ENGAGE AFRICA FOUNDATION

POLICY RECOMMENDATIONS FOR ADDRESSING BEHAVIORAL RISK FACTORS FOR NON-COMMUNICABLE DISEASES

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Executive Summary

The overarching mission of Engage Africa Foundation is to fight non-communicable diseases in Africa through elevating the voices and creativity of everyday people and increasing the global awareness of non-communicable diseases (NCDs) through research, health promotion and advocacy.

Addressing the burden that NCDs has to the health system, communities, and individuals is important to us. The World Health Organization (WHO) projects that NCDs will result in an upwards of 44 million deaths in the next decade globally (2015). In Africa, NCD related deaths are anticipated to be 3.9 million by 2020 (WHO, 2015). Although much of the health focus on the continent has been on communicable diseases, the increase in urbanization with challenges such as pollution, poverty, high stress levels, and the globalization of the commercial determinants of disease such as tobacco and fast foods coupled with weak health systems has resulted in the surge of conditions such as heart disease, high blood pressure, cancer, chronic respiratory conditions and the alike. This issue demands our attention, collaboration, and political power.

At Engage Africa Foundation, we asked – how exactly are African countries doing so far in the fight against chronic diseases, and where should critical investments be made? This launched us into a project to create policy tools to inform civil society, political leaders, global health influencers, research, practice and community groups on where we need to come together to fight chronic diseases in Africa. This particular report samples countries across Africa to identify how they are doing thus far, in comparison to the best practices required for addressing behavioral risk factors for chronic diseases on the continent. Upcoming reports will tackle health system infrastructure and environmental risk factors in more depth.

The WHO created a 2015 report on the status of major health risk factors for non-communicable diseases: for the WHO African region. The data from these surveys show us that most adults have one of the five major risks factors, and about 25% of adults have at least three of the five major risk factors for NCDs. These include: being a daily smoker; consuming less than five

serving of fruits and vegetables per day; low level of physical activity, being overweight; and having high blood pressure. Major risk factors are based on findings from the STEPwise and global school-based student health surveys, which is a tool that was used to help collect population-based information. The data from these surveys show that the median prevalence of tobacco use was 12% among adults, 7% for smoking among youth, 21% of alcohol use among adults, 13% for heavy episodic drinking among adults, and 16% among youth. The data also revealed that most adults were not consuming recommendations of 5 servings of fruits and vegetables per day---the average was 2.8 days per week among adults, and an average of 1 serving per day, and for vegetables the median was 4 days per week. The prevalence of physical inactivity (less than 600 metabolic equivalent minutes per week) was a median of 22% among adults. In terms of physical activity--32% youth reported spending 3 or more hours being sedentary and the prevalence of being overweight was a median of 35% among adults. In relation to chronic disease, the prevalence for hypertension was a median of 31% and the median prevalence of pre-diabetes was 4% among adults. Lastly, a median of 14% was reported for the prevalence of raised total cholesterol (WHO, 2015).

We want to see everyone on the continent aware of how to prevent and manage non-communicable diseases and be empowered to pass the message on. This is done through the work of people like you: community advocates, health professionals, policy makers, political leaders, and scientists. Policy change can have a significant impact in either aiding or inhibiting the work that you do. This policy brief was created to support and advance your work. This literature review and policy brief is informed by research from the World Health Organization, research from other professionals in the field, and examples of success from the work other organizations have done. Our team has compiled a brief addressing the main areas of concern we identified through research of the current country statistics and WHO country profiles on NCDs.

Our research was limited by the limited availability of NCD data in certain areas, the lack of knowledge on the capacity to carry out interventions and policies, as well as the lack of key informant interviews to better understand the context of local and national needs. This work could further be strengthened through key informant interviews and knowledge of capacity and funding to better make this research more specific. It would also be further strengthened by

future development of data systems to research NCDs in African countries, to meet the paucity of current data available.

This work is to be the catalyst to advise and enhance the policy work of your nation, to understand the policy context and understand gaps that need to be addressed to make maximum impact in fighting this epidemic. We would love to connect with you and support you. For comments and collaborations, please feel free to follow up with our team: info@engageafricafoundation.org.

Yours in solidarity,

Ebele Mogo, President

on behalf of the entire Engage Africa Foundation Team

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I. Review of the 7 Priority Action Steps for NCD Prevention and Management in Africa

Our team conducted a literature review on the priority action steps that we identified as crucial for preventing and managing NCDs in Africa. The areas we identified are: reducing tobacco use, creating a population based-cancer registry, creating a national strategy to promote physical activity, creating a national strategy to promote healthy diets, creating a national surveillance system, and establishing primary care. In order to inform our understanding of these areas of priority, we looked to research institutions such as the World Health Organizations and summarized their recommendations on the best practices to tackle non-communicable diseases. This literature review has informed the recommendations that we made for the selected countries.

a. Reducing Alcohol Use

According to the World Health Organization (WHO) (2010) alcohol abuse ranks 3rd globally as one of the risk factors for poor health outcomes. Alcohol abuse increases the risk for non-communicable diseases, which are largely preventable through the modification of behaviors and systems to decrease the harmful use of alcohol (WHO, 2011). A global and national level approach to curtail the adverse effects of alcohol misuse and abuse involves the recognition of the intersections between as the WHO states, "harmful use of alcohol and socioeconomic development" (WHO, 2010, p.3). The WHO's report on strategies to reduce harmful alcohol use provides a multiple of policy options and interventions (2010). These strategies involve the collaboration of national, state, and local governments, policymakers, health and public health professionals, community workers, and citizens in order to improve the health of communities. A majority of the research and work done on interventions for reducing alcohol abuse come from high incomes countries, however, each individual country must modify their interventions based on the context and needs of the country.

For sustainable impact the WHO recommends first having "strong leadership, solid base of awareness, political will, and commitment" (WHO, 2010, p. 11). Having strong leadership is important for pushing the direction and vision of the policy and intervention, disseminating responsibility, and also for increasing the engagement of stakeholders. The policies must be informed by evidence-based research and should ensure access to information through education and increasing public awareness about the importance of the policy and measure to reduce the abuse of alcohol (WHO, 2010).

Another area of intervention involves health services (WHO, 2010, p. 11). Health services are important on the primary level of prevention and tertiary level of treatment to those at risk or impacted by alcohol related ailments (WHO, 2010). The WHO recommends that health services engage the community as part of prevention efforts, as well as engage stakeholders outside the realm of health (WHO, 2010). Systematically, health services require funding in order to be equipped with the resources and staff in order to take on the burden of alcohol related health problems.

