Moving forward, taking NCDs into the SDG era with political will, policy coherence and stewardship

A REPORT TO INFORM THE MINISTER OF HEALTH, DR ZWELI MKHIZE

June 2019

SOUTH AFRICAN
NON-COMMUNICABLE
DISEASES ALLIANCE

Compiled by
Dr Vicki Pinkney-Atkinson, PhD
Director SA NCDs Alliance

In collaboration with NCDs stakeholders who are acknowledged for their input. A full list is available on request.

Declaration of interest.
The SANCDA and Dr Pinkney-Atkinson have no conflicting commercial interests. The SANCDA is funded by successive grants through the NCDs Alliance and Medtronic Philanthropy.
VPA is a person living with nearly 20 NCDs and the main condition, psoriasis, since birth. She motivated to live beyond premature mortality and wants equitable access to quality health care to avoid catastrophic health expenditure. The conditions are at different stages: with some treated actively and others requiring palliative care.

Contents

LIST OF FIGURES

EXECUTIVE SUMMARY

The appointment of a new health minister in May 2019 is a tipping point for health services in South Africa. The South African NCDs Alliance (SANCDA) welcomes the appointment and looks forward to engaging and collaborating to achieve the Sustainable Development Agenda 2030. This is a critical point at which equitable access to quality healthcare is at the centre of health policy coherence for sustainable development.

1. This report outlines the currents status of NCDs highting the current inequitable care meted out to people living with NCDs (PLWNCDs). The SANCDA asks that it is urgent priority to position NCDs coherently within the context of the Agenda 2030. We ask that NCDs, with a revised scope, are prioritised equitably alongside Communicable Diseases (CDs) to achieve Sustainable Development Goal 3.4.
2. NCDs, as a disease group, is the leading cause of death in South Africa. The South African Government demonstrates minimal political will to address NCDs prevention and treatment. The few exceptions relate to fiscal measures and selected primary prevention interventions.
3. Policy, including budgets, reflect this systemic neglect. The 2019 Vote for Programme 3 shows the gross inequity between communicable diseases and NCDs in a ratio of 99:1. The NCDs line item sustained the deepest cut of all, with a 48% reduction.
4. We propose two main short-term interventions in support of SDG consistent transition accompanied by stewardship for people-centred health systems strengthening. The SANCDA has limited funds available but undertakes to use these and its other resources to support the these interventions as listed below.
5. **Transformation of NCDs group of subprogrammes to show political will for equity through SDGs alignment and its positioning within the NHI to commence by the end of July 2019.**
6. **Mainstream NCDs group of subprogrammes by:**
    a. **The urgent creation of a national multistakeholder intersectoral high-level coordination and collaboration NCDs body within the NHI (similar to SANAC) to commence by the end of August 2019 and be fully operational by 2021.**
    b. **Developing and implementing an overarching costed NCDs national strategic plan based on the revised NCDs+ scope and positioning that overcomes the failings of the expired 2013-2017 NCDs plan**.
7. The SANCDA requests a meeting with the Minister of Health to engage about the above interventions by mid-July 2019

INTRODUCTION

8. The UN "Transforming our World: The 2030 Agenda for Sustainable Development" marks the start of a more participatory era in global policy that requires holistic and integrated action continued and sustainable life on this planet. The 17 sustainable development goals (SDGs), including for one for health, reflects a major paradigm shift from dependency to collaboration and growth. South Africa, a member of the UN, is a signatory to this agreement. As a partner, the Government agreed to collaborative action and transparent governance with stewardship to meet the goals from 2015.(1)
9. From 2000 – 2015 the Millennium Development Goals (MDGs) way a global push in which developed countries assisted developing countries to achieve eight outcomes through technocratic assistance and "command and control" plans (2). In South Africa, this resulted in unprecedented amounts of development assistance for the mainly communicable disease, HIV and TB and programmes with links to maternal-child health and "under" nutrition. However, it fundamentally changed how the health system provided services. It resulted in an inflexible unidimensional siloed health system that is unresponsive to the needs of PLWNCDs.
10. There are three objectives of this NCDs report to the incoming Minister of Health:
    - To explore the South African health system through the eyes of people living with NCDs (PLWNCDs) between the years 2010-2019;
    - To highlight key policy shifts that are required to transform the health system and wider government to achieve NCDs-related SDGs;
    - To offer solutions in whereby PLWNCDs participate in and receive equitable health services through an agreed system of universal health coverage (UHC).
11. Health systems stewardship is at the heart of this report, and it concerns oversight and guidance of the whole health system which is the function of the National Department of Health (NDoH) and is one of the six building blocks of a health system of governance/leadership. We seek a facilitated stewardship process that reframes NCDs equitably to achieve SDG 3. We particularly focus on the most vulnerable people in our country s is on health system stewardship
12. The SANCDA's mission is to support and advocate for NCDs policy at all levels that is transparent, inclusive and accountable to

the people of South Africa and the global commitments made by the government on our behalf. The organisations that constitute the SANCDA and its network collectively as civil society organisations have more than 300 years of advocacy, service, education and research knowledge and experience. Long before "Thuma mina" entered our lexicon, we were working for our people. We continue to do so unasked and usually to support government at all levels in a disrespectful manner. The NGOs, particularly within the NCDs space, are usually unsupported and unrecognised by the South African Government and at this point relations with the government are rocky and characterised by mistrust.

SOUTH AFRICA'S NCDS COMMITMENTS IN THE SDGS ERA

13. Underpinning this report are the South African Government's commitments has made to the UN and WHO in support of SDGs. Including NCDs-related commitments from 2011 culminating with the 2018 UN Third NCDs Political Declaration on NCDs (3) and the current process to develop a UHC political declaration (4).

14. SDG 3 focusses on health and well-being with nine targets, indicators and means of implementation.[1] The first impression is that target 3.4 is the NCDs-related: *to reduce by 1/3 premature*[2] *death and disability from NCDs through prevention and treatment AND to promote mental health and well-being*

15. However, as Figure 1 shows, 3/9 health targets relate to NCDs with link means of implementation (5). The SANCDA's priority is to achieve the NCDs-related targets through awareness, advocacy and accountability.

16. The SDGs require integrated and interwoven priorities and action, which in Figure 2 shows that 10/17 SDGs impact on health and therefore, NCDs.

