemia (high levels of fat in the blood). The latest available data for indicators on some of these risk factors in Eswatini are presented below.

2.4 NCDI RISK FACTORS

2.4.1 HARMFUL USE OF ALCOHOL

Global per capita consumption has continued to decline since 2015 from 8.4 litres of pure alcohol per capita (persons aged 15 years or older) to 5.5 Litres per capita in 2019. Eswatini has a per capita consumption of 8.1 Litres in 2019, a slight decrease from 9.9 in 2016 but almost twice the global capita consumption for the same period. The kingdom's alcohol consumption per capita is also quite high when compared to its peers in SADC where it is only exceeded by South Africa (8.8 litres at the end of 2019)[8].

The 2024 survey found that although the country had relatively high alcohol abstention rates (64.0%), 1 in 10 Emaswati (10.2%) engage in heavy episodic drinking with significantly higher rates of heavy episodic drinking among males (17.8%) than females (3,8%). Amongst those engaged in heavy episodic drinking, the proportion of those needing a first drink in the morning to get going after a heavy drinking session on a monthly or more frequent basis was 16.4 %[9].

Hazardous use of alcohol is a major contributor to road traffic accidents and has been linked to poor adherence to treatment of chronic disease. Driving under the influence of alcohol was responsible for 68% of the 150 fatal and serious road traffic injuries reported in 2021

5WHO (2020) World Health Organization, Global Health Observatory Data Repository
6WHO (2017, 2020, 2022) Global NCD progress monitor data reports
7WHO (2020) Global health estimates: Leading causes of DALYs

2.4.2 TOBACCO USE

With over 8 estimated million tobacco-related deaths a year globally tobacco use continues to be one of the biggest public health threats and tobacco control remains a global health priority. The 2024 STEPS survey reports the prevalence of tobacco use was11% (males 19.8% and females 2.4%. There was a recognition of the deleterious effects of tobacco use among those who smoke as over half (53.2 %) reported trying to stop smoking in the past 12 months[16].

It is estimated that more than 600 people die every year due to tobacco-related illness, accounting for nearly 6% of all deaths in the country with 66 percent of these deaths among individuals under age 70 (i.e. premature death). Nearly a quarter (24 percent) of lives lost from tobacco use are due to exposure to second-hand smoke.

The 2021 Investment Case for Tobacco Control in Eswatini noted that in 2017, tobacco use cost the Eswatini economy SZL 684 million ($45 million at the exchange rate at the time), equivalent to 1.1 percent of its GDP. These annual costs include (a) SZL 64 million in healthcare expenditures, and (b) SZL 620 million in lost productive capacities due to premature mortality and disability as well as workplace smoking breaks.

2.4.3 UNHEALTHY DIET

Unhealthy diet is a huge component of one's metabolic health and is critical in the gradual development of non-communicable diseases (NCDs) including Diabetes and Hypertension. Many Emaswati neither meet the daily required intake of fibre in fruit and vegetable, nor limit their intake in harmful substances such as salt and fats. The 2024 STEPs survey found that 8 in 10 Emaswati (84.7%) eat less than 5 servings of fruit and/or vegetables on average per day. Further, 1 in 4 EmaSwati (24.7%) always or often add salt or salty sauce to their food or as they are eating.

2.4.4 PHYSICAL INACTIVITY

A lack of physical activity plays a role in the early development of non-communicable diseases (NCDs) leading to a substantial reduction in the quality of life and life expectancy. According to the STEPs 2024, the prevalence of insufficient physical activity is 10.6% (14.1% in females and 7.0% in males). Further, 1 in 2 Emaswati (54.0%) do not engage in vigorous activity.

2.4.5 OVERWEIGHT/OBESITY

With the low levels of physical activity described above, it is not surprising to note that 26% and 33% of the population presenting at Outpatient Departments (OPDs) in 2020 and 2021 respectively were overweight and 42% and 49% presenting at OPDs in 2020 and 2021 respectively were obese[14]. The 2024 STEP surveys reported obesity prevalence rates of 24.7% (37.5%[15] among females and 12.1% among males).

Eswatini's obesity prevalence is higher than the regional average of 20.8% for women and average of 9.2% for men[16]. Overall, the obesity rates in Eswatini have been increasing steadily over the years, contributing to the burden of non-communicable diseases in the country.

8 WHO (2023) World health statistics 2023: monitoring health for the SDGs, Sustainable Development Goals

9 2024 Eswatini STEPS survey

10 Chang et al (2022) Hazardous alcohol use and HIV indicators in six African countries: results from the Population-based HIV Impact Assessments, 2015–2017. JIAS. https://doi.org/10.1002/jia2.26029

11 Eswatini National Road safety strategy 2023-2030

12 WHO (2023) Report on the global tobacco epidemic, 2023

13 UNDP Eswatini (2021) Investment Case for Tobacco Control in Eswatini: the case for scaling up WHO FTC implementation.

2.4.6 RAISED BLOOD PRESSURE

High blood pressure is one of the world's leading risk factors for death and disability. The 2023 Global Report on Hypertension notes that the number of people living with hypertension (blood pressure of ≥140 mmHg systolic or ≥90 mmHg diastolic or on medication) doubled between 1990 and 2019, from 650 million to 1.3 billion[17].

Hypertension is a problem that leads to stroke, heart attack, heart failure, kidney damage amongst other health problems and a study of 87 behavioural, environmental, occupational and metabolic risk factors found that high systolic blood pressure was the single most important risk factor for early death worldwide, leading to an estimated 10.8 million avoidable deaths every year, and a burden of 235 million years of life lost or lived with a disability (disability-adjusted life years, DALYs) annually[18].

There has been a steady increase in the number of Emaswati seen at OPDs with Hypertension from 29,139 in 2018 and almost doubling to 56,211 at the end of 2022 of whom 59% were controlled or on treatment. The 2024 STEP surveys reported that 21.7% presented with high blood pressure or were on treatment. 1 in 6 people on medication for BP had raised blood pressure indicating poor control. 4 out of 5 diagnosed with raised blood pressure during the survey were not currently on medication for raised BP. Of the 45.3% who had never taken a blood pressure measurement, 55.1% of those were men and 37% were women, indicating that many men do not visit health facilities as frequently as women do.

2.4.7 HYPERLIPIDAEMIA

From the 2024, STEPS report 98.1% of respondents had never had their cholesterol levels checked. Of the <2% screened, only 0.4% had been diagnosed with raised cholesterol in the past 12 months. Over two-thirds (72.7%) of all who had ever been diagnosed reported being on treatment for raised cholesterol. Currently there is no routine data collected specifically for hyperlipaemia.

2.5 NCDS, INJURIES AND MENTAL HEALTH BURDEN

2.5.1 CARDIOVASCULAR DISEASES

Cardiovascular diseases in Eswatini have progressively increased. Routine data shows that the commonest CVD is Congestive Cardiac failure followed by strokes, deep venous thrombosis, ischemic heart disease, and myocardial infarction.

2.5.2 HYPERGLYCAEMIA AND DIABETES

As is the case with hypertension, there has been a steady increase in the number of new cases of diabetes in Eswatini over the years. The 2024 STEP surveys reported that 3.7%(CI:3.1-4.6) of people have impaired fasting glycaemia, and this was 1.7 times higher among females than males. 1 in 2 had raised fasting blood glucose also higher among males (52.8%). Of those diagnosed with raised blood sugar 40.6% were currently taking drugs (medication) prescribed for diabetes The most common complications of diabetes in Eswatini in descending order include Diabetic retinopathy, Diabetic cataract (both of which account for 2% of all complications from Diabetes) followed by Diabetic neuropathy (0.2%) and Diabetic foot ulcers (0.02%)[20].

[14]CMIS daily morbidity data 2020 and 2021

[15]A study of obesity among women living with HIV in Eswatini 2022 (Becker et al: https://doi.org/10.1186/s12889-022-13036-9) reported obesity prevalence rates of 22.5% among them with 32.5% overweight)

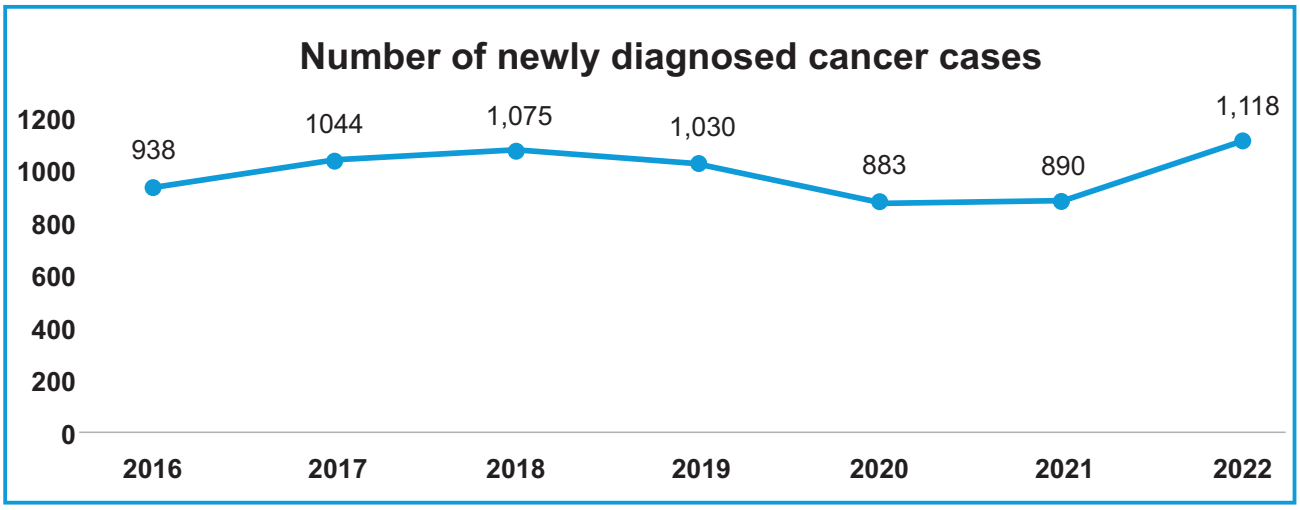
[16]2022 Global Nutrition Report
[17]https://www.who.int/publications/i/item/9789240081062 2023 WHO Global Hypertension Report

[18]GBD 2019 Risk Factors Collaborators. Global burden of 87 risk factors in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2020 Oct 17;396(10258):1223-1249. doi: 10.1016/ S0140-6736(20)30752-2.

2.5.3 CANCERS

Cancers account for 7% of all deaths in the country according to routine data.

Figure 1: Number of newly diagnosed cancer cases in Eswatini

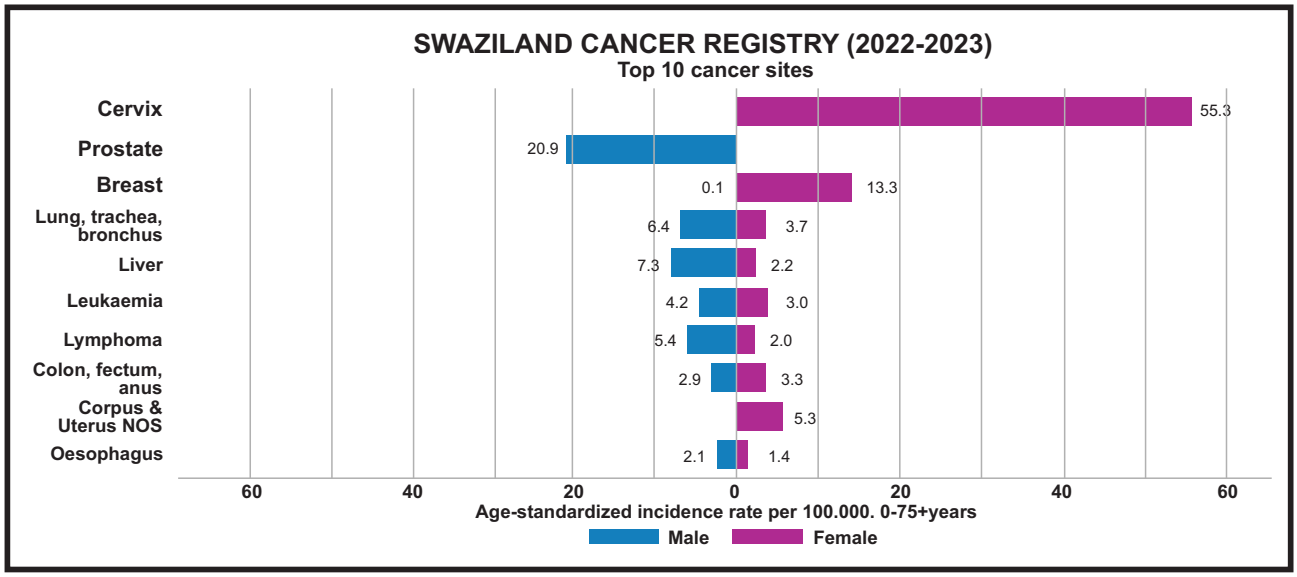


Source: Cancer registry 2016-2022

The population-based national cancer registry, reports that 6 978 cancers were diagnosed and registered between 2016 and 2022, with an average of 996 cases registered annually as shown in figure 1 above. A majority (66%) of the cancer cases diagnosed between 2016 and 2022 are among women. Routine data for cancer cases on admission shows cancers of the reproductive system as leading (top two) at inpatient, particularly cervical and prostate cancers. along with cancers of the digestive system organs. Brain cancer is also among the top ten admissions and deaths at inpatient