Mobilizing the community for action is also another important strategy for reducing alcohol use (WHO, 2010). Communities should be back by their local governments and engaged to use their "local knowledge and expertise" in creating appropriate and cost- effective strategies to reduce and prevent alcohol abuse (WHO, 2010, p. 12).

The WHO also recommends policy interventions to reduce alcohol use, that involves drinking & driving policies (WHO, 2010). In order to reduce alcohol motor related deaths and injuries, policies that enforce policies against driving under the influence, as well as interventions that decrease the likelihood of a person driving while intoxicated are important measures for reducing the risks of alcohol abuse.

Another recommendation that the WHO makes involves decreasing the availability of alcohol (WHO, 2010). Strategies that serve to regulate access to alcohol via the regulations of operation times and days; advertisements; age restrictions; licensing of vendors; the quantity and placement of outlets; and selling of alcohol during events are among the evidence based strategies proven to restrict the sale and manage the availability of alcohol (WHO, 2010, p. 14-15). In addition creating policies that would not result in the growth of an underground market is important for not undermining the policy efforts for to reduce alcohol abuse (WHO, 2010).

By regulating the advertisements of alcohol products, it can help to reduce its spread and appeal(WHO, 2010). In order to reduce the impact of advertisements on youth, it is important to create regulations that control the content, quantity, and various forms of marketing that is directed towards youth (WHO, 2010). Another policy recommendation is to increase the warning labels on alcoholic beverages (WHO, 2010).

The next strategy involves controlling pricing (WHO, 2010). Instituting pricing policies can be a great way to reduce drinking, particularly among youth (WHO, 2010). It is a proven that increasing the price of alcoholic substances is an effective strategy to reduce alcohol abuse (WHO, 2010). The concern with this policy is that an increase in prices, may result in the development of illicit markets (WHO, 2010). To address this unintended consequence, efforts must be make by the government to manage and reduce the growth of these markets (WHO,

2010).

Lastly, the WHO stresses the importance of creating monitoring and surveillance platforms (WHO, 2010). Developing information systems that help to collect and organize data is vital for assessing the success and areas of improvement in interventions and policies (WHO, 2010). Data can be used to strengthen the work that is already being done by proving it's effectiveness. In addition data can be used to advocate for more resources and support from local, national, and global governments and organizations. It also helps to capture that story of what is happening and increases awareness of public health issues.

b. Reducing Tobacco Use

Tobacco use is another risk factor that has contributed to rising non-communicable disease rates in Africa. It is a "preventable cause of death in the world," and is among the leading risk factors for various cancers and other poor health outcomes (WHO, 2008). Tobacco use is usually framed as a behavioral issue that can be resolved through individual change, however, there is in fact a "powerful global industry that spends tens of billions of dollars annually on marketing" that shapes individual decisions, access to education and resources (WHO, 2008, p.7). Reducing tobacco use requires strategic systematic change.

The WHO Framework Convention on Tobacco Control (WHO FCTC) created a policy pack called Mpower that includes policies, interventions, and strategies for mobilizing political and financial resources to control tobacco use (WHO, 2008). Mpower stands for "monitor tobacco use, protect people from tobacco smoke, offer help to quit tobacco use, warn about the dangers of tobacco, enforce bans on tobacco advertising and promotion, and raise taxes on tobacco products" (WHO, 2008, p. 10).

The letter in Mpower "M" is to "monitor tobacco use" (WHO, 2008, p. 12). This is done through collecting and assessing "nationally representative and population-based data based on key indicators of tobacco use for youth and adults" (WHO, 2008, p. 12). The second letter "P" stands for "protecting people from tobacco smoke" (WHO, 2008, p. 12). In order to protect people from tobacco smoke the WHO recommends creating and enforcing policies that require a smoke-free environment in various occupational and vocational settings (WHO, 2008, p.12). The third letter "O" stands for "offer help to quit tobacco use" (WHO, 2008, p. 12). This involves creating and bolstering health systems so that they can provide tobacco cessation resources, create community programs, and provide access to low cost treatment (WHO, 2008). The fourth letter "w" stands for "warning about the dangers of tobacco" (WHO, 2008, p. 12). This initiative requires warning labels on tobacco products as well as advertising to discourage the use of tobacco related products (WHO, 2008). The fifth letter "E" stands for "enforcing bans on tobacco advertising, promotion, and sponsorship" (WHO, 2008, p. 12). This entails creating and enforcing policies that prohibits explicit and implicit tobacco advertising, promotion and sponsorship (WHO, 2008, p. 12). The sixth letter "R" stands for "raising taxes on tobacco products" (WHO, 2008, p. 12).

This means raising taxes on tobacco products as well as monitor and reduce the sale black market tobacco products (WHO, 2008, p. 12).

Institutionalizing and implementing practices and policies to control tobacco use requires the collaboration of and commitment of the government, academia, health orgs and hospitals, health care workers and advocates, and also community support (WHO, 2008). Implementing the goals of the mpower policy package necessitates the importance of policies and interventions that are not only informed by data, but also have an evaluation and monitoring process (WHO, 2008).

c. National Population Based Cancer Registry

National population-based cancer registries (PBCR) are essential to developing a complete picture of a country's cancer burden and, in turn, informing the policy responses to it. PBCR's centralize and organize cancer data in a given geographical region and provide vital information to governments, health authorities, and civil society in order to plan and evaluate health services. Very few sub-Saharan African countries currently have what is considered a 'high-quality' PBCR, but the literature shows that progress has been made toward establishing registration systems in many regions and that resources are available to those countries interested in developing or strengthening their own registries.

The Union for International Cancer Control argues that cancer registration is always feasible because cancer is, relative to other diseases, easy to monitor (Union for International Cancer Control [UICC], n.d.). As the literature shows, cancer registries do not need significant resources and, in the long run, the benefits of having one are well worth the minimal costs associated. However, PBCR's still face the same challenges as many other health services, including a lack of dedicated financial resources and a lack of expertise.

'National' population-based cancer registries are in reality smaller, geographically- stratified registries that work individually or in tandem with others to be a representative sample for the entire nation. The UICC (n.d). notes that building PBCR can be challenging due to the cost to implement and also due to the scale of the work. In order to evaluate and monitor cancer on a population level, it requires accessing a sample of the national population, which can then be used to explain national level data (UICC, n.d.).