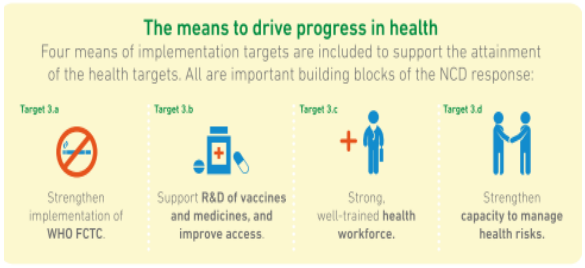


Figure 1: SDG 3 NCDs targets and implementation(5)

[1] Full list of SDG 3 targets, indicators and xxx found here https://sustainabledevelopment.un.org/sdg3

[2] Premature mortality is defined as death between the ages of 30-70 years at it includes vulnerable groups of children and the elderly (2 ¶ 12, 13).

17. The SANCDA is deeply concerned about the lack of progress on NCDs-related global commitments and, closer to home, the abject failure of the national *Strategic plan for the prevention and control of NCDs 2013-2017* (6). The NDoH and political officials must be held accountable for the knowing neglect of coherent NCDs policy.

18. We ask the NDoH to commit to and create all policy coherent with the SDGs and the needs of PLWNCDs. The NDoH must lead by example through governance and stewardship to transform the health system so that all citizens benefit (7).

19. As civil society and representatives of healthcare users, we desire to be integral to the co-produced solutions in support of, and, to accelerate SA's achievement of the SDG 3. Last year at the UN, the SA Government committed to:

    … *"provide strategic leadership for the prevention and control of non-communicable diseases by promoting greater policy coherence and coordination through whole-of-government and health-in-all-policies approaches and by engaging stakeholders in an appropriate, coordinated, comprehensive and integrated, bold whole-of-society action and response;"* (3) *¶17)*

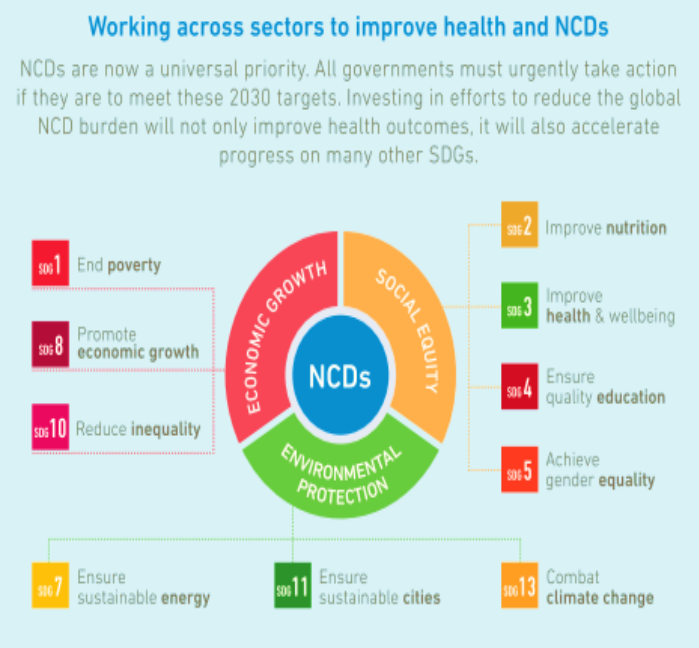


Figure 2: Working across sectors to improve health & NCDs

20. In September 2018, when the NCDs Political Declaration was adopted, the lack of commitment shown by our politicians and executive level officials was painfully clear. Not a single politician or official (above the level of director) attended the HLM NCDs plenaries. This is in contradistinction to attendance of the Mandela Centenary celebrations and the HLM on TB on held in the same venue on preceding days.

NCDS EQUITY BENCHMARK IS COMMUNICABLE DISEASES

21. In this report, the benchmark for equity is the HIV, AIDS and STIs subprogramme based on its prominence in policy and financing at a national level. The many policy interventions that have been rolled out include administrative, structural, educational resources available and as common practice within the CDs group of programmes.

22. The act of highlighting this inequity must not be misinterpreted as a competition between illnesses and causes of death or the people living with different kinds of health conditions. We are equally concerned that five million of our compatriots, currently receiving ARV therapy, are likely to have comorbid NCDs requiring prevention and treatment. Therefore, we fully support the coherent people-centred integration of the CD and NCDs programmes balanced with equitable resources, consultation and respect. (9) (3:¶ 39)

23. The HIV activists and people living with HIV have our profound admiration for what has been achieved. They provided the template for our action today. How people with NCDs are treated, or usually not, demands civil action. However, within the health system, the CDs+ have become an elite. Only extreme cases like the Life Esidimeni catastrophe for mental health patients and the failure of cancer care show the complete failure. Most people with NCDs live and work in the community and don't make it to clinics, let alone diagnosis. The point being that PLWNCDs have been silent for too long.

24. The management of multiple morbidity or comorbidity no matter whether NCDs or CD requires equity and a different frame of performance together with the conscious integration and implementation within the NHI framework. Current processes and health policy are notable by this absence. We are tired of being fobbed off.

25.

INEQUITY FOR NCDS+ PREVENTION & TREATMENT

26. In this section, we explore the inequity between the major illness groups, CDs+ and NCDs+. Differentiating between illness groups and programmes gets very confusing. So we use the term CDs+ and NCDs+ to denote the larger grouping as used in by Statistics SA (Figure 4). Line items as in the budget are smaller focus areas (10).

27. We salute the recent policy coherent reconfiguration NDoH Programme 3, resulting with two main illness groups consisting of CDs+ and NCDs+ (11). At this point, it is important to clarify the different levels within this single programme. The classification below is used in financial reporting

28. The NCDs+ acronym is used to denote the group consisting of two sub-programmes NCDs and Health Promotion and Nutrition

(HPN) which previously situated in the Primary Health Care Services (Programme 2). It is not clear how NCDs+ came to be in Programme 2, but at this juncture, it seems and illogical misfit that exacerbated the marginalisation of NCDs in policy. However, to imply that the NCDs+ group is in anyway unified and coherent is just wishful thinking. In reality NCDs and HPN line items and policy areas represent an uncomfortable "marriage of convieniece." As stated in the most recent policy documents, HPN's scope is to serve all CDs and NCDs operations. This makes it similar to the pigs in George Orwell's classic book, *Animal Farm*: some programmes are more equal than others. However, in one way, HPN and NCDs are equal: both are excluded from the South African National AIDS Council (SANAC). It is hoped, but not yet evident, that the restructuring will foster policy coherence. In all other respects, these perform in disjunction and appear to be competitive rather than supportive of eachother.