Routine data for cancer cases on admission shows cancers of the reproductive system as leading (top two) at inpatient, particularly cervical and prostate cancers. along with cancers of the digestive system organs. Brain cancer is also among the top ten admissions and deaths at inpatient

Figure 2: Age standardised incidence rate per 100 000



Source: Cancer registry 2022

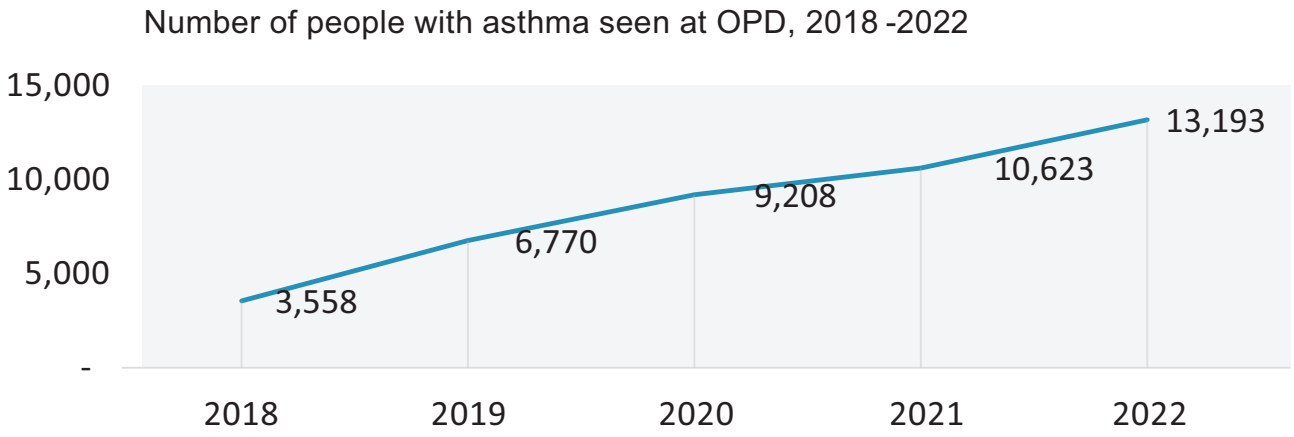
[19]CMIS daily morbidity 2018-2022
[20]CMIS daily morbidity 2021

The figure above shows the Age Standardized Incidence rate per 100 000 for the top (ten)10 cancers in Eswatini. Cervical cancer has the highest incidence at 55.3/100 000 women followed by prostate cancer at 20.9/100 000 men then breast cancer at 13.3/100 000 women. Compared to females, males have a higher lung cancer ASR at 6.4/100 000 and for liver cancer males also have a higher ASR at 7.3/100 000 compared to females.

2.5.4 CHRONIC RESPIRATORY DISEASE

Recent data on Chronic obstructive pulmonary disease (COPD) is not available. Nevertheless, previously COPD accounted for approximately 1% of NCD related admissions and 1% of NCD related deaths. Regarding Asthma, there has been a steady increase in the number of newly diagnosed cases doubling from 1,225 in 2021 to 2,463 in 2022 as reported in the CMIS daily morbidity reports. The total number of cases seen at OPDs has quadrupled from 3,558 in 2018 to 13,193 in 2022.

Figure 3: Number of people seen with asthma at OPD, 2018-2022



2.5.5 INJURIES

Injuries in Eswatini result primarily from road traffic accidents, drowning, falls, burns, poisoning and acts of violence against oneself or others, among other causes. Although there is limited data available, the data below shows that burns and physical assaults (acts of violence against oneself or others in the country) are the commonest cause of injuries. Poisoning and road traffic accidents follow closely with falls and drowning accounting for very few causes of reported injuries. Graph 5 below shows the commonest causes of violence and injuries in Eswatini in the last 5-years.

2.5.6 MENTAL HEALTH

STEPS 2024 survey reports that about 21.8% of respondents have experienced depressive symptoms in the past 12 months. Of these, only 11.8% received medication for 3 months or less. About 75.6% of the population with depressive symptoms did not receive counselling or therapy, with only 16.7% receiving counselling or therapy. Furthermore, suicidal ideation was 29.8%. MICS 2021-2022 shows that attempted suicide is 2.8% among men and 7.4% women of the reproductive age. There is inadequate routine data to quantify the burden of mental health conditions in the country.

[21] HMIS Inpatient 2016-2020

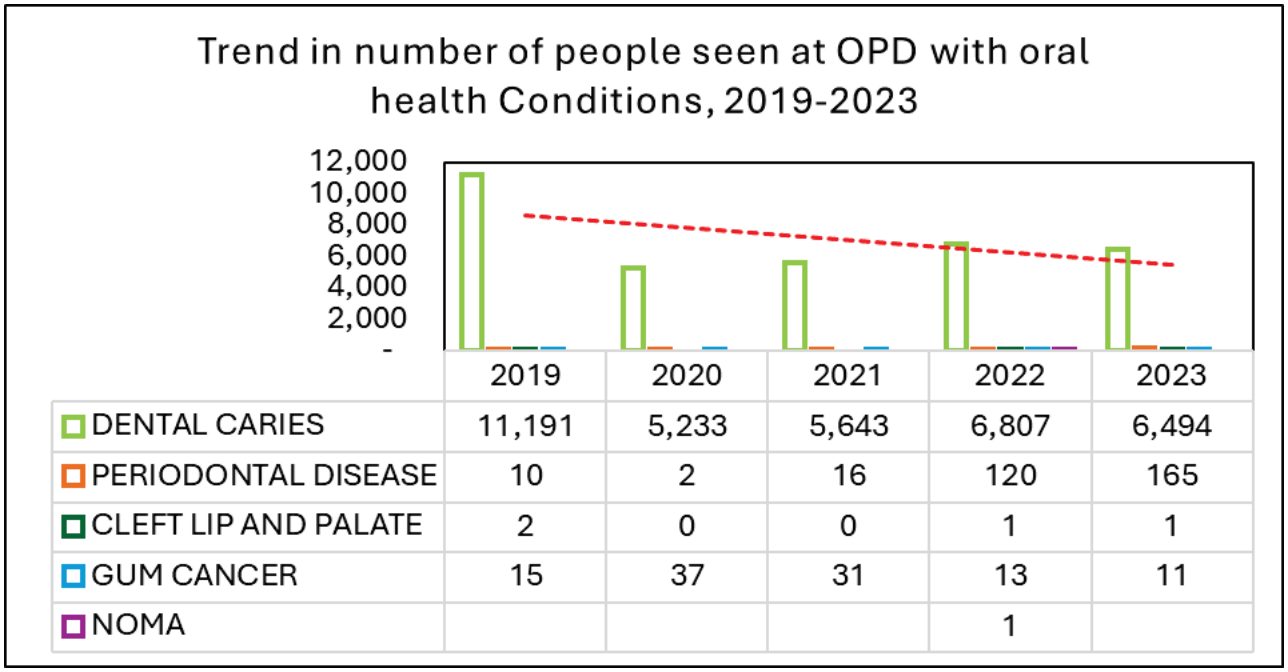
2.5.7 EYE HEALTH

The prevalence of blindness in Eswatini is around 1%, which is higher than the global average (International agency for the prevention of blindness 2022). The leading cause of eye problems is eye injuries accounting for 60% of presentations of eye conditions in the health facilities according to routine data. Cataracts, the second leading eye condition in Eswatini, are responsible for around 50% of blindness in the country. Refractive errors affect around 25% of the population. There are only around 10 ophthalmologists and 20 optometrists in Eswatini. Most eye care services are concentrated in urban areas, leaving rural populations underserved.

2.5.8 ORAL HEALTH

Eswatini has a high burden of oral diseases, with dental caries and periodontal diseases being the most common. The oral health system in Eswatini faces challenges such as limited access to oral health services, inadequate funding, and a shortage of oral health professionals.

Figure 4: Morbidity trends for Oral Health Conditions seen at OPDs, 2019-2023



	2019	2020	2021	2022	2023
DENTAL CARIES	11,191	5,233	5,643	6,807	6,494
PERIODONTAL DISEASE	10	2	16	120	165
CLEFT LIP AND PALATE	2	0	0	1	1
GUM CANCER	15	37	31	13	11
NOMA				1	

Source: CMIS daily morbidity 2023

CHAPTER 3 SWOT ANALYSIS FOR A MULTI-SECTORAL RESPONSE TO NCDs IN ESWATINI

The strenghths, weaknesses, opportunities and threats for a multisector response to NCDs, injuries and mental health are depicted in Table 2 below;

Table 2: NCD Stakeholder SWOT analysis

STRENGTHS	WEAKNESSES
• A recognised Government programme with a centre number for budget allocation • NCD training for health workers has been conducted at all levels • Decentralisation of NCDs integrated case management rolled out in line with WHO-PEN. • Availability of baseline NCD data (STEPS). • Availability of LMIS tool that allows facilities to order medicines and commodities directly from Central medical Stores (CMS) • Availability of NCD case management guidelines and protocols disseminated to all facilities and health workers trained on them • NCD indicators incorporated into Client Management Information System • Strong collaboration with palliative care service providers • Ongoing public health and community campaigns to raise awareness on NCDs endorsed, supported, and commemorated by MoH. • Existence of the Tobacco Investment case and multisectoral coordination committee. • Collaboration with other MoH programs and developmental partners • Availability of diagnostic and monitoring equipment	• Lack of clear organogram for the NCD programme at the MoH. • Unavailability of designated NCDs focal persons nationally and regionally. • Shortage of essential NCD drugs, commodities, and supplies • Poor maintenance of diagnostic equipment. • Limited operational research on NCDs. • Inadequate patient data management system. • Poor NCD surveillance system. • Lack of a robust Rehabilitation Programme. • Poor pharmacovigilance on NCDs medication • Unavailability of Food Based Dietary Guidelines • Weak engagement with recipients of care
OPPORTUNITIES	**THREATS**
• Recognition of NCDIMH as a public health priority in Eswatini. • Increasing political commitment to address NCDIMH. • Global, regional, and local push for action on NCDIMH. • Growing interest from partners, stakeholders, and donors. • Availability of lessons learnt on programming from other public health programmes like HIV and TB. • Service Integration of NCDIMH with other programmes. • Availability of a National Task Shifting framework. • Availability of multi-sectoral collaboration mechanisms for NCDIMHs.	• Uncertainty of Government funding due to fiscal crisis. • Rising cost of NCD referrals outside the country. • Weak logistics affecting the supply of NCD pharmaceuticals, laboratory commodities and medical equipment. • Weak referral and linkages for NCDs clients • Use of alternative medicine for management of NCDIMH. • Emergence of pandemics.

CHAPTER 4 ESWATINI HEALTH SECTOR RESPONSE PLAN FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES, INJURIES AND MENTAL HEALTH (NCDIMH).

4.1 VISION, MISSION & GOAL

This strategic framework builds on the previous strategy as well as the achievements and lessons learned implementing the national strategy and action plan for the prevention and control of NCDs 2021-2023 as well as global frameworks, roadmaps, and strategies. It represents a departure from the previous strategy in that it not only includes the traditional four NCDs and their modifiable risk factors but also incorporates injuries, and mental health, thus aligning with both WHO and Africa CDC agenda and strategies as recommended by WHO. It also aligns with the National Health Sector Strategic plan and thus has a five-year time frame for implementation. Costing of the Strategy will inform domestic and external resource mobilization efforts towards adequate financing for NCDIMH interventions.

Vision

A healthy and empowered population free from the avoidable burden of non-communicable diseases, injuries, and mental health disorders.

Mission

To reduce the burden of non-communicable diseases, injuries, and improve mental well-being in Eswatini through evidence-based, people-centered, and sustainable interventions and partnerships.

Goal Statement

A 30% reduction in premature mortality due to non-communicable diseases, injuries, and mental health disorders by 2028.

4.2 STRATEGIC OBJECTIVES

By 2028;

1. Raise political commitment for the prevention and control of non-communicable diseases, injuries, and mental health, and establish a national multisector coordination mechanism for NCDIMH.