To establish an effective sample, a geographic area with relatively well-developed diagnostic and treatment services should be chosen so that almost all residents will be diagnosed and treated there. An effective PBCR must collect information on every case of cancer within its identified population area, and it must be able to distinguish between residents of said area and those who are visiting from outside of it (Bray et al., 2015). Additionally, residents who seek treatment outside of the identified area must be accounted for.

It is important to note that a well-functioning registry must engage in an 'active' search for cancer cases (where registry staff track down cancer case information directly from health records and facilities themselves), because 'passive' registration (where health care professionals are responsible for notifying the registries of new cases) will never result in a complete and

accurate registry (UICC, n.d.). The basic infrastructure of a PBCR (staff, office space, running expenses, etc.) does not generally require significant resources (the Kampala registry in Uganda, for instance, covers a population of 2 million people with only 3 staff members), but it must be sustainable - as the UICC argues, no registry can survive long term as a research project or based on funding provided by outside donors.

Collecting information for the registry from multiple sources is essential to its completeness and validity. One survey found that current registries in Africa use an average of 9 sources for obtaining cancer incidence data (Gakunga & Parkin, 2015). Duplicate reporting of the same case is far less of a concern than under-reporting, since CanReg5 (the widely-used software developed by the WHO for cancer registries) can detect these duplicates (Bray et al., 2015). Important sources for data include both public and private hospitals/clinics, hospice/palliative care services, pathology labs, clinical hematologists labs, MRI and CT service providers, pharmacies, and death certificates (Bray et al., 2015). O'Brien et al. (2013) stress the need to link cancer cases across hospital departments (pathology, surgery, and medical oncology/radiotherapy), since their experience in Ghana showed that data on cancer incidence was only recorded in one department.

The International Agency for Research on Cancer (IARC) advises against including too many variables in a cancer registry. It reasons that since data is collected from secondary sources and not directly from the patients themselves, one should be careful not to include information that cannot be reliably collected on 80-90% of cases (Bray et al., 2015). Registries should include information on the patient (name, personal identification number, date of birth, sex, ethnic group, address & telephone number), the tumor (incidence date, primary tumor site, laterality, tumor histology, behavior, basis of diagnosis, TMN stage, initial therapy/treatment undertaken), the sources of information for each diagnosis and treatment modality (e.g. date and hospital/lab number), and follow-up information (last follow-up date, vital status, date of death). A full list of recommended variables can be found in Chapter 4 of IARC Technical Publication No.43.

The degree to which cancer registry data can be considered high-quality depends on four main features – comparability, validity, timeliness of reporting, and completeness (Bray et al., 2015). There can, of course, sometimes be a trade-off between completeness and timeliness of reporting. When it comes to reporting results, registries have a few options. Cancer incidence reports are the most basic way for registries to present data and should ideally be released annually, though smaller registries that cover fewer annual cases sometimes release theirs in

longer intervals of 2-5 years. Information and data from registries can also be disseminated through websites, research articles, press releases, and direct communication with health authorities, clinicians, academics, and the media (Bray et al., 2015).

It is extremely important that each registry establishes a fruitful working relationship and active engagement with their respective health authorities (both regional and national), as the literature shows there is commonly a disconnect or lack of support here (Gakunga & Parkin, 2015). To this end, some recommendations include having a registry representative serve as a member of any steering committee or advisory group of relevant health authorities (Gakunga & Parkin, 2015), as well as including the registry directly as a part of the health information system of these health departments (Bray et al., 2015). It is vital that every PBCR has the legal authority to request and obtain detailed clinical information on cancer cases from diagnostic/treatment facilities, so it's helpful to have functional linkages to government health services, other professional groups, or to be located inside a regional hospital (Bray et al., 2015). Finally, an advisory committee for the registry itself should be created and should consist of members from the public health, clinical, and academic communities (Bray et al., 2015). These committees should oversee activities, formulate training and review policies, and ensure that results and data are made available to decision makers. While the above presents a general outline for the development of a successful national population-based cancer registry, a great deal depends on the local context of each nation (their available resources, healthcare/insurance system, conflict status, etc.).

d. Creating a National Strategy to Promote Physical Activity

Non-communicable diseases (NCDs) are on the rise in Africa due in part to a decline in physical activity from increases in urbanization, sedentary work and motorized transport (WHO, 2014; Muthuri et al., 2014). It is critical for African nations to address the problem of NCDs by adopting, developing and implementing health promoting strategies specifically aimed at increasing physical activity. Strategies to increase physical activity will vary according to each country's socio-cultural, political and economic context, national public health priorities, funding for prevention and control for NCDs and national capacity (WHO, 2013).

Partnerships & Policies

To develop and implement policies that increase physical activity there should be a forging of partnerships between multiple agencies in the public and private sector that should be co-ordinate by Ministries of Health (Shilton et al., 2007; WHO, 2004). Governments should adopt or implement national guidelines for physical activity (WHO, 2013). Physical activity policies should be integrated within various sectors (urban planning, education, recreation, labour and health) with the aim of reducing barriers to physical activity by increasing safety and accessibility to health-enhancing environment(s) (Shilton et al.,2007; WHO, 2004; WHO, 2013). To effectively develop and implement physical activity interventions there should be high level of political commitment and funding (Shilton et al., 2007; WHO, 2005). There is also a need to rigorously evaluate government-sponsored physical activity interventions thereby connecting applied research directly with policy for evidence informed decision-making (WHO, 2013; Parra et al, 2013). Community interventions that are shown to increase physical activity and are cost-effective have the potential of being scaled up to other townships/cities and could be implemented nationally (WHO, 2013; Parra et al, 2013).

Community Involvement

Integrating physical activity into daily living requires understanding the cultural context gender issues, social norms, religious values to create culturally competent ways to engage in physical activity (WHO, 2004; WHO, 2010). The security situation at the national/local level and availability of safe spaces should also be considered (WHO, 2010). Environments should also facilitate physical activity through the provision of supportive infrastructure and suitable facilities in workplaces, schools and in neighborhoods (WHO, 2010). A 2014 school-based study by Kinsman et al. on South African adolescent girls study determined that barriers to physical activity were attributed to poverty, body image ideals, gender, family life, demographic factors, perceived

health effects and human and infrastructure resources. There was push back among school administrators, parents and peers that resulted in a deprioritized of physical activity among girls (Kinsman et al., 2014). Administrators worried that physical activity deviated from academic work, parents were concerned about the safety of their daughters and peers thought of thinness as associated with the having HIV AIDs (Kinsman et al., 2014). These cultural and social factors disincentive girls from engaging in physical activity, that coupled with lack of appropriate sports infrastructure and trained sports teachers and youth leaders compounded the problem. To address these barriers and facilitate physical activity among girls a two-prong strategy was suggested: (1) providing resources and training individuals, schools and organizations and (2) awareness raising through empowering health messages, incentivizing physical activity and encouraging parental engagement (Kinsman et al., 2014). One incentive for engagement in physical activity involved a conditional cash transfer in the form of payment s and/or healthy food vouchers given to families that fulfil the requirement of having their daughter(s) participate in physical activities and competitions (Kinsman et al., 2014).