29. The stark reality is that there is no political will to redress the neglect of NCDs prevention and treatment. Figure 4 shows that since 2010, NCDs+ remain the leading cause of death in South Africa with diabetes mellitus the leading cause of death in women (12).

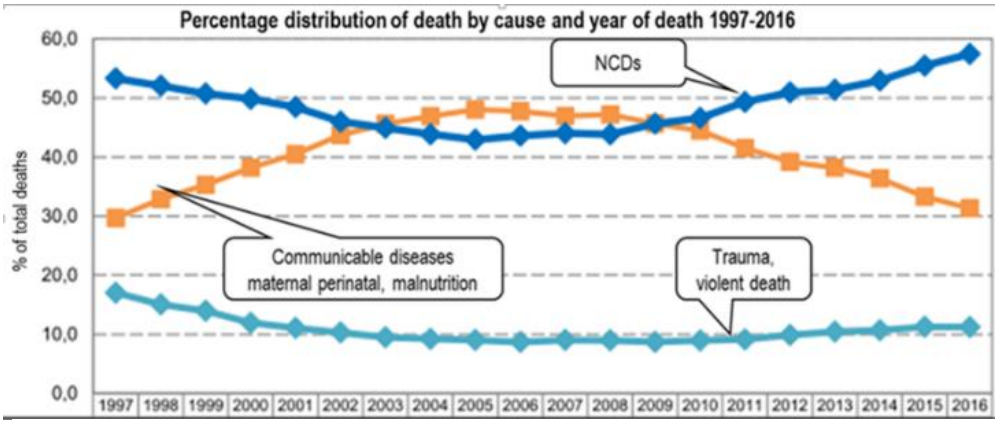


Figure 3: Percentage mortality by cause group in South Africa 1997-2016

30. Morbidity and the loss of productivity from NCDs in the WHO African region is now marginally higher than that for CDs+ as shown inFigure 5 (13). There is increasing evidence on the global burnden of NCDs and this requires incorporation to policy(14)(8).

Figure 4: Productivity loss fron conditions in the WHO Afro region, 2015xx

31. PLWNCDs often have had to listen to NDoH officials, from the level of Chief Director and higher, that even if NCDs are the biggest killer, it doesn't count as much as morbidity and the overall burden of disease. The inference is that from a population perspective NCDs+ are less worthy of treatment and that public health measures such as primary prevention strategies will suffice. PLWNCDs agree with the concept of fiscal measures and the like but insist that the treatment for NCDs lowers the burden of disease and is a Section 27 right. Money spent on NCDs treatment is not seen as part of the continuum of prevention. Unlike ARV medication, which is somehow deemed in policy terms, as a preventive measure! This is the predominant dialogue with civil society and PLWNCDs face in most interactions emanating from the CDs cluster and pervading much of the NDoH. PLWNCDs want equity for a real burden of disease, and we want to stop having to justify why our health system should care for all citizens irrespective of illness. The pendulum has swung to a the point of NCDs+ denialism. We trust that the global investment case for NCDs is now accepted (15)(16).

32. Despite the increasing rise in the NCDs burden of disease, the CDs+ together with NHI remain the priority in health policy and top the recent election manifesto for the African National Congress(10, 13). If unexamined this looks coherent; however, both the NHI and the National Development Plan 2030 reflect the MDGs era bias in favour of CDs siloes. (3 ¶ 2 7,8,9). NCDs civil society has failed to get any acknowledgement that the NHI should reflect integrated people-centred health services that is the imperative of the SDGs and that it must have a vision beyond CDs. Nor, is there, to our knowledge a collectively operationalised definition of people-centred health services despite it being said to be central to NHI.

33. Health systems strengthening initiatives undertaken in the name of NHI over the last decade focussed exclusively on the CDs+. In policy terms, health system strengthening is really code for ensuring quality services for CDs with NCDs included cynically

except when included for specific campaigns.

34. An example is the ongoing Wellness Campaign to meet CDs and NCDs screening targets in sequential NDoH Annual Performance Plans from 2014 onward (18)(19). NDoH action plans set the goal for the provinces to screen 10 million people for diabetes and hypertension with no transparently developed screening standard operating procedures or standardized data collection parameters. For equity purposes, this must be compared with the HIV counselling and testing (HCT) guideline that runs to 52 pages (20). If and when NCDs are included in CDs+ activities, it is purely as window dressing and unsupported by resources, equipment, training or budgets.

35. NCDs+ indicators are only being introduced and are very rudimentary with on explanatory criteria when compared to CDs+ (21). The Sustainable Development Index (SDI) comprises 33 of indicators shows, if the current trajectory continues in South Africa, SDG 3 will not be achieved by 2030. (8) It is a global phenomenon. Figure 5

36. There are many other examples of health systems strengthening interventions with a CDs-only focus such as Operation Phakisa, the "Ideal Clinics" and the integrated clinical service management (ICSM) along with chronic medicines distribution (22).

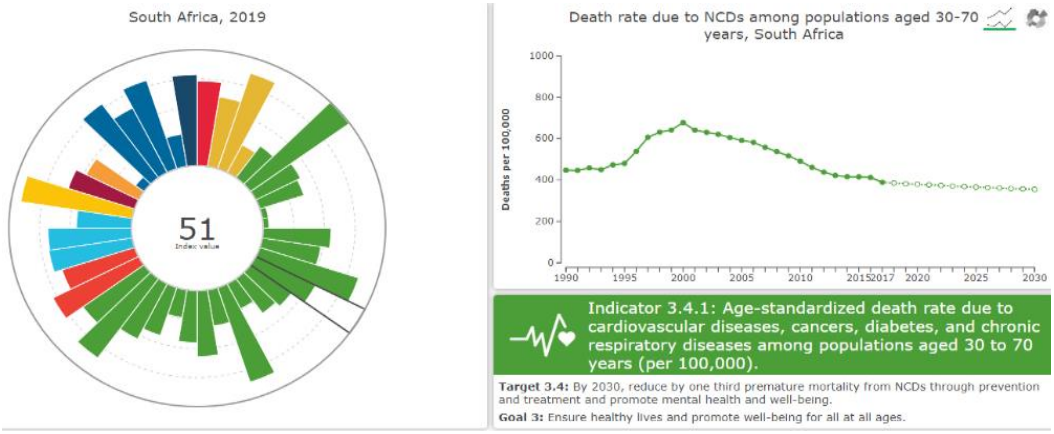


Figure 5: SDG Idex projection for SA to achieve SDG 3.4 by 2030

FINANCIAL INEQUITY FOR NCDS

37. Nowhere is the inequity more apparent than in successive financial policy documents like the NDoH budget vote that shows estimates of national expenditure by financial year. The NDoH mandate is described in terms of 11 performance indicators with not a single specific mention of any NCDs. Knowing the systemic bias and the lack of political will it is clear that if we continue with business as usual, then NCDs will remain unprioritized (23).