2. Strengthen health system governance, leadership, coordination, and progressively increase program financing, while filling all vacant NCD program posts for an effective national response to NCDIMH, using 2024 as the baseline.

3. Reduce the prevalence of modifiable behavioral and metabolic risk factors for NCDIMH (e.g., tobacco use, harmful alcohol use, obesity, hypertension) from the 2024 baseline as measured in the STEPS survey.

4. Deliver high-quality, evidence-based, and people-centered NCDIMH services, and improve service coverage and control for NCDs, injuries, and mental health, using the 2024 baseline for comparison.

5. Establish a fully functional national monitoring and evaluation (M&E) system for NCDIMH that integrates routine data collection, enhances data use for policy and programmatic decisions, and supports at least 80% of both private and public health facilities in using timely, high-quality data to improve service delivery and outcomes.

4.3 GUIDING PRINCIPLES

PEOPLE CENTREDNESS: Placing the client at the centre of rights-based health system responses – by organizing services around their needs rather than around diseases, and by promoting integrated patient centred approaches and linkages with primary health care services.

UNIVERSAL ACCESS AND EQUITY: Policies and interventions to reduce the burden of non-communicable diseases and injuries and improve the mental wellbeing of the population should aim to reduce health inequalities and protect people in different groups and be of sufficient scale and coverage to reach all.

EVIDENCE-BASED APPROACH: Policies and interventions should be based on the best available evidence and sensitive to context in which they are being implemented.

EMPOWERING OF PEOPLE AND COMMUNITIES: Interventions should include inputs from persons and communities with lived experiences of non-communicable diseases and injuries and mental health disorders.

MULTISECTORAL ACTIONS: The development, implementation and enforcement of interventions require concerted multisectoral actions, in a coordinated and strategic manner with the engagement of the health sector and other relevant sectors.

LIFE-COURSE APPROACH: Interventions and actions should protect people at all stages of life, especially the vulnerable, including the unborn child, children, young people, and the elderly.

Table 3: Targets and Indicators

	Indicator	Data source	Baseline	Targets	
			2023/2024	Mid-term	End-term
1	Prevalence of harmful use of alcohol	STEPS	22.2%	21.09%	20.03%
2	Reduction in risk of premature mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory diseases		21%	20.5%	19.5%
3	Prevalence of insufficient physical activity	STEPS	10.6%	10.07%	9.5%
4	Inpatient mortality due to NCDs per 1000 population	NCDIMH annual report	159	151	143
5	Prevalence of current tobacco use in person aged 18+years	STEPS	11%%	10.45%	9.9%
6	Prevalence of raised blood pressure	STEPS	21.7%	20.6%	19.57%
7	Prevalence of diabetes	STEPS	3.7%	3.5%	3.5%
8	Halt the rise in obesity	STEPS	24.7%	24.7%	24.7%
9	Proportion of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	STEPS	27.6%	41.4%	62.1%
10	Availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities	HHFA	60%	70%	80%

CHAPTER 5 STRATEGIC FRAMEWORK: INTERVENTIONS, ACTIVITIES & TARGETS

To achieve the strategy objectives and targets the following intervention and activities have been prioritised for implementation

OBJECTIVE 1: BY 2028, RAISE POLITICAL COMMITMENT FOR THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES, INJURIES, AND MENTAL HEALTH, AND ESTABLISH A NATIONAL MULTISECTOR COORDINATION MECHANISM FOR NCDIMH.

Strong national leadership and political commitment are critical to the successful prevention and control of Non-Communicable Diseases, Injuries, and Mental Health (NCDIMH). Achieving this requires strategic advocacy, evidence-based policymaking, and sustained multisectoral engagement. Raising awareness among policymakers about the health, social, and economic burden of NCDIMH - as well as the cost-effectiveness of prevention interventions—will help position NCDIMH as a national public health priority. This includes integrating NCDIMH into development and poverty reduction strategies, addressing legislative and policy gaps, and creating an enabling environment for sustainable action. Through stakeholder engagement, investment cases, legislative reforms, and coordinated national strategies, Eswatini can secure the political will and resources needed to implement effective, long-term NCDIMH responses.

Interventions and activities

1. Raise political commitment, understanding, and practice about prevention and control of NCDIMH

- Advocate for the establishment of multi-sectoral committee for stakeholder engagement and to champion NCDIMH agenda.
- Host forums with policymakers to emphasize the economic and social impacts of NCDIMH.
- Produce and distribute a national investment case showcasing the cost-effectiveness of prevention strategies.

2. Integrate NCDIs and Mental Health into the social and development agenda and poverty alleviation strategies.

- Advocate for the declaration of NCDIMH as a National Public Health threat.
- Incorporate NCDIMH goals into national poverty reduction and development plans.

3. Address policy and legislative gaps

- Advocate for amendment and enforcement of regulations on alcohol.
- Lobby for approval and implementation of tobacco and tobacco products regulations
- Advocate for the enforcement of regulations addressing road safety and occupational health.
- Advocate for review of the mental health order of 1978
- Finalise Mental Health policy

4. Create an enabling environment for prevention and control of NCDs

- Develop and validate strategies to curb obesity.
- Develop public food procurement policy
- Develop and implement the health sector NCDIMH prevention acceleration plan
- Formulate NCDI and mental health stigma reduction plan
- Develop suicide prevention plan
- Develop a drowning prevention plan
- Collaborate with relevant stakeholders to review and implement policies that promote physical education across all school levels

Table 4: Targets for Objective 1

	Indicator	Data source	Targets				
			2023/ 2024	2025	2026	2027	2028
1	Endorsed and disseminated obesity acceleration roadmap	NCD annual report		1			
2	Endorsed and disseminated food procurement policy			1			

OBJECTIVE 2: BY 2028, STRENGTHEN HEALTH SYSTEM GOVERNANCE, LEADERSHIP, COORDINATION, AND PROGRESSIVELY INCREASE PROGRAM FINANCING, WHILE FILLING ALL VACANT NCD PROGRAM POSTS FOR AN EFFECTIVE NATIONAL RESPONSE TO NCDIMH, USING 2024 AS THE BASELINE.

Effective NCDIMH prevention and control in Eswatini requires strong governance, leadership, and multisectoral coordination. The programme currently faces funding, staffing, and capacity challenges. To address these, it must be fully institutionalized within the Ministry of Health with adequate resources and trained personnel. Strengthening coordination structures and mobilizing both domestic and external financing—including innovative sources like health taxes - is essential. A whole-of-government and whole-of-society approach is key to achieving sustainable impact.

Interventions and activities

1. Fully Institutionalize the NCDIMH Programme within the Ministry of Health

- Lobby for the official approval of the NCDIMH department structures and organogram.
- Advocate for adequate financial and human resources to support program implementation.
- Train NCDIMH program officers in leadership, management, and resource mobilization
- Revive national technical working groups (TWGs).

2. Mobilize Domestic and External Financing for NCDIMH

- Engage the Ministry of Health Planning Unit for funding.
- Advocate for increased taxes on alcohol, sugary beverages, and tobacco products
- Engage donors and private sector partners to mobilize external resources.

Table 5: Targets for Objective 2

	Indicator	Data source	Baseline	Targets			
			2023/2024	2025	2026	2027	2028
1	Approved NCDIMH department organogram	NCDIMH annual report			1		
2	Percentage of positions within the NCDIMH department filled in line with the organogram	NCDIMH annual report	0	4	2	2	2
3	Number of meetings held by the NCDIMH TWG	MSAP annual report	0	4	4	4	4
4	Stock out rates of NCDIMH tracer medicines at facility level	CMS reports	79%	70%	60%	40%	20%
5	Proportion of Ministry of health budget allocated to the NCDIMH centre number	Budget allocation report	E985 188/3B	E5M	E10M	E15M	E20M
	Investment case developed and disseminated	NCDIMH annual report	0	1	1	1	1

OBJECTIVE 3: BY 2028, REDUCE THE PREVALENCE OF MODIFIABLE BEHAVIORAL AND METABOLIC RISK FACTORS FOR NCDIMH (E.G., TOBACCO USE, HARMFUL ALCOHOL USE, OBESITY, HYPERTENSION) FROM THE 2024 BASELINE AS MEASURED IN THE STEPS SURVEY.

This strategic objective aims to address the challenges posed by NCD risk factors and the diseases themselves through policy and regulations. Much of the NCD risk factors will be addressed through appropriate national policies and regulatory measures. Specific policies and legislations are required to address the rising burden of NCD risk factors. This objective outlines interventions to reduce behavioural and metabolic risk factors for non-communicable diseases and mental health issues while establishing a framework to support and enhance health promotion.

Interventions and activities

1. Raise Public Awareness on modifiable and metabolic risk factors

- Review and update the evidence-based Social and Behaviour Change Communication (SBCC) framework targeting key risk factors.
- Conduct targeted campaigns on tobacco use and harmful alcohol consumption.
- Promote healthy eating and physical activity through culturally relevant campaigns.
- Engage, schools, workplaces, faith-based organizations, media, traditional and community leaders in promoting healthy behaviours.
- Conduct capacity building on air pollution and climate change

- Conduct public awareness campaigns on air pollution and climate change
- Promote vaccination for vaccine-preventable diseases in populations aged five years and above.
- Promote exclusive breastfeeding and provide support for breastfeeding mothers.

2. Enhance Screening Services

- Scale up NCDIMH screening services to reach all communities.
- Train healthcare workers to conduct screening and counselling on risk reduction.
- Integrate screening services into existing healthcare services across all levels of care.

3. Foster Community Engagement

- Sensitize NGOs and civil society on their role in prevention and control of NCDIMH
- Train community health workers (CHWs) to educate households on NCDIMH risk factors.
- Commemorate Global NCDI and mental health days.
- Provide technical support for networks for individuals at risk of or managing NCDIMHs.
- Collaborate with other programmes to develop standardized NCDIMH community feedback mechanisms

Table 6: Targets for Objective 3

	Indicator	Data source	Baseline	Targets			
			2023/2024	2025	2026	2027	2028
1	Number of media and community-based campaigns conducted	NCDIMH annual report	Schools: FBOs: Communities: Wellness Media	40 20 64 24 40	40 20 64 24 40	40 20 64 24 40	40 20 64 24 40
2	Number of global NCDIMH days commemorated	NCDIMH annual report	4	16	16	16	16
3	HPV immunisation coverage	NCD annual report	61.7%	65%	70%	75%	80%
4	Proportion of infants <6 months exclusively breastfeeding	MICS 2021-2022	54.3%	55%	60%	65%	70%
5	Number of adults 18+ screened for NCD risk (diabetes, tobacco use and Alcohol consumption)	CMIS	138 437	200 000	250 000	300 000	400 000
6	Proportion/number of adults 18+ screened for Overweight and obesity	CMIS	303 727	310 000	330 000	350 000	400 000
7	Percentage of adults 18+ screened for diabetes	CMIS	66% (3973)	66%%	70%	75%	80%
8	Percentage of adults 18+ screened for hypertension	CMS	272 258	300 000	330 000	350 000	400 000
9	Percentage of adults 18+ screened who are overweight and obese at OPD	CMS	Overweight: 28% Obese: 29%	27%	25%	20%	19.2%

OBJECTIVE 4: BY 2028, DELIVER HIGH-QUALITY, EVIDENCE-BASED, AND PEOPLE-CENTERED NCDIMH SERVICES, AND IMPROVE SERVICE COVERAGE AND CONTROL FOR NCDS, INJURIES, AND MENTAL HEALTH, USING THE 2024 BASELINE FOR COMPARISON.

Utilise evidence-based guidance and innovative service delivery methods to improve equitable access to and increase the use of a comprehensive range of high-quality non-communicable diseases and mental health services. These services should be decentralised to meet the needs of diverse populations and settings, ensuring that no one is left behind.

Interventions and activities

1. **Update and disseminate guidelines for NCDIMH**
   - Revise the national NCDIMH clinical management guidelines.
   - Disseminate the updated NCDIMH guidelines using various platforms
   - Train health care workers on updated NCDIMH guidelines.

2. **Integrate NCDIMH Services**
   - Finalise and operationalize the ICDM framework to integrate NCDIMH screening and management into existing services.
   - Launch pilot programs in selected facilities to assess integrated service models.
   - Train healthcare workers to effectively deliver integrated services
   - Scale up integrated service delivery models across the healthcare system.