Communication & Information dissemination

Public health messages to promote physical activity should be simple and direct (WHO, 2004). The dissemination of messages on the recommended levels of physical activity can be performed through various channels (print media, electronic media, role models, advocates etc.) (WHO, 2005). Additionally, awareness raising of health professionals and groups can be delivered to a target population (WHO, 2005). To maximize impact, communication campaigns on physical activity should be linked to supporting actions within the community (WHO, 2013). There should also be national awareness campaigns to bring attention to the importance of engaging in physical activity (WHO, 2005).

e. Creating a National Strategy to Promote Healthy Diets

For the national strategy to succeed in promoting a healthy diet, commitment is needed from the government to work with international and national agencies as well as relevant ministries within it and with private sector enterprises.

In the process of creating a national strategy, data and research analysis is crucial for assessing the current situation (WHO, 2004). Diets can differ among age, sex/gender, and culture, so specific attention should be paid in regards to the differences amongst these groups and how they may change over time. Also, in the data and research process, researchers should establish which diets are related to NCD prevalence. This piece will guide what type of policies and interventions need to be created. This research should be let by a group of experts and other select stakeholders in order to prevent bias. Lastly, the research should monitor and evaluate the impact of the policies and initiatives in promoting a healthy diet (WHO, 2004).

The process of creating a national strategy to promote healthy diets also involves the development of government policies, and federal funding to support intersectoral collaboration between governmental and private sectors. Intersectoral collaboration involves supporting local authorities with the resources to implement these policies. Additionally, federal funding should be provided to ministries of health, education, transport, and agriculture who are all key to ensuring that these policies are effectively implemented. It is important to support the ministry of education, because they can play a key role in ensuring that children learn about healthy diets and are provided with school lunches that meet the national dietary guidelines (WHO, 2008). Another strategy that the government can use to promote healthy diets is through the use of taxation. This can be used to discourage the purchase of unhealthy foods, but policy makers should also be aware that it does not negatively affect vulnerable populations. The regulation of advertising and marketing of products that target children is also important to the work of promoting health diets (WHO, 2004).

Another important part of creating national strategy is making sure that information on health diets is accessible to everyone. Information provided needs to be easily understood by all. Therefore, the literacy levels of various groups must be taken into consideration (WHO, 2004). Proving parents and caregivers with the information and material to instill a healthy diet in their

children is key in preventing and controlling NCDs related to a poor diet. Incorporating health literacy not only to schools but also to adult education programs to achieve a fully comprehensive education on healthy diets. This is a sure way to reach every aspect of the population (WHO, 2004).

f. Creating A National Surveillance System

Through the literature review, it has become evident that like the recommendations made on establishing a national strategy to combat NCD risk factors, government commitment and collaboration with various stakeholders is the key for a functioning surveillance system. It is clear that many aspects of the surveillance resources themselves need to be tackled before any data can be collected. This starts with making data collection for NCD risk factor a priority for governments. (Ye et al, 2012, p.2)

Taking Sub-Saharan African (SSA) countries for example, we can immediately see red flag areas of concern. There has been a lack of commitment and political will as well as many instabilities and war that has prevented data to be collected over a continuous period. Although some data has been collected, it has resulted in an unclear situation as to the realities of NCDs in these countries.

Efforts have been made to increase the number of health and demographic surveillance systems (HDSS) with 32 sites in SSA, however, it only investigates a defined population thus not reaching the entire population. (Ye et al, 2012, abstract)

(For all the 32 sites see https://www.mcgill.ca/lifehistoriesandhealth/data/hdsssites)

Furthermore, if governments do not use the data collected within these sites to change policy, any system in place becomes redundant.

Governments must first examine the location of these HDSS sites and move them strategically so that it can give the most comprehensive overview of the NCD situation and not just to a select portion of the population. HDSS can only serve as a short-term solution to tackling the NCD problem and governments must immediately begin to enact a civilian registration and vital statistics (CVRS) system which will reach every person in the country. The CVRS system must take into account the WHO surveillance strategies of STEPwise and Global School Based Student Health Survey (GSHS) which will be discussed further in this paper. They also need to widen the scope for surveillance to include those based in rural areas, children who do not have access to education, vulnerable groups etc. The planning of this surveillance system will involve

all ministries of the government from health, finance to planning are relevant stakeholders. Governments must understand the importance of enacting a permanent and continuous CRVS systems as well as establishing qualified teams to unbiasedly asses the data and present the findings to the government. The government, then needs to find political will to use these findings to introduce or change policies. Only when all these steps are taken, will the national surveillance system for monitoring NCDs be effective.

The WHO Guiding Principles of NCD Surveillance:

i. Identification and description of the key NCD risk factors, using recommended WHO definitions. ("Risk Factors"2017)
ii. A standardized approach for conducting surveillance of risk factors to allow international comparisons within and between countries.
iii. Continuous risk factor surveillance.
iv. Providing data for policy.

As we briefly touched on 3 and 4, we will be outlining the standardized approach as recommended:

The STEPwise approach is a method of gathering and analyzing data as well as establishing how to effectively put the results to use. It is simple and flexible, allowing governments to tailor it to local and regional interests. ("STEPwise," 2017)

The STEPwise approach consists of 3 parts. The first two are questionnaires regarding data on NCD risk factors such as tobacco use and nutritional status and information on the individual including height, weight, etc. The questions regarding NCD risk behaviors should be "simple and few in number and are not intended to give a complete picture of each behavior but rather to provide info on the population distribution at risk" ("STEPwise," 2017). The third step is a little bit more complex as it requires blood to be collected and analyzed to get more of an in depth result. While steps 1 and 2 are considered "desirable and appropriate for most developing countries", the third step can only be completed if the resources are available and can result in the increase of funds needed and make collecting data more complicated ("STEPwise," 2017). The third step can

only be completed when steps 1 and 2 are established and yielding consistent data.