38. The SANCDA and NCDs civil society organisations believe that the financial inequity severely impinges on the right to health.(11) It appears contrary to the commitment made to allocate resources to Agenda 2030. (1 ¶ 46) (2 ¶) (24)

39. In this section, we feature a comparison of the expenditure for CDs+ and NCDs+ from 2015/6 to this year (23). Since this is the first year that both appear in the same budget (Programme 3) it should be clear cut analysis with more than any lion's share of 99.48% going to CDs+ leaving the rest, 0,52% to NCDs+. Figure 6 shows the stark reality of the inequity that PLWNCDs face every day within the health system. This disproportionate allocation has not changed in the SDG era. When comparing MTEF expenditures. The inequity ratio between CDs+ and NCDs+ is 196:1 (CDs+ to NCDs+).

40. The skewed allocation of funds is nothing new. One reason for the gargantuan differences is that the CDs+ contain earmarked amounts (conditional grants) that are allocated to the provinces to provided the services. So this covers critical items like drugs, diagnostic tests, education and salaries. The detailed costs of the programme are calculated and predicted in advanced. There are many indicators used for monitoring and evaluation. The exact opposite is true for the NCDs+ budget. The paltry amounts cover salaries of NDoH personnel, and that is about it. At a provincial level, there are no official NCDs plans, and there is not a single line item that suggests how money is spent on health services for NCDs prevention and treatment (25).

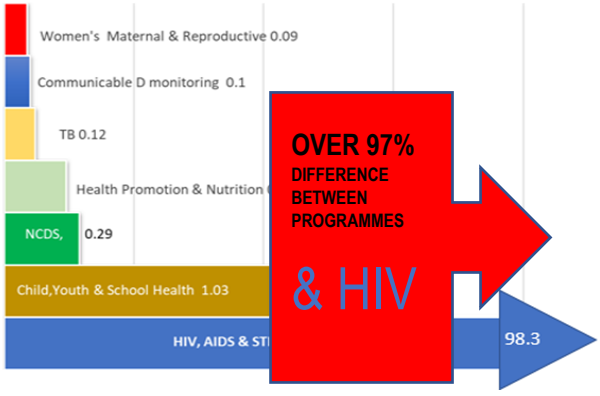


Figure 6: % Breakdown CDs NCDs budgets

41. However, we consider that the real emerges after deconstructing the recently combined CDs+ and NCDs+ to the original budget votes (Table 3). The table compares expenditure from 2015 to the current 2019/20 that is to be defended by the new minister of Health. Using a historical perspective line items are tracked and compared for the changes in within the subprogrammes. The changes are not evident in the current budget. This highlights that NCDs (the line item for the policy function of NCDs) has, once again, the target of the biggest cut amounting to nearly have of the budget.

42. The table is complex and is difficult to explain. It is important to read related notes and the colour coding. And the actual numbers are very different, so tracking and comparison is difficult. The analysis that follows may be flawed but it deserves to be addressed and explained. a debate, or at least a discussion about the issues.

43. The **budget line item analysis** using the historical perspective show the internal variation over time.

    a. **NCDs line item** is cut by -47,7% responsible for the bulk of NCDs policy and implementation continues to decline in the largest amounts in the SDGs era.

    b. **HPN line item** show variations that require further explanation but most recently has been increased by +110,3%. It is not clear what warrants this increase.

    c. **HIV line** item is reduced by -0.04% it is not clear if this is due to anticipated reduction in donor funding due in part by not meeting targets related to maintaining people on ARV treatment.

Table 2: Comparision of CDs+ and NCDs+ in budgets from 2015/16

Subprogramme		Audited outcome				MTEF 18 19/20[3]	MTEF 19 19/20[4]	% 18-19 budget change [5]	MTEF in R change [6]	MTEF % change[7]
R thousands		15/16	16/17	17/18	18/19					
Communicable Disease CDs+ [1]										
HIV, AIDS & STIs		13,962,474	15,712,480	18,024,381	20,441,530	22,582,308	22,572,400	-0.04%	-9,908	-0.04%
TB		20,094	24,326	26,298	27,240	27,708	27,748	0.00%	40	0.14%
Women's Maternal & Reproductive		13,717	11,569	18,190	19,907	20,259	20,299	0.00%	40	0.20%
Child, youth, and School Health		177,328	212,361	222,451	224,971	237,558	237,608	0.00%	50	0.02%
CD control		21,100	17,600	18,400	22,700	24,000	24,058	0.00%	58	0.24%
Sub total		**14,194,713**	**15,978,336**	**18,309,720**	**20,736,348**	**22,891,833**	**22,882,113**	**-0.04%**	**-9,720**	
NonCommunicable Diseases NCDs+[2]										
Health Promotion & Nutrition	2018[8]	22,107	19,135	26,256	24,682	25,770	54,196	0.12%	28,426	110.31%
	2019[9]	168,800	19,400	31,400	49,800					
NCDs		20,562	19,425	22,491	74,183	125,682	65,702	-0.26%	-59,980	-47.72%
Sub total		***42,669***	***38,560***	***48,747***	***98,865***	***151,452***	***119,898***	***-0.14%***	***-31,554***	
Total		**14,237,382**	**16,016,896**	**18,358,467**	**20,835,213**	**23,043,285**	**23,002,011**	-0.18%	**-41,274**	**-0.18%**