3. **Decentralize NCDIMH Services**
   - Review NCDIMH decentralisation framework to incorporate mental health services
   - Scale up the decentralisation of NCDIMH services to primary healthcare centres and community levels.
   - Advocate for the availability of infrastructure, including diagnostic devices, medicines, and essential rehabilitative tools enabling the provision of NCDIM services.
   - Collaborate with community leaders and local organisations to strengthen awareness about the availability of decentralised NCDIMH services.
   - Integrate and decentralize rehabilitative and palliative care services for NCDIMH services to all levels of care as aligned with national guidelines.
   - Declassify mental health drugs to support decentralisation

4. **Capacity building for Health Workers on integrated care**
   - Scale up the WHO Package of Essential Non-Communicable Diseases Interventions (WHO-PEN), integrate the HEARTS initiative for cardiovascular health.
   - Pilot and scale up mental health gap action program (mhGAP).
   - Revise training curricula to cover the prevention and management of NCDIMHs, including modules on patient-centred care, communication, and evidence-based practices.
   - Develop training package for the prevention and management of injuries
   - Pilot the implementation of WHO PEN-Plus for managing severe chronic NCDs at designated facilities.
   - Implement mechanisms to encourage adherence to NCDIMH treatment regimens
   - Strengthen referral and linkage pathways to ensure timely access to care at all levels
   - Advocate for the recruitment of specialised NCDIMH health care workers as per national requirements.

5. Quality Improvement Systems for Improved Service Delivery

- Revise the NCDIMH supporting supervision tool
- Implement regular mentorship and supervision to enhance the quality of services and data collection
- Collaborate with relevant programs to develop and implement national quality improvement systems to monitor the delivery of NCDIMH services.
- Collaborate with relevant programs to revise patient satisfaction surveys to assess and address gaps in the quality of NCDIMH service delivery.

Table 7: Targets for Objective 4

	Indicator	Data source	Baseline	Targets			
			2023/2024	2025	2026	2027	2028
1	Proportion of facilities with updated NCDIMH guidelines	SARA/Facility assessment	0	70%	80%	90%	100%
2	Hypertension incidence rate per 100 000	CMIS	1201		1140		1083
3	Diabetes incidence rate per 100 000	CMIS	421		390		379
4	Number of people newly diagnosed with hypertension	CMIS	7 837	7 000	6 500	6 000	5 250
5	Number of people newly diagnosed with diabetes	CMIS	2 747	2747	2747	2747	2747
6	Number of people newly diagnosed with asthma	CMIS	2 639				
7	Proportion of NCD patients screened for HIV, TB	CMIS	HIV: 0 TB: 0	50%	70%	80%	100%
8	Percentage of newly diagnosed hypertension patients initiated on treatment	CMIS	78%	80%	80%	80%	80%
9	Percentage of newly diagnosed diabetes patients initiated on treatment	CMIS	77%	80%	80%	80%	80%
10	Percentage of newly diagnosed asthma patients initiated on treatment	CMIS	14.5%	80%	80%	80%	80%
11	Number of health facilities implementing ICDM	Facility assessment	0	8	10	30	40
12	Percentage of facilities receiving supportive supervision	Supportive supervision report	26	288	288	288	288
13	Blood pressure control among people with hypertension	CMIS	Hypertension only: 71% HTN&DM 39%	80%	80%	80%	80%
14	Glycaemic control among people with diabetes	CMIS	39%	80%	80%	80%	80%
15	Percentage of hypertension patients living with HIV and are on ART	CMIS	28%	28%	27%	26.5%	26%
16	Percentage of diabetes patients living with HIV and are on ART	CMIS	27%	28%	27%	26.5%	26%
	Percentage of diabetes patients living with active TB Disease	CMIS	0%				
17	Proportion of NCD clients screened for complications	CMIS	0	50%	70%	90%	100%

	Indicator	Data source	Baseline	Targets			
			2023/2024	2025	2026	2027	2028
18	Inpatient mortality rate per 1000	HMIS_Inpatient	Hypertension =39/1000 Diabetes mellitus =57/1000 Cancer =60/1000 Asthma =3/1000				26/1000 38/1000 40/1000 2/1000
19	Proportion of people screened for suicide ideation/thoughts at OPD	CMIS	0	50%	100%	100%	100%
20	Proportion of people screened for Suicide attempt at OPD						
21	Burden of mental health at OPD: Depression, Anxiety, Substance use disorder, Suicide			5% reduction of morbidity baseline	5% reduction	5% reduction	5% reduction
22	Burden of oral health conditions at OPD: Dental Caries Periodontal disease Cleft and lip palate Gum cancer Noma	CMS	N/A	5% reduction of morbidity baseline	5% reduction	5% reduction	5% reduction
23	Burden of neurological conditions at OPD Epilepsy, Dementia, Autism) conditions seen at OPD	CMS	N/A	5% reduction of morbidity from baseline	5% reduction	5% reduction	5% reduction
24	Number of trainings conducted for HCW on NCDIMH	NCDIMH annual report		16	16	16	16
25	Number of HCWs trained on NCDIMH at all levels	NCDIMH annual report	Nurses: 560 Doctors:160 CHWs:1088	560 160 1088	560 160 1088	560 160 1088	560 160 1088

OBJECTIVE 5: BY 2028, ESTABLISH A FULLY FUNCTIONAL NATIONAL MONITORING AND EVALUATION (M&E) SYSTEM FOR NCDIMH THAT INTEGRATES ROUTINE DATA COLLECTION, ENHANCES DATA USE FOR POLICY AND PROGRAMMATIC DECISIONS, AND SUPPORTS AT LEAST 80% OF BOTH PRIVATE AND PUBLIC HEALTH FACILITIES IN USING TIMELY, HIGH-QUALITY DATA TO IMPROVE SERVICE DELIVERY AND OUTCOMES.

This strategic objective calls for strengthening the MOH capacity to generate, manage, and utilize high-quality, timely data. This includes developing robust monitoring and evaluation systems, expanding surveillance and research, integrating data into policy and practice, and ensuring effective dissemination of findings to drive evidence-based actions across all levels of the health system for the prevention and control of NCDs, injuries, and mental health conditions.

Interventions and activities

1. Develop and align Monitoring and Evaluation Frameworks for NCDIMH interventions.

- Design a national M&E framework and action plan to track interventions effectively.
- Conduct periodic reviews of the NCDIMH strategic plan
- Advocate for continuous integration of NCDIMH monitoring into national data collection systems to enable routine programme performance tracking.

2. Enhance data use and policy integration.

- Develop and disseminate dashboards, policy briefs, and visual analytics to build a culture of data demand and use among policymakers and implementers.
- Produce and disseminate high quality programme performance reports with actionable insights for stakeholders.
- Conduct regular data quality audits and provide actionable feedback to healthcare providers.
- Conduct evaluation to assess the impact of decentralisation on service delivery and patient outcomes.

3. Expand surveillance and research capabilities.

- Develop registries to track the prevalence, incidence, and outcomes of NCDIMH
- Partner with academic institutions and organisations to conduct research aligned with national priorities.
- Conduct standardised NCDIMH surveys.
- Outline NCDIMH research priorities in line with the National Health Research Agenda.

4. Disseminate research and drive innovation.

- Capacitate NCDIMH staff in operational research skills
- Share research in peer-reviewed journals and present findings at conferences.
- Conduct workshops and discussions to ensure findings inform policies and interventions.
- Provide public access to up-to-date NCDIMH information to foster transparency and stakeholder engagement.

Table 8: Targets for Objective 5

	Indicator	Data source	Baseline	Targets			
			2023/2024	2025	2026	2027	2028
1	Endorsed 2024-2028 NCDIMH operational plan	NCDIMH annual report	Hypertension =39/1000		1		
2	Number of data reviews conducted	NCDMIH annual report	N/A	2	2	2	2
3	Number of information products disseminated	NCDIMH annual report	Annual Report Quarterly report	1 4	1 4	1 4	1 4
4	Number of data quality audits conducted	NCDIMH annual report		2	2	2	2
5	Number of implementation research studies conducted	NCDIMH annual report	2	3	3	3	3

CHAPTER 6 IMPLEMENTATION PLAN.

Below is the detailed implementation plan for the period 2024-2028.

Table9: Implementation plan

OBJECTIVE 1	By 2028, raise political commitment for the prevention and control of non-communicable diseases, injuries, and mental health, and establish a national multisector coordination mechanism for NCDIMH.							
INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
1.1 Raise political commitment, understanding, and practice about prevention and control of NCDIs and Mental Health	1.1.1Advocate for the establishment of multi-sectoral committee for stakeholder engagement and to champion NCDIMH agenda.	Program Manager		X	X	X	X	Availability of multisectoral committee
	1.1.2 Host forums with policymakers to emphasize the economic and social impacts of NCDIMH	Program manger			X	X	X	Meetings held with policymakers
	1.1.3 Produce and distribute a national investment case showcasing the cost-efectiveness of prevention strategies	Program manager, M&E, EDCU		X	X	X	X	Disseminated NCDIMH investment case
1.2 Integrate NCDIs and Mental Health into the social and development agenda and poverty alleviation strategies.	1.2.1 Advocate for the declaration of NCDIMH as a National Public Health Threat.	NCDIMH Program Director's office		X	X	X	X	NCDIMH declared as a National Public Health Threat
	1.2.2 Incorporate NCDIMH goals into national poverty reduction and development plans.	Program manager		X	X	X	X	NCDIMH integrated into the national poverty reduction and development plans
1.3 Address policy and legislative gaps	1.3.1 Advocate for amendment and enforcement of regulations on alcohol	NCDIMH program manager		X	X	X	X	Availability of amended alcohol regulation
	1.3.2 Lobby for approval and implementation of tobacco and tobacco products regulations	NCDIMH program manager	X	X	X	X	X	Existence of regulations
	1.3.3 Advocate for the enforcement of regulations addressing road safety and occupational health.	NCDIMH program manager	X	X	X	X	X	Advocacy meetings held
	1.3.4 Advocate for review of the mental health order of 1978	NCDIMH PROGRAM	X	X	X	X	X	Reviewed Mental Health Act

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	1.3.5 Finalize Mental health policy	NCDIMH PROGRAM			X			Finalised Mental Health policy
1.4 Create an enabling environment for prevention and control of NCDs	1.4.1 Develop and validate strategies to curb obesity	Paediatric NCDIMH focal person	X	X	X	X	X	Disseminated obesity roadmap
	1.4.2 Develop public food procurement policy	Nutrition Council		X				Public Food procurement policy developed
	1.4.3 Develop and implement the health sector NCDIMH prevention acceleration plan			X				Existence of prevention acceleration plan
	1.4.4. Formulate NCDI and mental health stigma reduction plan				X			Stigma reduction plan developed
	1.4.5 Develop suicide prevention plan			X				Suicide prevention plan developed
	1.4.6 Develop a drowning prevention plan			X				Drowning prevention plan developed
	1.4.6 Collaborate with relevant stakeholders to review and implement policies that promote physical education across all school levels.		X	X	X	X	X	Meetings held
OBJECTIVE 2	By 2028, strengthen health system governance, leadership, coordination, and progressively increase program financing, while filling all vacant NCD program posts for an effective national response to NCDIMH, using 2024 as the baseline.							
2.1 Fully Institutionalize the NCDIMH programme within the Ministry of Health	2.1.1 Lobby for the official approval of the NCDIMH department structures and organogram	NCDIMH Program manager	X	X	X	X	X	Existence of approved NCDIMH organogram Availability of NCD program offices
	2.1.2 Advocate for adequate financial and human resources to support programme implementation	NCDIMH Program manager	X	X	X	X	X	Availability of personnel in the NCDIMH in line with the organogram (Number, Cadre)Increased government budget allocated for the prevention and control of NCDIMH

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	2.1.3 Train NCDIMH program officers in leadership, management, and resource mobilization	NCDIMH Program manager	x	x	x	x	x	Officers trained
	2.1.4 Revive national technical working groups (TWGs).	NCDIMH Program manager	x	x	x	x	x	TWG meetings held
2.2 Mobilize Domestic and External Financing for NCDIMH	2.2.1 Engage the Ministry of Health Planning Unit for funding.	NCDIMH	x	x	x	x	x	Advocacy meetings
	2.2.2 Advocate for increased taxes on alcohol, sugary beverages, and tobacco products	MoH NCDIMH	x	x	x	x	x	Increased taxes on alcohol, sugary beverages, and tobacco products
	2.2.3 Engage donors and private sector partners to mobilise external resources	NCDIMH						Availability of funds/financial support from external sources
OBJECTIVE 3	By 2028, reduce the prevalence of modifiable behavioral and metabolic risk factors for NCDIMH (e.g., tobacco use, harmful alcohol use, obesity, hypertension) from the 2024 baseline as measured in the STEPS survey.							
3.1 Raise Public Awareness of modifiable and metabolic risk factors	3.1.1 Review and update evidence-based Social and Behaviour Change Communication (SBCC) framework targeting key risk factors.	NCDIMH prevention Officer		x				Reviewed SBCC framework
	3.1.4 Conduct targeted campaigns on tobacco use and harmful alcohol consumption.	NCDIMH prevention Officer	x	x	x	x	x	Campaigns conducted
	3.1.5 Promote healthy eating and physical activity through culturally relevant campaigns.	NCDIMH prevention Officer	x	x	x	x	x	Number of media and community-based campaigns conducted.
	3.1.6 Engage schools, workplaces, media, faith-based organisations, traditional and community leaders in promoting healthy behaviours.	NCDIMH prevention Officer	x	x	x	x	x	Number of schools, workplaces, media, faith-based organisations, traditional and community leaders engaged
	3.1.7 Conduct capacity building on air pollution and climate change	NCDIMH programme manager		x	x	x	x	Trainings conducted