GSHS is a surveillance project which collects and analyses data on risk behaviors in 10 key areas such as alcohol use and dietary behaviors for people between 13-17 years old. Like the STEPwise approach, it requires students to fill out a questionnaire which is a low cost solution to collecting data ("Global School," 2017).

If countries want to get more specific data on a certain risk factor, they can conduct a more detailed questionnaire such as the Global Youth Tobacco Survey which focuses on pin pointing tobacco use in adolescence between the ages of 13-15 ("Global Youth Tobacco," 2017).

Outlining these surveillance methods enshrined by the WHO almost lets us believe that collecting data can be an easy task. However we must be realistic especially when dealing with developing countries as to what resources are actually available on the ground. No matter how comprehensive and simple these steps may be, it is not useful if data cannot be collected. If there are not good resources on the ground, any data collected will be lost and no policy change can come from it.

g. Establishing Primary Care

One of the major issues around primary care on the continent is the lack of trained health workers (Fairall L, Bateman E, Cornick R, et al., 2015). The rising prevalence of non-communicable diseases is increasing the burden on primary care. In order address the challenges with primary care, the Knowledge Translation Unit of the University of Cape Town Lung Institute created packages to support health workers. The Practical Approach to Care Kit (PACK adult) is made up of policy and evidence-based guidelines, trainings, such as non-physician prescribing, and a "cascade system of scaling up" (Fairall L, Bateman E, Cornick R, et al., 2015). The PACK Adult's has 20 guidelines which includes "symptom-based algorithms" and a checklist to help health workers to "Assess, Advice, and Treat" patients' condition. The trainings focus on educational outreach as well as guidelines for health workers such as nurses. Through the trainings, nurses can also learn how to prescribe medications for chronic disease management (Fairall L, Bateman E, Cornick R, et al., 2015).

Before implementing the PACK Adult, it is important that the guidelines are appropriately adjusted to fit local needs and can be feasibility based on current policies, resources and health services (Fairall L, Bateman E, Cornick R, et al., 2015). Also if face-to-face training is not feasible, on screen training should also be considered as a way to train health workers. It is also important to note that if this package is used by non-physicians that they are given the authority to prescribe medications. Lastly, it is important to ensure that sufficient funding is given to sustain this program (Fairall L, Bateman E, Cornick R, et al., 2015).

II. Policy Briefs

After conducting the literature review, we used information from current events as well as the WHO's Country Profiles on Non-Communicable diseases, to assess a sample of West African countries to see their alignment with these best practices. The countries we selected were Nigeria, Gambia, Mali, Mauritania, Niger, Senegal, and Cape Verde. We selected a few West African nations as a pilot to inform further investigations. These briefs include an executive summary, brief overview, and key recommendations we felt were important to highlight based on our understanding of current events.

Nigeria

NCD POLICY BRIEF

EXECUTIVE SUMMARY

- Cardiovascular diseases are the highest contributors to Non-Communicable disease (NCD) related deaths in Nigeria, closely followed by cancer and diabetes (WHO, 2014).
- Areas of opportunities exist to translate research available into actionable solutions. However, this is challenged by the lack of various levels of resources to sustain this work in addition to lack of political will on the local and national level.
- Tackling issues such as alcohol abuse and misuse, and the promotion of healthy diets and physical activities, can all be supported by strengthening the primary care system to alleviate the health and economic burden of non-communicable diseases.

OVERVIEW

Nigeria is facing the same problems as any other country emerged in urbanization. The drastic changes in lifestyle that come with the stress of modern day living, fast food, and sedentariness, are just some of the main contributors. The government of Nigeria introduced the National Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases in 2015, in order to reduce the growing burden of NCDs. This plan of action is anticipated to be effective by 2020 (National Strategic Plan 2015).

The 2014 Census by the World Health Organization (WHO) estimates that non-communicable diseases (NCDs) account for 24% of Nigeria's mortality rate. Cardiovascular disease and cancer are the primary contributors to this figure.

While the policy team at EAF understands the limited resources available to Nigeria with respect to health reform, transparency about ongoing issues is important for stakeholders' capacity building efforts. The primary areas of concern include:
Implementing strategies to reduce and prevent alcohol abuse and misuse
Decreasing the rising rates of diabetes and high blood pressure through health promotion of healthy diets and physical activity strengthening the primary care sector.

Nigeria

NCD POLICY BRIEF

RECOMMENDATIONS

Alcohol Abuse Control

The total alcohol consumption per capita among drinkers (15+) in liters of pure alcohol, is 25.6 for males, and 17.7 for females. The prevalence of heavy episodic drinking is 11.3% for males (15+) and 2% for females (15+) (WHO, 2014). In order to reduce alcohol abuse Nigeria must:

1. Galvanize a multi-sector collaboration among the national, state, and local governments, health professionals, community workers, and citizens in prevention efforts. (WHO, 2010).
2. Create and enforce drinking and driving policies to reduce alcohol motor related deaths and injuries (WHO, 2010).
3. Decrease the availability of alcohol through regulation strategies (i.e. advertisements, age restrictions) (WHO, 2010).
4. Regulate the marketing of alcohol products to youth (WHO, 2010).
5. Control pricing (WHO, 2010).
6. Create monitoring and evaluation plan to measure the impact of alcohol control interventions (WHO, 2010).
7. Legally require the placement of health warning labels on alcohol advertisements (WHO, 2010)

Healthy diet promotion

Nigeria has seen its traditional diet of fiber rich carbohydrates, minimal fat and sparing protein replaced with foods high in salt and sugar (National Nutritional Guideline, 2004). This is reflected in the rise of obesity (6.5% of adults) (WHO, 2014) and prevalence of raised blood pressure in adults (34.8%) (WHO, 2014). In order to increase healthy diet promotion, Nigeria must:

1. Review school and university curricula to include emphasis on nutrition programs and physical activity education. Programs like Nestle Healthy Kids Program (Nestle, 2015) is a step in the right direction. The education on healthy diets must also extend into community based programmes.
2. Control the availability and advertisement of unhealthy products, particularly towards children. Limit the availability of products that are high in salt and sugar content. This could be done through taxation, in which the collected tax could be used to support local businesses that are promoting healthier diets or similar initiatives (National Action Plan, 2014).
3. Implement surveillance and data collection on physical activity patterns and dietary habits (Oyeyemi, 2016).
4. Create inclusive and participatory national policies on physical activities and healthy diets could be developed (Abaraogu et al, 2016).