Notes

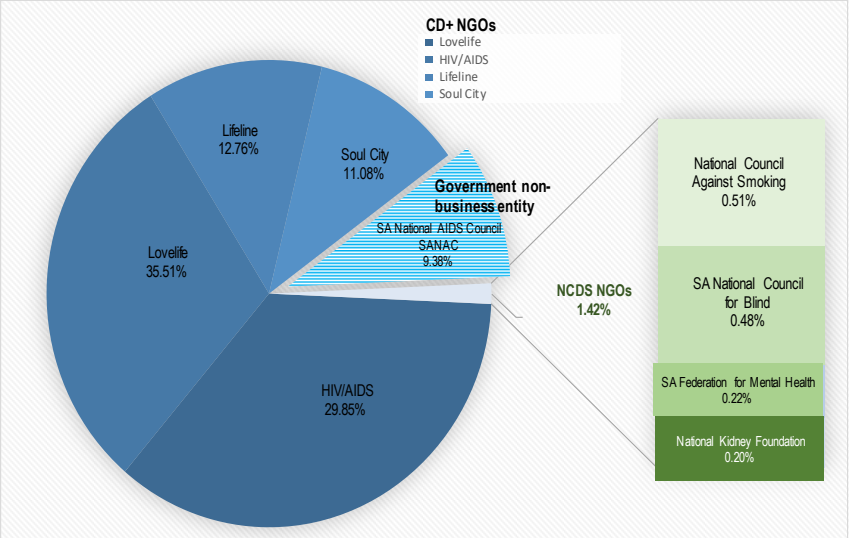
1. CDs+ always located in Programme 3 highlighed in blue with the only new item *CD control* moved from Programme 2.
2. NCDs+ showing the HPL and NCDs line items originally in Programme 2. HPL audited figures for 2018 and 2019 differ without explanation in the 2019 budget. The differences is substantial and discussed further in Table 3
3. MTEF 2018 figures for financial year 2019/20 budget vote Programme 3 (CDs+) and Programme 2 (NCDs+) showing the figures for projected figures for 2019/20
4. MTEF 2019 for the financial year 2019/20 showing the revision to MTEF 18. For the first time all CDs+ and NCDs+ are allocated with in Programme 3.
5. Budget change % for 2019/20 using MTEF19 as the denominator. The numerator is the difference between MTEF 18 (see note 3) and MTEF19 (see note 4) for this financial year. Two line items were reduced HIV and NCDs by less than 0.3%
6. Rand value of the budget change 2019/20 between MTEF18 and MTEF19.
7. Budget change for 2019/20 It reflects total line item Rand value in MTEF18 less the actual value of the change shown as a %. It shows the real magnitude and impact for small subprogramme budgets like HPN and NCDs.

44. The HPN line item analysis is even more complicated, shown in Table 3. The green line shows audited figures from Programme 2 (with the yellow row showing the line item as it appears in the current budget vote for the same line item. The differences are huge, and we have not been able to find an explanation. Over the period the total show amounts to a whopping +R177 million additional funding notwithstanding the 110% increase in the budget for this year.

Table 1: HPN line item variances

R Thousands	15/16	16/17	17/18	18/19
2018 PROGRAMME 2	22,107	19,135	26,256	24,682
2019 PROGRAMME 3	168,800	19,400	31,400	49,800
Total	146,693	265	5,144	25,118

45. However, the inequity does not stop at the NDoH policy functions. It is carried over into the support of and allocation financial resources to **government units and non-governmental organisations.** We believe that the same skewed distribution is self-evident in Figure 7: CDs+ and NCDs+ comparison of funding for NGOs and SANAC.



'2020

INTEGRATED PEOPLE CENTRED HEALTH SERVICES

46. Despite the evident needs of our people, NCDs policy development, implementation and evaluation remains neglected at the all levels. In this report, we focus on the national and provincial levels. The people living with NCDs (PLWNCDs) rightly say, "it would be better if I have AIDS than diabetes, I would get care." PLWNCDs and their significant others demand accountability for equitable NCDs prevention and treatment within government health services. (2 ¶ 14) The time is long overdue for the meaningful and respectful involvement of PLWNCDs in NCDs policy making and stewardship towards attaining the SDGs. In the SDG-era language: "Nothing about us, without us." And "leave no one behind."(26) The lessons learned from the HIV epidemic and its management need to be applied equitably to NCDs. We want "batho pele" for PLWNCDs, not just compassionate care (27).

47. During December 2014 resolutions adopted at a SANCDA, multi-stakeholder NCDs health systems strengthening workshop were presented to Deputy Minister Dr Joe Phaahla.3 (28) Five years later these remain important unmet priorities.

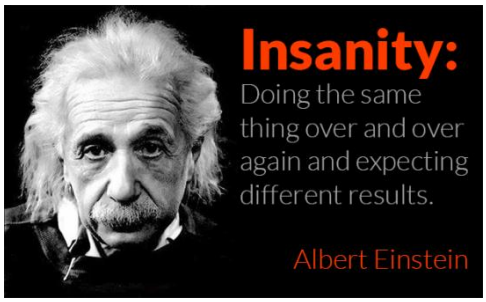
Figure 8: December 2014 meeting of the SANCDA with Deputy Minister Phaahla.

48. In March 2019 we again presented these to the NDoH representatives, this time to include Dr Yogan Pillay. (29) With hindsight, we understand that response must be considered a response. However, at this pivotal moment for us, no response is take as a very clear signal to civil society.

49. It concerns us immensely that many of the strategic processes currently underway, including the Presidential Health Summit and the development of a health compact, are insufficiently inclusive of PLWNCDs and related civil society voices. The exclusion reinforces divisions while retaining the fragmented MDGs fault lines like vertical siloes. It is reminiscent of the treatment of HIV activists in the AIDS-denialist era. New structures are being enabled together with privileged communication based on false categories. For example, SANAC, a government unit with funding of R17-million this year, was designated as the leader of the civil society stream. "Users" also known as the people who use the crisis-ridden services, were almost completely ignored. After expressing our dissatisfaction to both the former Minister and Professor Shisana, a "user" group was formed in an ad hoc and spurious manner driving wedges with civil society. It is also reminiscent of the Health Market Inquiry where the people who fund the who health system are largely unacknowledged and without a voice (30)(31).

[3] Adopted at the second national SANCDA multistakeholder NCDs convening with participants the included civil society and officials from the NDoH and seven provincial health departments. (28)

50. Processes such as these, are neither transparent nor informed by the SDGs, and it appears likely that, without reframing the thinking within these initiatives, these will be doomed to the same results. It reminds us of Albert Einstein's observation that "insanity is doing the same things over and over again and expecting a different result."