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	3.1.8 Conduct awareness campaigns on air pollution and climate change	NCDIMH prevention Officer		x	x	x	x	Number of media and community-based campaigns on air pollution conducted.
3.2 Enhance Screening Services	3.2.1 Scale up NCDIMH screening services to reach all communities.	Prevention officer	x	x	x	x	x	Number of people screened for NCDIMH
	3.2.2 Train healthcare workers to conduct screening and counselling on risk reduction.	NCDIMH	x	x	x	x	x	Advocacy meetings
	3.2.2 Train healthcare workers to conduct screening and counselling on risk reduction.	NCDIMH Prevention officer		x	x	x	x	Number of healthcare workers trained Number of trainings conducted
	3.2.3 Integrate screening services into existing healthcare services across all levels of care.	NCDIMH Prevention officer	x	x	x	x	x	Number of health facilities integrating screening services
3.3 Promote Public Adoption of Preventive Practices	3.3.1 Promote vaccination for vaccine-preventable diseases in populations aged five years and above.consumption.	NCDIMH prevention Officer	x	x	x	x	x	HPV immunization coverage Number of Vaccination campaigns conducted
	3.3.2 Promote exclusive breastfeeding and provide support for breastfeeding mothers.	NCDIMH Prevention officer	x	x	x	x	x	Number of media and community-based campaigns conducted.
	3.1.6 Engage schools, workplaces, media, faith-based organisations, traditional and community leaders in promoting healthy behaviours.	NCDIMH prevention Officer	x	x	x	x	x	Percentage of infants >=6 months who are exclusively breastfeeding Number of breastfeeding campaigns conducted
3.4 Foster Community Engagement	3.4.1 Sensitize NGOs and civil society on their role in prevention and control of NCDIMH.	NCDIMH Prevention officer		x	x	x	x	Meetings with CSOs held

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	3.4.2 Train community health workers (CHWs) to educate households on NCDIMH risk factors.	NCDIMH prevention Officer	x	x	x	x	x	Number of community health workers trained Trainings conducted for CHW
	3.4.3 Commemorate Global NCDI and Mental Health days.	NCDIMH Prevention offier	x	x	x	x	x	Global NCDIMH days commemorated
	3.4.4 Provide technical support for networks for individuals at risk of or managing NCDIMH.	NCDIMH Programme	x	x	x	x	x	Technical support sessions conducted
	3.4.5 Collaborate with other programmes to develop standardized NCDIMH community feedback mechanisms	NCDIMH Programme		x	x	x	x	Collaboration meetings held
OBJECTIVE 4:	By 2028, deliver high-quality, evidence-based, and people-centered NCDIMH services, and improve service coverage and control for NCDs, injuries, and mental health, using the 2024 baseline for comparison.							
4.1 Update and disseminate guidelines for NCDIMH	4.1.1 Revise the national NCDIMH clinical management guidelines.	NCDIMH Case management focal person	x	x	x			Existence of finalized and formatted guidelines
	4.1.2 Disseminate the updated NCDIMH guidelines using various platforms	NCDIMH Case manageme nt focal person		x	x	x	x	Percentage of facilities with updated NCDIMH guidelines and standards
	4.1.3 Train healthcare workers on updated NCDIMH guidelines.	NCDIMH Case management focal person		x	x	x	x	Number of trainings conducted Number of healthcare workers trained
4.2 Integrate NCDIMH Services	4.2.1 Finalise and operationalize the ICDM framework to integrate NCDIMH screening and management into existing services	NCDIMH Case management focal person		x				Availability of the finalised ICDM framework
	4.2.2 Launch pilot programs in selected facilities to assess integrated service models.	NCDIMH Case management focal person		x				Number of facilities launched ICDM model Availability of Pilot report
	4.2.3 Train healthcare workers to effectively deliver integrated services	NCDIMH Case management focal person		x	x	x	x	Number of Health workers trained on ICDM Number of ICDM trainings conducted

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	4.2.4 Scale up integrated service delivery models across the healthcare system.	NCDIMH Case management focal person			x	x	x	Number of health facilities integrating service delivery
4.3 Decentralize NCDIMH Services	4.3.1 Conduct baseline assessment on mental health services	NCDIMH decentralisation officer		x	x	x	x	Decentralisation framework incorporating mental health
	4.3.2 Review NCDI and mental health decentralisation framework to incorporate mental health services			x	x	x	x	
	4.3.3 Review mental health desk guide to incorporate mhGAp			x				Mental Health desk guide reviewed
	4.3.4 Scale up decentralization of NCDIMH services to primary healthcare centres and community levels.	NCDIMH decentralisation officer	x	x	x	x	x	Primary healthcare facilities providing full package of NCDIMH services
	4.3.5 Pilot and scale up mental health gap action program (mhGAP).	NCDIMH Mental Health focal persons	x	x	x	x	x	Health facilities providing mhGAP packages to clients
	4.3.6 Advocate for the availability of infrastructure, including diagnostic devices, medicines, and essential rehabilitative tools enabling the provision of NCDIMH services	NCDIMH Programme manager	x	x	x	x	x	Facility assessment report Availability of infrastructure for service provision in facilities
	4.3.7 Collaborate with community leaders and local organisations to strengthen awareness about the availability of decentralised NCDIMH services.	NCDIMH prevention focal person	x	x	x	x	x	Communities sensitized on decentralization
	4.3.8 Integrate and decentralize rehabilitative and palliative care services for NCDIMH to all levels of care as aligned with national guidelines.	NCDIMH Programme manager	x	x	x	x	x	Health facilities providing integrated rehabilitative and palliative care services for NCDIMH
	4.3.9h Declassify mental health drugs to support decentralisation	NCDIMH Mental Health focal person	x	x	x	x	x	Mental Health LMIS tool Primary Health facilities able to order form mental health drugs

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	4.4.2 Revise training curricula to cover the prevention and management of NCDIMH including modules on patient-centered care, communication, and evidence-based practices.	NCDIMH Programme case management focal person			x	x	x	Availability of the revised NCDIMH training curricula
	4.4.3 Develop a training package for the prevention and management of injuries	NCDIMH Programme		x	x	x	x	Availability of training package for the prevention and management of injuries
	4.4.4 Pilot the implementation of WHO PEN-Plus for managing severe chronic NCDs at designated facilities.	NCDIMH Programme		x	x			Number of facilities implementing WHO PEN-plus
	4.4.5 Implement mechanisms to encourage adherence to NCDIMH treatment regimens	NCDIMH Programme	x	x	x	x	x	Percentage of NCDIMH clients on treatment achieving disease control
	4.4.6 Strengthen referral and linkage pathways to ensure timely access to care at all levels	NCDIMH Programme		x	x	x	x	Availability of NCDIMH referral and linkage pathways SOPs
	4.4.7 Advocate for the recruitment of specialised NCDIMH health care workers as per national requirements.	NNCDIMH Programme	x	x	x	x	x	Availability of specialized healthcare workers posts created and filled
4.5 Quality Improvement Systems for Improved Service Delivery	4.5.1 Revise the NCDIMH supportive supervision tool	NCDIMH Programme	x	x	x	x	x	NCDIMH supportive supervision tool revised
	4.5.2 Implement regular mentorship and supervision to enhance the quality of services and data collection	NCDIMH Programme	x	x	x	x	x	Mentorship and supportive supervision visits conducted
	4.5.3 Collaborate with relevant programs to develop and implement national quality improvement systems to monitor the delivery of NCDIMH services.	NCDIMH Programme	x	x	x	x	x	Health facilities developing and implementing quality improvement projects on NCDIMH services

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	4.5.4 Collaborate with relevant programs to revise patient satisfaction surveys to assess and address gaps in the quality of NCDIMH service delivery.	NCDIMH Programme person		x	x	x	x	Availability of NCDIMH patient satisfaction survey
OBJECTIVE 5:	By 2028, establish a fully functional national monitoring and evaluation (M&E) system for NCDIMH that integrates routine data collection, enhances data use for policy and programmatic decisions, and supports at least 80% of both private and public health facilities in using timely, high-quality data to improve service delivery and outcomes. The strategy defines clear targets for each strategic objective to guide implementation and measure progress.							
5.1.1 Develop and align Monitoring and Evaluation Frameworks for NCDIMH interventions.	5.1.1. Design a national M&E framework and action plan to track interventions effectively.	NCDIMH Programme M&E		x				M&E Framework embedded in response plan
	5.1.2 Conduct periodic reviews of the NCDIMH strategic plan	NCDIMH Programme M&E	x	x	x	x	x	Data reviews conducted
	5.1.3 Advocate for continuous integration of NCDIMH monitoring into national data collection systems to enable routine programme performance tracking.	NCDIMH Program		x				Additional components incorporated into CMIS (eg Mental Health, Injuries, asthma , foot and eye screening etc)
5.2 Enhance data use and policy integration.	5.2.1. Develop and disseminate dashboards, policy briefs, and visual analytics to build a culture of data demand and use among policymakers and implementers.	NCDIMH Program	x	x	x	x	x	Dashboards developed and disseminated
	5.2.3 Conduct regular data quality audits and provide actionable feedback to healthcare providers.	NCDIMH Programme	x	x	x	x	x	Data quality audits reports
	5.2.4 Conduct evaluation to assess the impact of decentralisation on service delivery and patient outcomes.	NCDIMH Programme	x	x	x	x	x	Evaluation report
5.3 Expand surveillance and research capabilities.	5.3.1 Develop registries to track the prevalence, incidence, and outcomes of NCDIMH	M&E		x				Injuries, diabetes and CKD registries developed

INTERVENTION	ACTIVITY	RESPONSIBLE PERSON	TIMELINE					MEASUREMENT
			2024	2025	2026	2027	2028	
	5.3.2 Partner with academic institutions and organisations to conduct research aligned with national priorities.	M&E	x	x	x	x	x	Research studies conducted
	5.3.3 Conduct standardised NCDIMH surveys.		x	x	x	x	x	STEPS survey conducted
	5.3.4 Outline NCDIMH research priorities in line with the National Health Research Agenda.			x				NCDIMH research priorities incorporated in research agenda
5.4 Disseminate research and drive innovation.	5.4.1 Capacitate NCDIMH staff in operational research skills	NHRD		x		x		NCDIMH staff trained
	5.4.2 Share research in peer-reviewed journals and present findings at conferences.	NHRID	x	x	x	x	x	Journals publishing NCDIMH research findings
	5.4.3 Conduct Workshops and discussions to ensure findings inform policies and interventions.	NHRID	x	x	x	x	x	Meetings held with policymakers
	5.4 4 Provide public access to up-to-date NCDIMH information to foster transparency and stakeholder engagement.	NHRID	x	x	x	x	x	Easy Access to research data to the public (Portal developed and disseminated)

CHAPTER 7 MONITORING AND EVALUATION FRAMEWORK

This Monitoring and Evaluation (M&E) Framework outlines a systematic approach to track and assess the implementation and effectiveness of the Health Sector Response Plan. It integrates priority impact, outcome, output, and process indicators to comprehensively monitor progress across all levels of the results chain. Routine monitoring will be conducted monthly, quarterly, and annually, depending on data availability, to evaluate performance against established targets. In addition, midterm and end-term strategy evaluations will be carried out to assess broader program performance towards achieving the set goals. The evidence generated through M&E activities will be essential for informed decision-making, continuous improvement, accountability, and organizational learning throughout the implementation period.