Primary care

Currently, Nigeria does not have national guidelines for the management of major NCDs through a primary care approach, as it lacks the capacity to provide essential health services due to issues with equipment, distribution of health workers, and condition of infrastructure (Chinawa, 2015). In order to address these issues, the government must:

1. Address overlapping responsibilities in the provision of healthcare services by establishing a clear division of roles and authorities (Kress, 2016).
2. Increase health care spending.
3. Develop an incentive based approach to address the unequal distribution of health workers throughout the country to ensure that quality and critical healthcare services reach populations located in remote areas.

Gambia

NCD POLICY BRIEF

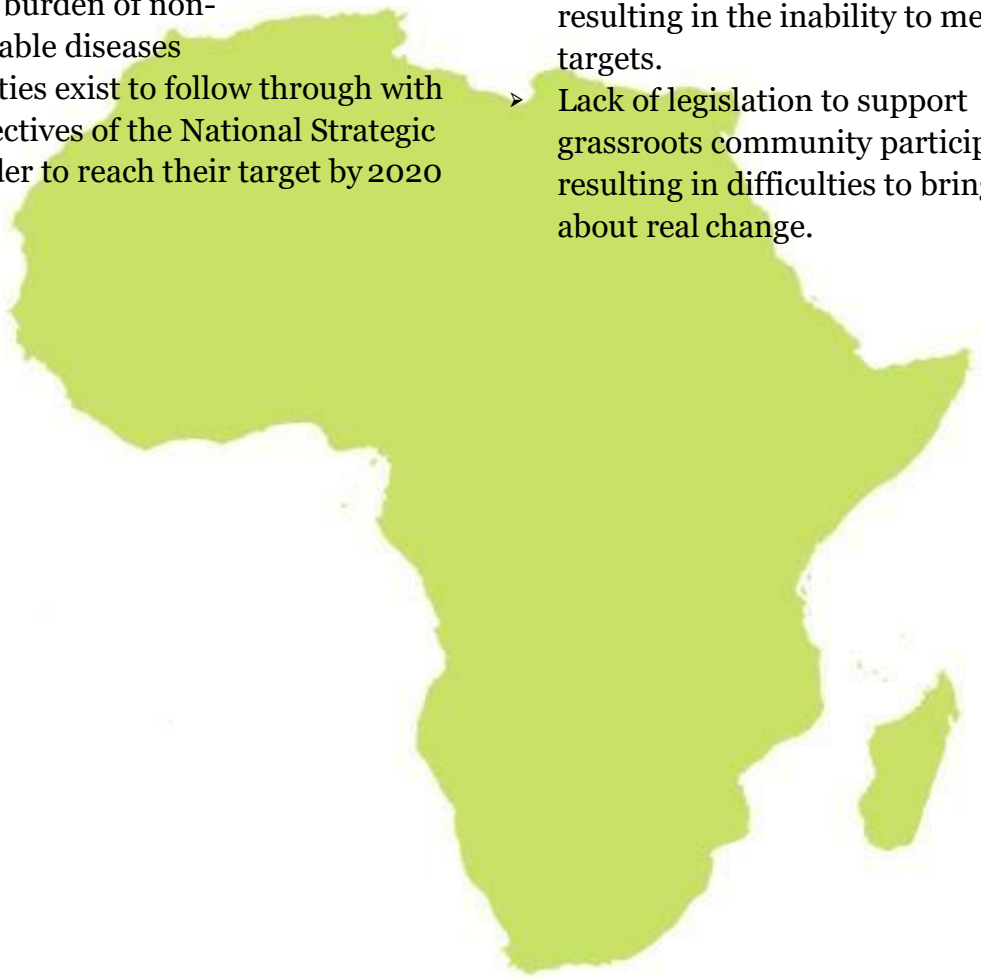
EXECUTIVE SUMMARY

- Cardiovascular disease is the highest contributor to NCD related mortality rates in Gambia (WHO, 2014). Gambia is still affected by malnutrition, there is a high prevalence of stunting among children (NLiS, 2014).
- The Government of Gambia has introduced the National Strategic Plan (2014-2020) that aims to reduce the burden of non-communicable diseases
- Opportunities exist to follow through with all the objectives of the National Strategic Plan in order to reach their target by 2020

OVERVIEW

The 2014 WHO Census for Gambia estimated that NCDs account for at least 32% of deaths in the country. The figure represents a gradual, but significant rise in NCD mortality rates. Although the Government of the Gambia has made positive steps to get NCDs under control by establishing clear objectives and strategies to be completed by 2020, significant institutional challenges remain. The primary areas of concern include:

- Lack of resources available between multiple health-related services, including school meals, health education, and surveillance programmes.
- Lack of coordination to effectively implement the National Strategy Plan, resulting in the inability to meet critical targets.
- Lack of legislation to support grassroots community participation, resulting in difficulties to bring about real change.



Gambia

NCD POLICY BRIEF

RECOMMENDATIONS

Addressing Cardiovascular disease through the importance of nutritional programmes:

- While the EU is one of the biggest contributors for school meals programme, two out of the five regions are still at risk of running out of funds. Therefore, increase resources available for school meals both as a way to improve childhood malnutrition and also to control diet related NCDs.
- Impose excise taxes on processed foods high in fat, sugar and salt to better address diet- related NCDs, including cardiovascular diseases. This should be combined with a marketing campaign to reduce the numbers affected by NCDs.
- Limit the media's advertisement of foods high in fat, sugar and salt. Canada serves as a great model in that the marketing of unhealthy food and beverage directed at children is prohibited, and also there are limitations on advertisements times.

Surveillance:

- In 2010 Gambia completed the STEPWise survey and no evidence of the survey being conducted after is available. Therefore, establish a surveillance task force that spans across the country to monitor NCD related cases on a regular basis (Health is Wealth, 2012).
- Ensure availability of financial resources for a task force to efficiently collect, analyze, and disseminate data.
- While plans for research and development of a national NCD strategy are in motion, ensure the inclusion of the primary risk factors associated with NCDs within existing primary care services. In addition, ensure that the MOHs action plan to enhance support in PHC villages, includes PHC village development.
- Existing rural health services are provided by NGOs (36%), Private Sector (33%) and Public Sector (31%), however coordination is sporadic and there are no existing control/benchmarking systems to ensure equitable PHC. Therefore, establish a surveillance entity to coordinate standard- setting, and ensure primary care accountability between all parties.