51. A different result a desperately need by PLWNCDs. We consider two critical steps will go a long way to achieve this: reframing the scope of NCDs and mainstreaming NCDs within national health policy and provincial implementation.
52. The SANCDA and members of the NCDs civil society community propose the three main interventions listed below to support transition to the SDGs and stewardship for people-centred health systems strengthening. We look forward to engaging with the Minister of Health as a matter of urgency. We stand ready to participate in achieving equity for PLWNCDs.
    a) **Transformation of NCDs+ to show political will by SDGs alignment and** it's positioning it equitably within the NHI to commence by the end of July 2019.
    b) **Mainstream NCDs** by:
        i) The urgent creation of a national multistakeholder intersectoral **high-level coordination and collaboration NCDs body within the NHI** (similar to SANAC) to commence by the end of August 2019 and be fully operational by 2021.
        ii) Developing and implementing an **overarching costed NCDs national strategic plan based on the revised NCDs+ scope** and positioning that overcomes the failings of the expired 2013-2017 plan.

INTERVENTION 1:
EMPOWERING NCDS+ SUBPROGRAMME TO FUNCTION EQUITABLY AND OPTIMALLY FOR THE SDGS

53. The NCDs+ group of illnesses were formerly know as chronic diseases. During the MDGs, in a move reminiscent of apartheid chronic illnesses were renamed and given a "non" status. So, for PLWNCDs, an important first step is that there is agreement on an inclusive operational definition of NCDs consistent with the SDGs. It is essential that the totality of the NCDs+ is clarified, acknowledged and accounted in policy. It status must be equal to that of the CDs+. It is a necessary step to bring coherence and a sense of inclusivity so there must be no orphan conditions. This applies as much to the big "killers" of lots of our people as it does to rarer illness that may just as easily cause catastrophic financial outcomes for families. Many illnesses with be interlinked by through comorbidity.
54. NCDs+ requires a clearly stated and endorsed operational definition for policy includes programmatic scope, consistent with the NCDs Political Declaration, includes but is not limited to, the key areas listed below. Most of these are already considered to be within the scope as noted in successive NDoH policy but it administration, resourcing and representation still occurs in silos. A suggested starting point exclusion from the reframing of NCDs that any item within the CDs+ programme and covered by policy with conditional funding attached and within the remit of SANAC. In time, it needs to be consciously realigned.
55. The NCDs+ consists of two parts the traditional chronic illnesses and the "public health subgroup"
    a) Chronic illness category
        - All conditions formerly know as chronic illness – all NCDs must be included under this umbrella term there must be strong leadership that coordinates a empowers all the different aspects.
        - The four main NCDs conditions responsponsible for premature mortality are regrouped by combining diabetes with heart and vascular disease, cancer and chronic respiratory illness. (SDG Target 3.4)
        - Mental health, substance abuse, neurological conditions (SDG target 3.4)
        - Disabilities and vulnerable populations a highlighted as NHI prioroite addressed from a NCDs perspective. Without carving out selectied vulnerable populations with in the HIV NSP notwithstanding, this includes the disabled and elderly vulnerable populations. The elderly were formerly inc.uded in this group.
        - Eye health
        - Oral health.
    b) Public health category
        - Health promotion and disease prevention that includes the risk factors of factors tobacco control, substance abuse, physical inactivity; and fiscal measures. (SDG targets 3.5)
        - Nutrition viewed holistically as both have strong links to poverty and food security (SDG 1)
        - Road traffic accidents. SDG target 3.8
        - The social and economic factors that influence health (SDH) – SDG 2.
56. The goal is to provide integrated person-centred NCDs health services with a focus on the primary health care level as defined by WHO. Indicators showing integration need development. Building integration is a deliberate strategy and must address the complex nature of the interplay of between SDH and NCDs without false separation. In the era of the SDGs we have creating a

silo for SDH and making it the domain of only CDs.

57. Other strategic include providing health services with implementation policy for provinces and other structures at district levels that are funded and achievable. (15)

INTERVENTION 2: MAINSTREAMING NCDS THROUGH A NATIONAL MULTISECTORAL COORDINATION STRUCTURE

58. Global NCDs policy calls for a NCDs multisectoral body, and it is one of the NCDs South Africa has consistently to address this issue head-on (3:¶ 18, 20, 25, 41, 45). The UN NCDs political declaration to which the SA government committed itself reaffirms that:

> *"… the primary role and responsibility of government, at all levels in responding to the challenge of [NCDs] by developing adequate national multisectoral responses for their prevention and control, and promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and underscore the importance of pursuing whole-of-government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches;"(3) ¶15.*

59. The SANCDA reaffirms that a reconfigured National Health Commission (acronym NHC+) must be established this financial year rather than the later date of March 2021 (23). A multisectoral coordination body to address the social determinants of health has lingered on the policy agenda since 2012 and is a unmet target of successive NDoH annual plans (32). We are convinced that this is passed its sell-by date and is at odds with the spirit of equity and integration implicit in the SDGs. (33) Such a body is coheret with SDG target 17.14 that looks at holistic policy so that it is coherent for sustainable development.

60. The NHC+ goal is create an environment for co-ordinated, consultative and critical action for the reframed scope of NCDs prevention and treatment within the NHI. Its organisational objectives and modus operandi are like those of the government unit, SANAC[4]. Given the development challenges experiences by SANAC, it is likely that NHC+ will require progressive realisation but must be time bound. A long-term objective is to combine SA National AIDS Council (SANAC) and NHC+ into a single organisation with expertise in each element required for NHI.

61. A priority of the NHC+ is to birth a comprehensive national NCDs strategic plan (NSP NCDs) which is the equivalent of the HIV/AIDs National Strategic Plan (34). Within in this structure is possible to create key committees by specific focus area to develop policy and related issues. For example, in the cancer domain will absorb the functions of the Ministerial Advisory Committee on Cancer.

62. The NHC+ requires operational funding and an enabling organisational structure to align and streamline the SDG 3 targets and activities and the NDP 2030 health targets other than those of the CDs+ cluster.