Table 10: List of Indicators

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILITY	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
IMPACT INDICATOR						
Premature mortality from NCDs (CVD, cancer, DM, COPD)	**NUMERATOR:** Total deaths from NCD causes between exact age X and exact age X +5 **DENOMINATOR:** Total Population between exact age X and exact age X +5	**Sex** **Age group**	Global health estimates	NCDIMH program	Every 5 years	Annual report STEPS report
OUTCOME						
Inpatient mortality due to NCDs per 1000 population	**NUMERATOR:** Total deaths from NCDs (hypertension, diabetes, cancer, COPD) at inpatient **DENOMINATOR:** Total Number of inpatient deaths X1000	**Sex** **Age group** **Condition**	HMIS INPATIENT	NCDIMH program	Annually	Annual report
Age standardized prevalence of heavy episodic drinking	**NUMERATOR:** Number of survey respondents reporting consuming 60 grams or more of pure alcohol on at least one occasion monthly **DENOMINATOR:** Number of survey respondents	**Age** **Sex**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report

OUTCOME						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPONSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Age-standardized prevalence of insufficiently physically active persons aged 18+ years	**NUMERATOR:** Age-standardized prevalence of current tobacco use among persons aged 18+ years **DENOMINATOR**: Number of current tobacco users aged 18+ years. “Current users” includes both daily and non-daily users or smoked or smokeless tobacco.	**Age** **Sex**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report
Prevalence of raised blood pressure	**NUMERATOR:** Number of respondents with systolic blood pressure ≥140mmHg or diastolic blood pressure ≥90mmHg. Ideally three blood pressure measurements should be taken and the average systolic and diastolic readings of the second and third measures should be used in this calculation. **DENOMINATOR:** All respondents of the survey aged 18+ years.	**Age** **Sex**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report
Prevalence of overweight and obesity in adults 18+ years	**NUMERATOR:** Number of respondents aged 18+ years with fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose **DENOMINATOR:** All respondents of the survey aged 18+ years.	**Age** **Sex**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report
Prevalence of overweight and obesity in adults 18+ years	**NUMERATOR:** Number of respondents aged 18+ years who are overweight. Number of respondents aged 18+ years who are obese. **DENOMINATOR:** All respondents of the survey aged 18+ years	**Age** **Sex**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report

OUTCOME						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPOMSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Proportion of eligible people receiving drug therapy and counselling (including glycemic control) to prevent heart attacks and strokes	**NUMERATOR: NUMERATOR:** Proportion of eligible people (defined as aged 40 years and older with a 10-year cardiovascular risk _30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycemic control) to prevent heart attacks and strokes **DENOMINATOR:** All patients eligible	**Sex** **Age**	STEPS SURVEY	NCDIMH program	Every 5 years	Annual report STEPS report
Availability of affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities	**NUMERATOR:** Number of facilities that have available during assessment the minimum list of essential medicines and basic technologies. The minimum list is Medicines - at least aspirin, a statin, angiotensin converting enzyme inhibitor, thiazide diuretic, a long-acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant. Technologies - at least a blood pressure measurement device, a weighing scale, height measuring equipment, blood sugar and blood cholesterol measurement devices with strips and urine strips for albumin assay. **DENOMINATOR:** Number of surveyed facilities	**Facility Type**	HHFA report	NCDIMH program	Every 2 years	Annual report HHFA report

INPUT						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPOMSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Stock out rates of NCDIMH tracer medicines at facility level	**NUMERATOR:** Number of facilities reporting stock out of at least one NCD tracer element **X100** **DENOMINATOR:** Total number of facilities assessed	**Facility Type** **Region**	NCDIMH annual report	M&E_CMS	Annually	Annual report
OUTCOME						
HPV immunization coverage	**NUMERATOR:** Number of children 9-14 years vaccinated with HPV **X100** **DENOMINATOR:** Total population of children 9-14 years	Age group Sex Region	CMIS MICS	NCDIMH program EPI Program	Annually	Annual report
Proportion of infants <6 months exclusively breastfeeding	**NUMERATOR:** Number of infants exclusively breastfed for the first 6 months of life **X 100** **DENOMINATOR:** Total population of infants <5 months	Age group Sex Region	CMIS MICS	NCDIMH program SRH Program	Annually	Annual report
OUTPUT						
Number/Percentage of adults 18+years screened for NCD risk (diabetes, tobacco use and Alcohol consumption) at OPD	**NUMERATOR:** Number of people visiting the facility screened for NCD risk factors **DENOMINATOR:** Total number of people eligible for screening	Age group Sex Region	CMIS	NCDIMH program	Annually	Annual report
Number of adults 18+ years screened for Overweight and obesity at OPD	**NUMERATOR:** Number of people visiting the facility screened with a documented height and weight **DENOMINATOR:** Total number of people eligible for screening	Region Age group Sex	CMIS	NCDIMH program	Quarterly	Annual report

OUTPUT						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPONSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Number of adults 18+years screened for diabetes at OPD	**NUMERATOR:** Number of adults with a higher risk (with a score of >5 or 16-20) of diabetes with a random blood glucose measurement documented **DENOMINATOR:** Total number of people at risk for diabetes	Region Age group Sex	CMIS	NCDIMH program	Annually	Annual report
Number of adults 18+ years screened for hypertension at OPD	**NUMERATOR:** Number of adults with a blood pressure measurement (excluding those already diagnosed with hypertension) **DENOMINATOR:** Total number of eligible for hypertension screening	Region Age group Sex	CMIS	NCDIMH program	Annually	Annual report
Percentage of adults 18+ years screened at OPD who are overweight and obese	**NUMERATOR:** Number of adults with BMI of 25-29.9 kg/m2 (overweight) and >30kg/m2 (Obese) **DENOMINATOR:** All adults with documented height and weight	Age group Sex Region	CMIS	NCDIMH program	Annually	Annual report
Percentage of people newly diagnosed with raised blood pressure / hypertension	**NUMERATOR:** All adults diagnosed with diabetes for the first time on screening: BP of >=140/90 mmHg or have an ICD hypertension diagnosis **DENOMINATOR:** All adults screened for hypertension	Region Age group Sex	CMIS	NCDIMH program	Annually	Annual report

OUTPUT						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPONSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Percentage of people newly diagnosed with raised blood pressure / hypertension	**NUMERATOR:** All adults diagnosed with diabetes for the first time on screening: BP of >=140/90 mmHg or have an ICD hypertension diagnosis **DENOMINATOR:** All adults screened for hypertension	Region Age group Sex	CMIS	NCDIMH program	Annually	Annual report
Percentage of adults newly diagnosed with raised blood glucose or diabetes	**NUMERATOR:** All adults diagnosed with diabetes for the first time on screening: RBG of >=18 mmol/L or FBG of >=7mmol/L and have an ICD diabetes diagnosis **DENOMINATOR:** Number of adults screened for hypertension **DENOMINATOR:** Total number of eligible for hypertension screening	Region Age group Sex	CMIS	NCDIMH program	Annually	Annual report
Proportion of adults newly diagnosed with asthma	**NUMERATOR:** Number of people newly diagnosed with asthma who reported asthma related symptoms and were tested for asthma using peak flow measurement as a confirmatory test in the reporting period **DENOMINATOR:** Total number of people newly diagnosed with asthma in the reporting period	Age group Sex Region	CMIS	NCDIMH program	Annually	Annual report

INPUT						
INDICATOR	**DEFINITION**	**DIS-AGGREGATION**	**DATA COLLECTION METHOD**	**RESPOMSIBILIT**	**FREQUENCY/ TIMELINE**	**REPORTING/ DISSEMINATION**
Proportion of health facilities with updated NCDIMH guidelines	**NUMERATOR:** Number of facilities that have received updated NCDIMH guidelines **DENOMINATOR:** Total number of facilities eligible to provide NCDIMH services	Age group Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTPUT						
Hypertension incidence rate per 100 000 population	**NUMERATOR:** Number of adults newly diagnosed with hypertension at OPD X 100 000 **DENOMINATOR:** Number of adults at risk for hypertension	Age group Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
Diabetes incidence rate per 100 000 population	**NUMERATOR:** Number of adults newly diagnosed with diabetes at OPD X 100 000 **DENOMINATOR:** Number of adults at risk for hypertension	Age group Sex Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
Proportion of NCD patients screened for HIV, TB	**NUMERATOR:** Number of people with NCDs screened for HIV Number of people with NCDs screened for Diabetes **DENOMINATOR:** Total number of all NCD clients	Condition Age group Sex Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
PROCESS						
Percentage of facilities receiving supportive supervision	**NUMERATOR:** Number of facilities visited for supportive supervision **DENOMINATOR:** Number of facilities targeted for supportive supervision **X 100**	Facility Type Sex Region	CMIS	NCDIMH programNCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
OUTCOME						
Percentage of people newly diagnosed with diabetes initiated on treatment	**NUMERATOR:** All adults diagnosed with diabetes initiated on hypoglycemic agent **DENOMINATOR:** All adults diagnosed with diabetes for the first time	Age group Sex Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
Percentage of people newly diagnosed with hypertension initiated on treatment	**NUMERATOR:** Number of people with asthma registered who are initiated on long-term treatment in the reporting period **DENOMINATOR:** All adults diagnosed with asthma for the first time	Age group Sex Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
Percentage of people newly diagnosed with asthma initiated on treatment	**NUMERATOR:** All adults diagnosed with hypertension initiated on antihypertensive agent **DENOMINATOR:** All adults diagnosed with hypertension for the first time	Age group Sex Region	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTPUT						
Percentage of NCD patients living with HIV and are on ART	**NUMERATOR:** Number of NCD patients living with HIV and are on ART **DENOMINATOR:** Total number of NCD patients	Region Type of facility	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTPUT						
Proportion of NCDIMH clients living with active TB disease	**NUMERATOR:** Number of NCD clients living with active TB disease **DENOMINATOR:** Total number of NCD clients	Condition Sex Age group Region	CMIS	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
Proportion of people screened for suicide ideation/thoughts at OPD	**NUMERATOR:** Number of people screened for suicide ideation **DENOMINATOR:** Total number of people seen at OPD	Region Sex Age group Condition	CMIS	NCDIMH program	Quarterly Annually	Annual report
Proportion of people screened for Suicide attempt at OPD	**NUMERATOR:** Number of people screened for suicide attempt **DENOMINATOR:** Total number of people seen at OPD	Region Sex Age group Type of service	CMIS	NCDIMH program	Quarterly Annually	Annual report
Outpatient rate of NCDIMH patients seen at OPD per 1000	**NUMERATOR:** Number of clients living with NCDs accessing health services at outpatient **DENOMINATOR:** Number of all clients accessing health services at OPD X1000	Condition Region Age group Sex	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTPUT						
Burden of mental health at OPD: Depression, Anxiety, Substance use, Suicide	**NUMERATOR:** Number of clients living with mental health conditions accessing health services at outpatient **DENOMINATOR:** Number of all clients accessing health services at OPD X1000	Condition Region Age group Sex	HMIS Inpatient	NCDIMH programprogram	Quarterly Annually	Annual report
Top five oral health (Dental caries) conditions seen at OPD	**NUMERATOR:** Number of clients living with oral health conditions accessing health services at outpatient **DENOMINATOR:** Number of all clients accessing health services at OPD X1000	Condition Region Age group Sex	CMIS	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
INPUT						
Proportion of facilities providing NCD services in line with PEN PLUS	**NUMERATOR:** Number of health facilities providing NCD services in line with PEN PLUS **DENOMINATOR:** Number of facilities eligible to provide PEN PLUS package	Region Facility type	Supportive supervision report Facility Assessment report	NCDIMH program	Quarterly Annually	Annual report
Blood pressure control among people with hypertension	**NUMERATOR:** Number of people registered for hypertension treatment in the facility whose BP was controlled at the last clinical visit in the reporting period, excluding those who were newly diagnosed with less than 3 months of treatment. Systolic blood pressure (SBP) <140 mmHg and diastolic blood pressure (DBP) <90 mmHg SBP <130 mmHg among people with history of CVD SBP <130 mmHg among high-risk people with hypertension, i.e., those with high CVD risk, diabetes mellitus, chronic kidney disease (CKD) Denominator: Number of clients with NCDs who have been on treatment for >=6 months **DENOMINATOR:** Total number of people registered for hypertension treatment in the facility, excluding those who were newly diagnosed with less than 3 months of treatment	Region Sex Age group	CMIS	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
OUTCOME						
Glycaemic control among people with diabetes	**NUMERATOR:** Number of people with diabetes registered in the facility with HbA1c <8% (64mmol/mol) at the last clinical visit in the reporting period, excluding those who were newly diagnosed with less than three months of treatment: Glycaemic control is achieved when: HbA1c <7% (53mmol/mol) [or fasting plasma glucose (FPG) <7.0 mmol/l or <126 mg/dl] HbA1c <8% in people with frequent severe hypoglycemia, severe complications and low life expectancy **DENOMINATOR:** Total number of people with diabetes registered in the facility, excluding those who were newly diagnosed with less than three months of treatment	Region Sex Age group	CMIS	NCDIMH program	Quarterly Annually	Annual report
Asthma control	**NUMERATOR:** Number of people registered for treatment of asthma with controlled asthma at the last clinical visit in the reporting period, excluding those who were newly diagnosed with less than six months of treatment Asthma is controlled when none of the following are reported: Asthma-related events in the past six months, such as hospital admission, unplanned healthcare visit, missed school/work	Region Sex Age group	CMIS	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
OUTCOME						
	Asthma symptoms in the past four weeks such as daytime symptoms present more than twice per week, use of short-acting β2 agonist (SABA) more than twice per week, limitations of activities or night waking **DENOMINATOR:** Total number of people registered for treatment of asthma, excluding those who were newly diagnosed with less than six months of treatment					
Proportion of NCDIMH clients living with complications Stroke: Renal failure: Myocardial infarction: Heart failure	**NUMERATOR:** Number of NCD clients newly diagnosed with complications **DENOMINATOR**: Number of clients with NCDs assessed for complications	Region Condition Sex Age group	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTPUT						
Burden of neurological conditions at OPD Epilepsy, Dementia, Autism) conditions seen at OPD	**NUMERATOR:** Number of people accessing services for neurological conditions at OPD *1000 **DENOMINATOR**: Total number of people accessing services at OPD	Condition Sex Age group Region	CMIS	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
PROCESS						
Number of supportive supervisions conducted	**NUMERATOR:** Number of supportive supervisions conducted **DENOMINATOR:** Number of Facilities eligible to receive supportive supervisions	Regions Facility type	Supportive supervision report Facility Assessment report	NCDIMH program	Quarterly Annually	Annual report
INPUT						
Proportion of inistry of health budget allocated to the NCDIMH centre number	**NUMERATOR:** Proportion of health budget allocated to NCD program **DENOMINATOR:** Total budget allocated to Ministry of Health		Ministry of health budget allocation	NCDIMH program	Annually	Annual report
OUTPUT						
Burden of injuries due to road traffic accidents at OPD per 1000 population	**NUMERATOR:** Number of injuries due to road traffic accidents at OPD *1000 **DENOMINATOR:** Total number of outpatient conditions seen	Region Facility type	CMIS	NCDIMH program	Quarterly Annually	Annual report
OUTCOME						
Mortality rate due to road traffic accidents per 1000 at inpatient	**NUMERATOR:** Number of deaths due to road traffic accidents **DENOMINATOR:** Total number of inpatient deaths reported **X1000**	Region Facility type	HMIS_inpatient	NCDIMH program	Quarterly Annually	Annual report
PROCESS						
Number of trainings conducted 1. NCD case management 2. M&E 3. Research	**NUMERATOR**: Number of training courses conducted for health care workers on NCD case management **DENOMINATOR:** Number of training courses targeted per year	Region cadre Topic	Attendance registers Training report	NCDIMH program	Quarterly Annually	Annual report