Primary Care:

- With the 1: 6132 doctor to patient ratio and the 1:1554 nurse to population ratio (HRH Situation Analysis Report), address the shortage and inequitable distribution of healthcare staff throughout the country.
- Solidify the implementation of the National Health Policy (2007-2020) and Health Strategic Plan, and strengthen the capacity building of health systems at all levels: from financing, to infrastructure and human resources development.
- Address the lack of financial and resource incentives by providing enhanced professional development support through training from NGOs and offering incentive programmes for relocation through educational grants in exchange for a rural placement contracts.
- Prioritize development of an accelerated training program for doctors, similar to the one that has already been successfully implemented for nurses to address limited availability of healthcare providers in rural areas.

Mali

NCD POLICY BRIEF

EXECUTIVE SUMMARY

- Cardiovascular and chronic respiratory diseases are major contributors to Non-Communicable Disease (NCD) mortality rates. These rates can be mitigated through the recognition of their correlation to early childhood nutritional development (Vorster & Kruger, 2007).
- Malnutrition among children under five is a significant risk factor for NCDs. The prevalence rates for stunted and underweight children under five afflict 38.5 and 27.9% of the population, respectively (NLiS, 2010).
- Opportunities exist to strengthen existing National Health Strategies in areas of multi-stakeholder coordination, interdepartmental communication infrastructure, and primary care. decentralization.

OVERVIEW

The 2014 WHO Census for Mali estimates that NCDs account for approximately 31% of mortality rates, with cardiovascular diseases (CV) accounting for 11% (WHO, 2014). Poor nutritional dieting has a strong correlation to this figure.

We recognize that there are limited resources available to Mali's Ministry of Health to mandate fundamental health reform in its National Strategy program. The nation also relies heavily on international aid for financial, human, and infrastructural resources.

The primary areas of concern include:

- The lack of recognition of NCDs or shared risk factors within primary care
- Underdeveloped communications department to monitor coordination between all stakeholders
- No mandated benchmarks to ensure accountability throughout implementation phase
- Limited target-setting to establish financial stability for the Ministry of Health
- The lack financial resource coordination that hinders geographically universal development of preventative NCD programmes

Mali

NCD POLICY BRIEF

RECOMMENDATIONS

Addressing Cardiovascular Disease through Nutritional Programming

- Establish a multi-sectoral national policy to develop a plan that would address the issues of food security and diet related NCDs focusing on CV disease. This should also extend to controlling taxation. Nutritionally unhealthy products, such as salty, sugary and fast food products, should be taxed and also have limitations in advertisements towards children.
- Subsidise domestic food production over export-based agricultural production to lower costs of fresh food and its availability.
- Malnutrition significantly contributes to both child mortality rates and CV disease. Develop an action plan to address nutrition for school meals.

Primary Care Decentralisation

- Ensure that quality and critical healthcare services reach populations located in remote from the capital areas, by creating an action plan to address the unequal distribution of health workers throughout the country.
- Solidify the implementation of the National Policy and National Strategic HRH Plan
- Prioritize addressing the lack of financial and resource incentives by providing enhanced professional development support through training.

Enhanced Intersectoral Coordination and Benchmarking:

- Develop a feasible five-year action plan to establish communication infrastructure between USAID, Ministry of Health, and other NGOs to coordinate more equitable financial and human resource support for rural districts.
- Primary Care decentralization should prioritise addressing nutritional development for women and children, with reference to strategies established in PRODESS II and III.
- Create community-based educational programming on nutrition to reduce the intergenerational cycle of poverty and undernutrition (Vorster and Kruger, 2007).
- Establish a multi-stakeholder community-based surveillance system to ensure accountability of all healthcare development contributors.
- Use benchmarking indicators with clear target-setting and performance assessments to guide the development and sustainability of health initiatives and programs

Mauritania

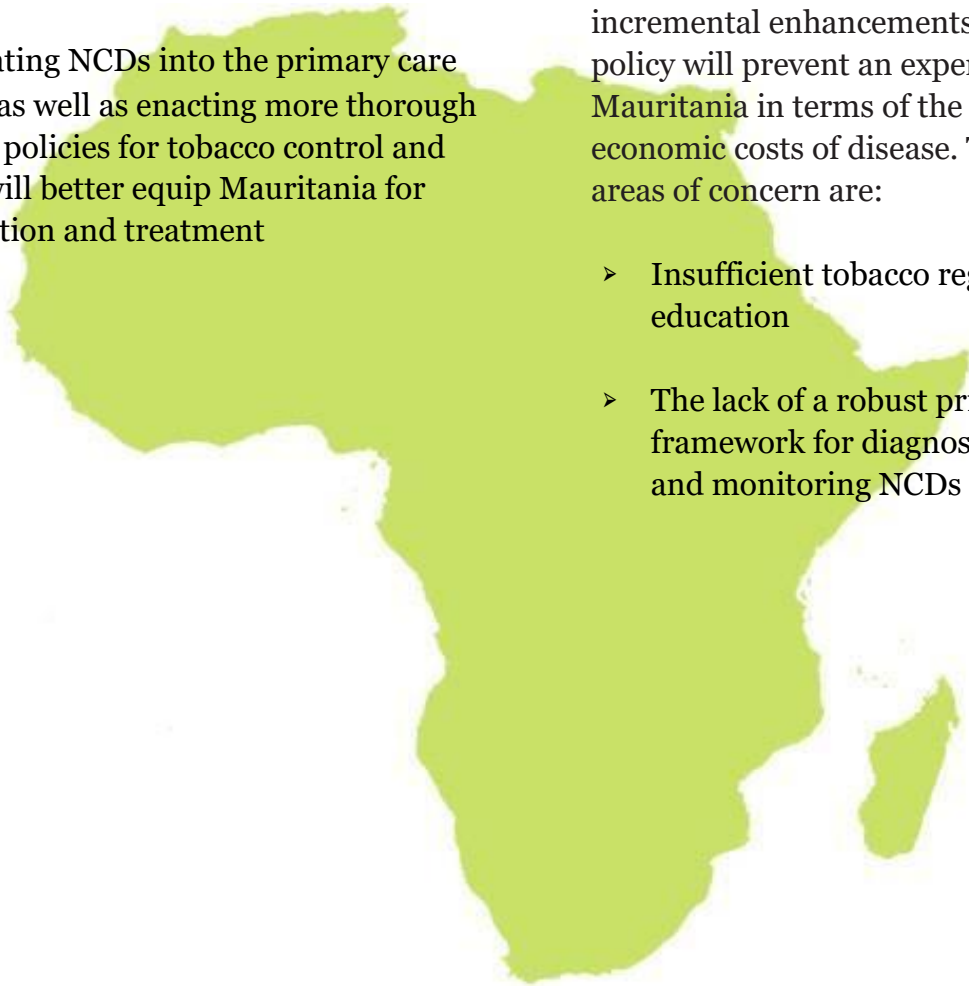
NCD POLICY BRIEF

EXECUTIVE SUMMARY

➢ Noncommunicable diseases (NCDs) account for roughly 32% of Mauritania's mortality rate, and this number continues to rise