63. The positioning the NHC+ within NHI must institutionalise NCDs on an equitable basis with CDs+ in all service planning and resourcing. It is a critical step to signal the political will to prevent and treat NCDs+. This is stewardship measure recommended for integrated health systems strengthening so long denied to NCDs. (35)

INTERVENTION 3: MAINSTREAMING A NATIONAL STRATEGIC PLAN FOR NCDS (NSP NCDS)

64. A transparent people-centred NSP NCDs is long overdue and must not repeat the shortcomings of the previous plan. It must serve as the overarching integrated roadmap to achieve the an enlarged NCDs scope within the integrated SDGs vision. Its goals and objectives must reflect the negotiated needs of each "disease" condition area that are informed by intersectoral collaboration, population health data, and other important trends and research. It follows on an agreement of the empowered and reframed scope for NCDs54. The NSP NCDs is informed by evidence-based guidelines for specific key areas.

65. The 2013-2017 national NCDs plan expired with most of the 19 targets unmet and unmeasured over two year ago. The lack of specificity in the plan is epitomised in the contestation of even its start and end dates. In the April pre-election period civil society was alarmed by NDoH moves to hold consultations on the a revised NCDs plan. Communication, transparency and a lack of trust surround the invitation to a stakeholder meeting with five days' notice (36) and the circulation of the supporting documents:

    a. 2018 NCDs Review (37);

    b. 2019 NCDs concept note(38).

66. The contents must be studied with care when policy is revised. Instead, civil society participants were asked to give consent through "rubber stamping" or a "box checking" exercise. The engagement and communications process again show the lack of any respectful inclusion and transparency and drew objections from 18 civil society organisations serving PLWNCDs.[5] Many

---

[4] SANCA objectives https://sanac.org.za/about-sanac/

[5]List of SANCDA network organisations objecting to the short notice given to the NCDs policy consultation on 15 April 2019: Campaigning for Cancer, Cancer Alliance, Cancer Association of SA, Childhood Cancer Foundation, Dementia SA, Diabetes SA, Genetic Alliance SA, Global Mental Health Peer Network, Heart and Stroke Foundation SA, Hospice and Palliative Care Association of SA, Igazi Foundation, Lupus Foundation SA, National Kidney Foundation SA, Pink Drive, Rare Diseases SA, SA Anxiety and Depression Group, SA Haemophilia Foundation, CannaLand

were of us noted the 45 minute delay of the consultation and inaudible audio communication for most civil society participants.

67. Deputy Director-General, Dr Yogan Pillay, stated that there are no urgent timelines that call for the rapid development of a new NSP NCDs but the need for MTEF estimates for NCDs by July 2019.

68. We request the following interventions that are consider essential for the HIV NSP:

    a. Using and operationalising the reframed scope of NCDs ; (see ¶ 54
    b. Formation of a project team based within the NDoH, responsible for the development and implementation processes with a project plan;
    c. Concurrent review of the expired plan that addresses issues about why it failed with lessons learned from a population of engaged stakeholders including NCDs civil society organisations;
    d. Co-production that including NCDs civil society and PLWNCDs and other key stakeholders such as provincial officials. (3 ¶ 41& 42)
    e. A conceptual framework that includes equity, SDGs, PCH and people-centred integrated health services, indicators etc. (39)(40)
    f. NCDs are equitably embedded within the NHI/UHC processes;
    - Stakeholders agreement on policy priorities targets for each key area.
    - Financial costing, including the implementation of basic service packages (PMB that include patients and are transparent) indicators etc. at a provincial level. The current structure and functioning of the Council for Medical Schemes makes it elitist and separates it from the people it is supposed to serve and protect. PMB development is not inclusive of patients.

69. The NCDs Review requires further interrogation and must look at solutions and the lessons learned that are coherent and framed by integrative SDG concepts. (8) The SANCDA queried the status of the Review at many levels without response. Our most recent is a letter to Director-General Matsoso sent on 10 May 2019(41). This communication about our concerns remains unanswered and we still do not know the official status of the Review

70. There are many other possible interventions for the NSP NCDs that are accepted practice for CDs but are not equitably accessible. Some of these are listed below and remain recommended since 2014 (42).

    a. Health personnel capacitated to manage NCDs+ within NHI which requires careful consideration of how this is done;
    b. Task shifting or sharing for NCDs: like that undertaken for HIV, Nurse Initiated Management of anti-retroviral therapy (NIMART) but selected NCDs conditions. Programmes for the management of diabetes and hypertension have existed since for over 40 years without the necessary legal enablement to “initiate” and intensify therapy (43);
    c. Quality management of NCDs standards, practice guidelines, indicators and processes that conform to international standards. This must be done in a nationally agreed and transparent process similar to that of The UK National Institute for Clinical Excellence.

REFERENCES

1. United Nations Development Programme. UNDP support for the implementation of the 2030 Agenda for Sustainable Development. New York; 2016.
2. Schmets G, Kadandale S, Porignon D, D. R. Introduction. In: Strategizing national health in the 21st century: a handbook [Internet]. Geneva: WHO; 2016. p. 23. Available from: http://apps.who.int/iris/bitstream/10665/250221/29/9789241549745-chapter1-eng.pdf?ua=1
3. United Nations General Assembly. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases. In: A/RES/73/2 [Internet]. New York: United Nations; 2018. p. 1–7. Available from: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2
4. Niessen LW, Mohan D, Akuoku JK, Mirelman AJ, Ahmed S, Koehlmoos TP, et al. Tackling socioeconomic inequalities and non-communicable diseases in low-income and middle-income countries under the Sustainable Development agenda. Lancet [Internet]. 2018;6736(18):1–11. Available from: http://dx.doi.org/10.1016/S0140-6736(18)30482-3
5. NCD Alliance. Non-communicable diseases:A major challege for sustainable development [Internet]. London; 2015. Available from: http://bit.ly/2RntlVp
6. Department of Health. Strategic plan for the prevention and control of non-communicable diseases 2013-17 [Internet]. National Department of Health, editor. Pretoria: Department of Health; 2013. Available from: http://goo.gl/AqF2Ny
7. Brinkerhoff DW, Cross HE, Sharma S, Williamson T. Stewardship and health systems strengthening: An overview. Public Adm Dev [Internet]. 2019;39(1):4–10. Available from: https://rdcu.be/bFzrQ
8. Sachs J, Schmidt-Traub G, Kroll C, Lafortune G, Fuller G. SDG index and dashboards report 2018. New York; 2018.
9. World Health Organization. Framework on integrated, people-centred health services [Internet]. Geneva: World Health Assembley; 2016. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1
10. South Africa National Treasury. 2019 Budget health vote 16: estimaste of national expenditure [Internet]. Pretoria; 2019. Available from: http://bit.ly/2ZkLx4Q
11. South Africa Department of Health. Annual performance plans 2018/19-2020/21 [Internet]. Pretoria; 2018. Available from: http://www.health.gov.za/index.php/2014-03-17-09-09-38/annual-performance-plans?download=2513:annual-performance-plan-2017
12. Statistics South Africa. Mortality and causes of death in South Africa, 2016: Findings from death notification [Internet]. Pretoria; 2018 [cited 2018 Mar 28]. Available from: http://www.statssa.gov.za/publications/P03093/P030932016.pdf
13. WHO Regional Office for Africa. A heavy burden: the indirect cost of illness in Africa [Internet]. Brazzaville; 2019. Available from: https://goo.gl/Q7SuHE
14. GBD 2015 SDG Collaborators. Measuring the health-related Sustainable Development Goals in 188 countries: a baseline