INDICATOR	DEFINITION	DIS-AGGREGATION	DATA COLLECTION METHOD	RESPONSIBILIT	FREQUENCY/ TIMELINE	REPORTING/ DISSEMINATION
OUTPUT						
Proportion of facilities with at least one health care worker trained in NCDIMH case management	**NUMERATOR:** Number of facilities with at least one health care worker trained in NCD case management **DENOMINATOR**: Number of facilities providing NCD services	Region cadre Topic	1. HHFA report 2.Attendance registers 3. Training report 4. Facility assessment report 5. Supportive supervision report	NCDIMH program	Quarterly Annually	Annual report
PROCESS						
Number of data quality audits conducted	**NUMERATOR:** Number of data quality audits conducted **DENOMINATOR:** Target number of data quality audits planned in a year	Region Facility Type	DQA report Program report	M&E-NCD	Quarterly Annually	Annual report
Number of data review meetings conducted on NCDIMH	**NUMERATOR:** Number of data review meetings conducted **DENOMINATOR:** Target number of meetings planned in a year	Region Facility Type	Meeting reports Attendance register	M&E-NCD	Biannually Annually	Annual report
Implementation research studies conducted	**NUMERATOR:** Number of research studies conducted **DENOMINATOR:** Number of research studies planned for	Region Facility Type	Research agenda NHRD report	NHRD program	Annually	Annual report

CHAPTER 8 COSTING

To ensure the effective implementation of the strategic objectives outlined in this plan, a comprehensive costing and resource mobilization framework has been developed to guide the allocation and utilization of financial resources over the next five years.

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
STRATEGIC OBJECTIVE 1: By 2026, raise political commitment for the prevention and control of non-communicable diseases, injuries, and mental health, and establish a national multisector coordination mechanism for NCDIMH.							
1.1 Raise public and political awareness, understanding, and practice about preventing and controlling NCDIs and Mental Health	1.1.1 Advocate for the establishment of inter-ministerial committee for stakeholder engagement and to champion NCDIMH agenda.	-	60,000.00	60,000.00	60,000.00	60,000.00	**4,387,250.00**
	1.1.2 Host forums with policymakers to emphasize the economic and social impacts of NCDIMH	-		12,000.00	12,000.00	12,000.00	
	1.1.3 Produce and distribute a national investment case showcasing the cost-effectiveness of prevention strategies	-	1,027,812.50	1,027,812.50	1,027,812.50	1,027,812.50	
1.2 Integrate NCDIs and Mental Health into the social and development agenda and poverty alleviation strategies.	1.2.1 Advocate for the declaration of NCDIMH as a National Public Health Threat.	-	35,000.00	35,000.00	35,000.00	35,000.00	**179,000.00**
	1.2.2 Incorporate of NCDIMH goals into national poverty reduction and development plan.	-	7,500.00	7,500.00	7,500.00	7,500.00	
	1.2.3 Review the NCD decentralization framework to incorporate Universal Health Coverage standards	-	9,000.00	-	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
STRATEGIC OBJECTIVE 1:	By 2026, raise political commitment for the prevention and control of non-communicable diseases, injuries, and mental health, and establish a national multisector coordination mechanism for NCDIMH.						
1.3 Address policy and regulatory gaps	1.3.1 Advocate for amendment and enforcement of regulations on alcohol	30,000.00	30,000.00	30,000.00	30,000.00	30,000.00	**525,000.00**
	1.3.2 Lobby for approval and implementation of tobacco and tobacco products regulations	30,000.00	30,000.00	30,000.00	30,000.00	30,000.00	
	1.3.3 Advocate for the enforcement of regulations addressing road safety and occupational health.	21,000.00	21,000.00	21,000.00	21,000.00	21,000.00	
	1.3.4 Advocate for review of the mental health order of 1978	21,000.00	21,000.00	321,000.00	21,000.00	21,000.00	
	1.3.5 Finalize the mental Health Policy			15,000.00			
1.4 Create an enabling environment for prevention and control of NCDs and Mental Health	1.4.1 Develop, validate, and implement strategies to curb obesity	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	**1,757,500.00**
	1.4.2 Develop healthy public food procurement policy	-	242,500.00	-	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 1:	By 2026, raise political commitment for the prevention and control of non-communicable diseases, injuries, and mental health, and establish a national multisector coordination mechanism for NCDIMH.						
	1.4.4 Collaborate with relevant stakeholders to review and implement policies that promote physical activity across all institutions.	-	-	-	-	-	
	1.4.5 Formulate NCDI and Mental Health stigma reduction Plan	-	-	375,000.00	-	-	
	1.4.6 Formulate a national suicide prevention plan	-	-	-	-	-	
	1.4.7 Develop implementation plan for drowning prevention	-	375,000.00	-	-	-	
OBJECTIVE 2:	By 2028, strengthen health system governance, leadership, coordination, and progressively increase program financing, while filling all vacant NCD program posts for an effective national response to NCDIMH, using 2024 as the baseline.						
2.1 Fully Institutionalize the NCDIMH Programme within the Ministry of Health	2.1.1 Lobby for the official approval of the NCDIMH department structures and organogram	12,000.00	12,000.00	12,000.00	12,000.00	12,000.00	**2,845,200.00**
	2.1.2 Advocate for adequate financial and human resources to support program implementation	12,000.00	12,000.00	12,000.00	12,000.00	12,000.00	
		-	2,612,700.00	-	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 2	By 2028, strengthen health system governance, leadership, coordination, and progressively increase program financing, while filling all vacant NCD program posts for an effective national response to NCDIMH, using 2024 as the baseline.						
	2.1.3 Train NCDIMH program officers in leadership, management, and resource mobilization	-4,500.00	-4,500.00	-4,500.00	-4,500.00	-4,500.00	
	2.1.4 Revive national technical Working Groups (TWGs)	18,000.00	18,000.00	18,000.00	18,000.00	18,000.00	
2.2 Mobilize Domestic and External Financing for NCDIMH	2.2.1 Engage the Ministry of Health Planning Unit for funding.	2,250.00	2,250.00	2,250.00	2,250.00	2,250.00	**116,250.00**
	2.2.2 Advocate for increased taxes on alcohol, sugary beverages, and tobacco products to allocate funds toward NCDIMH efforts.	12,000.00	12,000.00	12,000.00	12,000.00	12,000.00	
	2.2.3 Engage donors and private sector partners to mobilize external resources	9,000.00	9,000.00	9,000.00	9,000.00	9,000.00	
OBJECTIVE 3:	By 2028, reduce the prevalence of modifiable behavioral and metabolic risk factors for NCDIMH (e.g., tobacco use, harmful alcohol use, obesity, hypertension) from the 2024 baseline as measured in the STEPS survey.						
3.1 Raise Public Awareness of modifiable and metabolic risk factors	3.1.1 Review and update evidence-based Social and Behaviour Change Communication (SBCC) framework targeting key risk factors.	–	375,000.00	–	–	–	**771,411.18**

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 3:	By 2028, reduce the prevalence of modifiable behavioral and metabolic risk factors for NCDIMH (e.g., tobacco use, harmful alcohol use, obesity, hypertension) from the 2024 baseline as measured in the STEPS survey.						
	3.1.2 Conduct targeted campaigns on tobacco use and harmful alcohol consumption.	26,782.24	26,782.24	26,782.24	26,782.24	26,782.24	
	3.1.3 Promote healthy eating and physical activity through culturally relevant campaigns.	-	-	-	-	-	
	3.1.4 Engage schools, workplaces, media, faith-based organizations, traditional and community leaders in promoting healthy behaviours.	-	-	-	-	-	
	3.1.5 Conduct capacity building on air pollution and climate change	-	65,625.00	65,625.00	65,625.00	65,625.00	
	3.1.6 Conduct awareness campaigns on air pollution and climate change	-	-	-	-	-	
3.2 Enhance Screening Services	3.2.1 Scale up NCDIMH screening services to reach all communities.	27,012.24	27,012.24	27,012.24	27,012.24	27,012.24	**2,475,061.18**
	3.2.2 Train healthcare workers to conduct screenings and counselling on risk reduction.	–	3562,500.00	562,500.00	562,500.00	562,500.00	
	3.2.3 Integrate screening services into existing healthcare services across all levels of care.	18,000.00	18,000.00	18,000.00	18,000.00	18,000.00	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
3.3 Promote Public Adoption of Preventive Practices	3.3.1 Promote vaccination for vaccine-preventable diseases in populations aged five years and above.	-	-	-	-	-	
	3.3.2 Promote exclusive breastfeeding and provide support for breastfeeding mothers.	-	-	-	-	-	
3.4 Foster Community Engagement	3.4.1 Sensitize NGOs and civil society on their role on prevention and management of NCDIMH	-	15,000.00	15,000.00	15,000.00	15,000.00	**2,020,000.00**
	3.4.2 Train community health workers (CHWs) to educate households on NCDIMH risk factors.	300,000.00	300,000.00	300,000.00	300,000.00	300,000.00	
	3.4.3 Commemorate Global NCDI and Mental Health Days.	56,000.00	56,000.00	56,000.00	56,000.00	56,000.00	
	3.4.4 Provide technical support for networks for individuals at risk of or managing NCDIMH.	18,000.00	18,000.00	18,000.00	18,000.00	18,000.00	
	3.4.5 Collaborate with other programs to develop standardized NCDIMH community feedback mechanisms	–	22,500.00	22,500.00	22,500.00	22,500.00	
OBJECTIVE 4:	By 2028, deliver high-quality, evidence-based, and people-centered NCDIMH services, and improve service coverage and control for NCDs, injuries, and mental health, using the 2024 baseline for comparison.						
4.1 Update and disseminate guidelines for NCDIMH	4.1.1 Revise the national NCDIMH clinical management guidelines.	104,166.67	104,166.67	104,166.67	104,166.67	104,166.67	**4,347,500.00**

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 4:	By 2028, deliver high-quality, evidence-based, and people-centered NCDIMH services, and improve service coverage and control for NCDs, injuries, and mental health, using the 2024 baseline for comparison.						
	4.1.2 Disseminate the updated NCDIMH guidelines using various platforms	-	8,750.00	8,750.00	8,750.00	8,750.00	
	4.1.3 Train healthcare workers on updated NCDIMH guidelines.	-	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00	
4.2 Integrate NCDIMH Services	4.2.1 Finalize and operationalize the ICDM framework to integrate NCDIMH	-	20,000.00	-	-	-	**1,688,080.59**
	4.2.2 Launch pilot programs in selected facilities to assess integrated service models.	-	93,580.59	-	-	-	
	4.2.3 Train healthcare workers to effectively deliver integrated services	-	390,625.00	390,625.00	390,625.00	390,625.00	
	4.2.4 Scale up integrated service delivery models across the healthcare system.	-	-	4,000.00	4,000.00	4,000.00	
4.3 Decentralize NCDI and Mental Health Services	4.3.1 Conduct baseline assessment of Mental Health Services.	-	-	888,160.30	-	-	**936,679.59**
	4.3.3 Review decentralization framework for NCDI and incorporate mental health services.						
	4.3.4 Review mental health desk guide to incorporate mh-GAP version 2						

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 4:	By 2028, deliver high-quality, evidence-based, and people-centered NCDIMH services, and improve service coverage and control for NCDs, injuries, and mental health, using the 2024 baseline for comparison.						
	4.3.5 Implementation of scale up plan. 5 sites per region every six months.	-	-	48,519.30	-	-	
	4.3.6 Advocate for the availability of infrastructure for, including diagnostic devices, medicines, and essential rehabilitative tools, enabling the provision of NCDIMH services.	-	-	-	-	-	
4.4 Integrate rehabilitative and palliative care services for NCDIMH to all levels of care as aligned with national guidelines.	4.3.4 Review guidelines to incorporate rehabilitation	-	-	312,500.00	-	-	**3,150,000.00**
	4.3.5 Validation of guidelines	-	-	20,000.00	-	-	
	4.3.6 Dissemination of guidelines	-	-	17,500.00	-	-	
	4.3.7 Capacity building on rehabilitation	-	-	2,800,000.00	-	-	
4.5 Capacity building for Health Workers on integrated care	4.5.1 Train healthcare workers on WHO Package of Essential Non-Communicable Disease Interventions (WHO-PEN), integrate the HEARTS initiative for cardiovascular health and mhGAP	161,788.00	161,788.00	161,788.00	161,788.00	161,788.00	**1,977,159.30**
		-	-	350,000.00	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
	4.5.2 Review training curricula to cover the prevention and management of NCDIMH including modules on patient-cantered care, communication, and evidence-based practices.	-	-	3,000.00	3,000.00	3,000.00	
	4.5.3 Identify community members to be trained as rescuers. 10 members per inkhundla.	-	15,000.00	15,000.00	-	-	
	4.5.4 Capacity building of identified rescuers.	-	175,000.00	175,000.00	-	-	
	4.5.5 Develop a training package for the prevention and management of injuries(drowning)	-	-	20,000.00	-	-	
	4.3.6 Dissemination of guidelines	-	89,000.00	89,000.00	-	-	
	4.5.6 Implement Establish mechanisms platforms to encourage adherence to NCDIMH treatment and care regimens	-	-	-	-	-	
	4.5.7 Collaborate with community leaders and local organizations to strengthen awareness about the availability of decentralized NCDI and Mental Health services.	-	-	121,909.65	-	-	
	4.5.8 Implement quarterly regular mentorship and supervision to enhance the quality of services and data collection (40 visits per year per region).	25,861.93	25,861.93	25,861.93	25,861.93	25,861.93	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
	4.5.9 Advocate for the government to recruit specialist ed for NCDIMH health care workers as per national requirements.	-	-	-	-	-	
4.6 Pilot the implementation of WHO PEN-Plus for managing severe chronic NCDs at designated facilities	4.6.1 Conduct base line assessment to designated facilities.	-	1,172.41	1,172.41	-	-	**2,344.82**
	4.6.2 Conduct analysis and report writing.	-	43,500.00	43,500.00	-	-	**87,000.00**
	4.6.3 Dissemination to RHMT. (2 regions)						
	4.6.4 Pilot WHO-PEN Plus in 3 regions (1 facility each region for 6 months)	-	16,331.77	16,331.77	-	-	**32,663.53**
	4.6.5 Develop pilot report	-	5,000.00	5,000.00	-	-	**10,000.00**
	4.6.6 Disseminate pilot report 1 meeting.	-	9,030.00	9,030.00	-	-	**18,060.00**
	4.6.7 Scale up of WHO-PEN plus to 2 other health facilities.						
4.7 Strengthen referral and linkage pathways to ensure timely access to care at all levels	4.7.1 Participate in the development referral and linkage pathways for NCDIMH.	-	2,807.89	2,807.89	2,807.89	2,807.89	**11,231.58**

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
4.8. Collaborate with relevant programs Quality Management Program (QMP) to develop Quality Improvement Systems projects for Improved Service Delivery. implement national quality improvement system framework to monitor the delivery of NCDIMH services.	4.8.1 Participate in the development of quality improvement framework	-	-	-	-	-	**51055.44**
	4.8.2 Conduct regular facility audits, collect performance data, and provide actionable feedback to healthcare providers.	10,211.09	10,211.09	10,211.09	10,211.09	10,211.09	
	4.8.3 Collaborate with relevant programs to revise patient satisfaction surveys to assess and address gaps in the quality of NCDIMH service delivery.	-	-	-	-	-	
	4.8.4 Collaborate with relevant programs to recognize facilities and staff delivering exceptional care	-	-	-	-	-	
	4.8.5 Revise the NCDIMH supportive supervision tool						
OBJECTIVE 5: Generate and use data to drive decisions for action at all levels.							
5.1.1 Develop and align Monitoring and Evaluation Frameworks for NCDIMH interventions.	5.1.1. Design a national M&E framework and action plan to track interventions effectively.	-	93,750.00	-	-	-	**1,285,891.49**
	5.1.2 Conduct periodic midterm and end term reviews of the NCDIMH strategic plan	-	-	674,747.02	-	-	
	5.1.3 Embed NCDIMH monitoring into national systems such as HMIS and CMIS to enable seamless data management.	-	-	-	-	-	

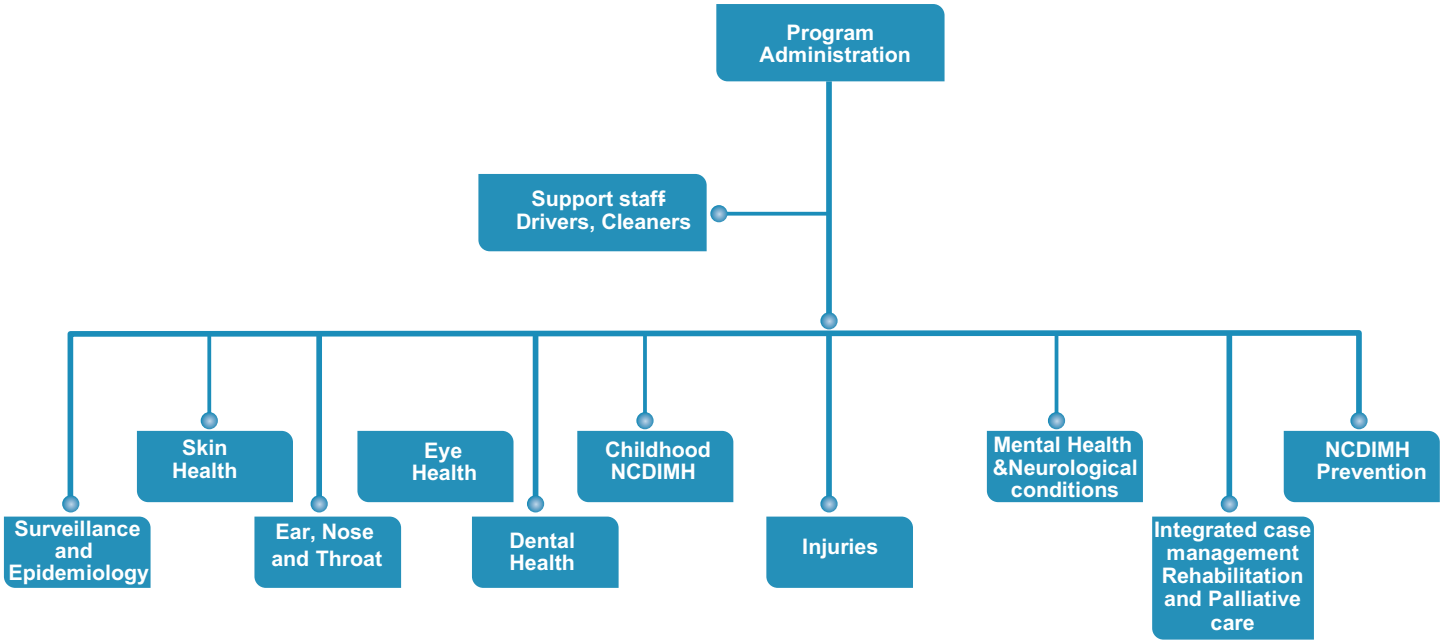
INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 5:	By 2028, establish a fully functional national monitoring and evaluation (M&E) system for NCDIMH that integrates routine data collection, enhances data use for policy and programmatic decisions, and supports at least 80% of both private and public health facilities in using timely, high-quality data to improve service delivery and outcomes.						
	5.1.4 Pilot the decentralization of mental health services in 20 facilities (5 per region) for 6 months.	-	-	348,144.47	-	-	
	5.1.5 Develop pilot report.	-	-	125,000.00	-	-	
	5.1.6 Dissemination of pilot report.	-	-	42,000.00	-	-	
	5.1.7 Develop scale up plan.	-	-	2,250.00	-	-	
	5.1.8 Identify and incorporate indicators that measure interventions' reach, effectiveness, and equity, in line with the global requirements.	-	-	-	-	-	
	5.1.9 Advocate for continuous integration of NCDIMH monitoring into national data collection systems to enable routine program performance tracking.	-	-	-	-	-	
5.2 Enhance data use and policy integration.	5.2.1. Develop dashboards, policy briefs, and visual analytics to build a culture of data demand and use among policymakers and implementers.	-	-	-	-	-	**10,163,161.18**
	5.2.2. Produce and disseminate high quality quarterly and annual M&E reports with actionable insights for stakeholders.	-	-	937,500.00	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 5:	By 2028, establish a fully functional national monitoring and evaluation (M&E) system for NCDIMH that integrates routine data collection, enhances data use for policy and programmatic decisions, and supports at least 80% of both private and public health facilities in using timely, high-quality data to improve service delivery and outcomes.						
	5.2.3 Schedule routine and episodic data quality audits to verify the accuracy and completeness of NCDIMH data.	1,432.24	1,432.24	1,432.24	1,432.24	1,432.24	
		-	-	111,000.00	-	-	
		-	-	45,000.00	-	-	
	5.2.4 Conduct bi-annual data review meetings.	1,750,000.00	1,750,000.00	1,750,000.00	1,750,000.00	1,750,000.00	
	5.2.5 Establish a monitoring and evaluation system to assess the impact of decentralization on service delivery and patient outcomes.	62,500.00	62,500.00	62,500.00	62,500.00	62,500.00	
5.3 Expand surveillance and research capabilities.	5.3.1 Develop registries to track the prevalence, incidence, and outcomes of NCDIMH (Renal complications, Injuries, DM)	-	175,000.00	-	-	-	**12,995,253.21**
	5.3.2 Partner with academic institutions and organizations to conduct research aligned with national priorities.	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	
	5.3.3 Conduct standardized NCDIMH surveys. (STEPS 2029)	2,560,050.64	2,560,050.64	2,560,050.64	2,560,050.64	2,560,050.64	
	5.3.4 Outline NCDIMH research priorities in line with the National Health Research Agenda.	-	-	-	-	-	

INTERVENTION	ACTIVITY	ANNUAL COST BREAKDOWN					Total (SZL)
		2024	2025	2026	2027	2028	
OBJECTIVE 5:	By 2028, establish a fully functional national monitoring and evaluation (M&E) system for NCDIMH that integrates routine data collection, enhances data use for policy and programmatic decisions, and supports at least 80% of both private and public health facilities in using timely, high-quality data to improve service delivery and outcomes.						
5.4 Disseminate research and drive innovation.	5.4.1 Capacitate NCDIMH staff in operational research skills	-	-	-	-	-	**932,898.40**
	5.4.2 Share research in peer-reviewed journals and present findings at conferences.	312,498.40	312,498.40	312,498.40	312,498.40	312,498.40	
	5.4.3 Organize workshops and discussions to ensure findings to inform policies and interventions.	-	-	-	-	-	
	5.4 4 Provide public access to up-to-date NCDIMH research findings information to foster transparency and stakeholder engagement.	98,800.00	98,800.00	98,800.00	98,800.00	98,800.00	
Total		**5,711,853.43**	**13,729,640.20**	**16,236,340.34**	**8,543,908.76**	**8,543,908.76**	**52,765,651.50**

ANNEX 1

NCDIMH PROGRAMME PROPOSED ORGANOGRAM



ANNEX 2: BIBLIOGRAPHY

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