analysis from the Global Burden of Disease Study 2015. Lancet. 2016;388(10053):1813–50.
15. World Health Organization. Saving lives, spending less A strategic response to noncommunicable diseases [Internet]. Geneva, Switzerland; 2018 [cited 2019 Jan 6]. Available from: http://apps.who.int/iris/bitstream/handle/10665/272534/WHO-NMH-NVI-18.8-eng.pdf
16. Institute for Health Metrics and Evaluation. Financing global health 2018: countries and programs in transition [Internet]. 2019 [cited 2019 May 29]. Available from: http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf
17. African National Congress. Election manifesto 2019 [Internet]. 2019. Available from: https://www.politicsweb.co.za/documents/the-ancs-2019-election-manifesto
18. Department of Health. Annual Performance Plan2014/15 - 2016/17 [Internet]. Pretoria; 2014. Available from: https://www.health-e.org.za/wp-content/uploads/2014/07/SA-DoH-Annual-Performance-Plan-2014-to-2017.pdf
19. Department of Health. Annual report 2015/16. Pretoria; 2016.
20. South Africa Department of Health. National HIV counselling and testing policy guidelines [Internet]. Pretoria; 2015. Available from: http://goo.gl/6Qdm5k
21. Department of Health. National Indicator Data Set (NIDS):Data element definitions April 2017 to March 2019 [Internet]. Health, editor. Pretoria: Department of Health; 2016. Available from: http://www.hst.org.za/sites/default/files/NIDS booklet 2016 FINAL 2dec2016.pdf
22. South African Government News Agency. Operation Phakisa betters health services [Internet]. 2nd ed. SANews.gov.za. 2015 [cited 2015 Sep 7]. Available from: http://www.sanews.gov.za/south-africa/operation-phakisa-betters-health-services
23. South Africa National Treasury. Vote 16 Health 2019-20: Estimates of national expenditure. Pretoria; 2019.
24. Director-General. Universal health coverage: Primary health care towards universal health coverage [Internet]. Geneva; 2019 [cited 2019 May 22]. Available from: https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf,
25. Pinkney-Atkinson VJ. Civil society status report 2010 - 2015: mapping South Africa 's response to the epidemic of non-c ommunicable diseases [Internet]. 2015. Available from: https://drive.google.com/open?id=0BwSCBZIT92UoZTJOalRPNTVIUm8
26. World Health Organization. Towards a Global Action Plan for Healthy Lives and Well-being for All : Uniting to accelerate progress towards the health-related SDGs [Internet]. Geneva; 2018 [cited 2019 Jan 24]. Available from: https://www.who.int/docs/default-source/global-action-plan/global-action-plan-phase-1-final.pdf
27. Department of Public Service and Administration. Batho Pele - " People first " White Paper on transforming public service delivery [Internet]. Government Gazette Pretoria, South Africa; 1997 p. 34. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/183401.pdf
28. Pinkney-Atkinson VJ. NCDs Kopano resoluitons letter. Johannseburg; 2014.
29. South African NCDs Alliance. NCDs prevention & treatment dialogue: Seeking a way forward in the SDGs era. Johannesburg; 2019.
30. Pinkney-Atkinson V. NCDs civil society exclusion from Health Summit, October letter. Johannesburg; 2018.
31. Pinkney-Atkinson V. Presidential Health Summit and involvement of NCDs civil society organisations letter. Johannesburg; 2018.
32. Perez a. M, Ayo-Yusuf O a., Hofman K, Kalideen S, Maker a., Mokonoto D, et al. Establishing a health promotion and development foundation in South Africa. South African Med J. 2013;103(3):147–9.
33. Pinkney-Atkinson VJ. Civil society status report 2010 - 2015: mapping South Africa 's response to the epidemic of non-c ommunicable diseases [Internet]. Johannesburg: South African NCD Alliance; 2015. Available from: https://drive.google.com/open?id=0BwSCBZIT92UoZTJOalRPNTVIUm8
34. South Africa Department of Health. National strategic plan for HIV, TB and STIs 2017-2022 [Internet]. Pretoria; 2017 [cited 2018 Nov 15]. Available from: http://bit.ly/319h6A7
35. Chan BTB, Veillard JHM, Cowling K, Klazinga NS, Brown AD, Leatherman S. Stewardship of quality of care in health systems: Core functions, common pitfalls, and potential solutions. Public Adm Dev. 2019;39(1):34–46.
36. Pillay Y. Stakeholder consultation: concept note informing the re-write of the National Strategic Plan on Non-Communicable Diseases 15 April 2019. Pretoria: National Department of Health; 2019. p. 3.
37. Freeman M. Review for the implementation of the South African " Strategic plan for the prevention and control of non-communicable diseases 2013-17". Pretoria; 2018.
38. Freeman M. Concept note for a policy framework and plan for prevention and control of NCDs. Pretoria; 2019.
39. Kanayson P, Dain K, Renshaw N. Ensuring health lives for all [Internet]. Geneva; 2018 [cited 2019 Jun 2]. Available from: https://ncdalliance.org/sites/default/files/resource_files/UHC and NCDs_EN.pdf
40. World Health Organization. Framework on integrated people-centred health services : an overview Vision Implementation principles.
41. SANCDA. Letter Director-General NCDs review 2018. 2019.
42. Alliance SAN-CD. NCDs Resolutions for health systems strengthening action [Internet]. 2014. Available from: https://goo.gl/tVRCNq
43. Pinkney-Atkinson VJ. Clinical nurse specialists in ambulatory tertiary health care. Nurs RSA. 1986;1(6).