➢ There are currently minimal policies in place that specifically address the NCD health burden in Mauritania

➢ Incorporating NCDs into the primary care framework, as well as enacting more thorough government policies for tobacco control and education, will better equip Mauritania for NCD prevention and treatment



OVERVIEW

The 2014 Census by the World Health Organization (WHO) estimates that noncommunicable diseases (NCDs) account for approximately 32% of Mauritania's mortality rate. Of the main NCDs, cardiovascular disease contributes to the largest portion of NCD deaths in both men and women, which can largely be attributed to high blood pressure. Individual risk factors vary among men and women, with tobacco consumption being significantly higher in men and a higher prevalence of obesity in women. (WHO, 2014)

With respect to existing barriers preventing the advancement of the healthcare system in Mauritania, it is important to note that incremental enhancements to government policy will prevent an expensive future for Mauritania in terms of the human and economic costs of disease. The primary areas of concern are:

- Insufficient tobacco regulation and education
- The lack of a robust primary care framework for diagnosing, treating, and monitoring NCDs

Mauritania

NCD POLICY BRIEF

RECOMMENDATIONS

Tobacco Control & Education

- It is critical that tobacco control be identified as a top public health priority by the Ministry of Health. Rates of tobacco product consumption are 29% and 4% for men and women respectively. (WHO, 2014)
- It is equally important to increase consumer education and awareness regarding the harms caused by tobacco use. Feasible options available to the Government of Mauritania include:
  - The introduction of a national ban on direct advertising alongside a ban on sponsoring and promoting tobacco products
  - The introduction of a national mandate for tobacco manufacturers to display graphic health warnings on their packages
  - Age restrictions on the sale of tobacco products
- It is also in the national government's best interest to periodically increase the excise tax on tobacco products, and to expand smoke-free legislation to include more public spaces. Currently, laws mandating smoke-free environments only cover healthcare facilities. (WHO, 2017)

Advancing NCDs Through Primary Care

- In order to advance primary health care, the WHO Package of Essential Non-communicable (PEN) Disease Intervention model suggests increasing the number of primary health facilities that have services for the treatment of NCDs, as well as the number of health professionals trained to diagnose and treat NCDs (WHO, 2010). Currently, there aren't a substantial number of health facilities in Mauritania; regardless, it would be beneficial for the Ministry of Health to devote resources to equipping existing facilities and staff for the treatment of NCDs.
- WHO recommends the provision of appropriate and evidence-based health education on the diagnosis and treatment of NCDs for patients (WHO, 2010). To be effective in combatting NCDs, this evidence- based health education should be extended beyond patients to the general public. Education should address the major risk factors for NCDs: dietary habits, tobacco use, harmful alcohol use and physical inactivity. This would be a worthwhile initiative to receive funding and resources for the Government of Mauritania.
- The Ministry of Health should make health information on cultural practices like *gavage* accessible to the public.
- At the national level, the government should mandate that primary care facilities maintain a health management information system to identify those with or at risk of NCDs and to effectively monitor and manage their risks and symptoms, as per WHO recommendations. (WHO, 2010)

Niger

NCD POLICY BRIEF

EXECUTIVE SUMMARY

- 25% of deaths in Niger are caused by Non- Communicable diseases, particularly cardiovascular disease with a high rate of high blood pressure
- NCD mortality rates can be mitigated by addressing health education, training and physical access
- Opportunities exist to strengthen policy in areas such as cancer health education and prevention, primary care training services, and a NCD surveillance and monitoring system

OVERVIEW

The 2014 Census by the World Health Organization (WHO) estimates that non-communicable diseases (NCDs) account for 25% of Niger's mortality rate. Cardiovascular disease and other NCDs are the primary contributors to this figure, with one of the largest individual risk factors being high blood pressure for men and women as well as tobacco use for the former.

While the policy team at EAF understands the limited resources available to Niger with respect to health reform, transparency about ongoing issues is important for stakeholders' capacity building efforts.

The primary areas of concern include:

- A lack of access to healthcare services, largely due to physical barriers which are exacerbated during the wet season.
- Insufficiently trained health professionals as well as ineffective treatment provided by traditional healers.
- Insufficient data on the primary non- communicable diseases which is needed for successful health intervention.

Niger

NCD POLICY BRIEF

RECOMMENDATIONS

Cancer Health Education & Promotion: Breast Self-Exams:

➢ Early detection of breast cancer is critical to combating mortality and mastectomy rates in Niger. Breast cancer accounts for 16.5% or more of all cancers in Niger. Also, 90% of patients only seek medical treatment in the advanced stages of the disease (Brinton et al., 2014).

➢ Increase population awareness about prevention regarding breast self-examinations (BSE's).

➢ Dedicate resources to seasonal workshops run by a health professional, along with the dissemination of step-by-step literature on how to properly conduct BSE's.

➢ Target rural areas with limited access to health facilities.

➢ A common cause of delay to seeking medical treatment is initial treatment by traditional healers. Advise women to seek medical treatment immediately.

Primary Care

- Though financial access for mothers and children under 5 years of age is covered by the government, the majority of the population is still left without physical access to a health facility, leaving only 24% of the population within 1 hours walking distance during the wet season (Blandford et al., 2012).
- Increases funds and resources for increased transportation services
- Alongside this, there are a limited number of healthcare professionals often leaving people in the hands of traditional healers.
- Provide onscreen training to curb the costs of face-to-face training.

NCD Surveillance & Monitoring System

➢ According to the WHO (2014) Non- communicable disease country profile of Niger, there is not an NCD surveillance and monitoring system in place. Data collection for the biggest NCDs in Niger such as diabetes, high blood pressure, and cancers is vital for addressing where interventions need to be made and the support needed for their success.

➢ The STEPwise approach by the WHO provides an efficient way to collect, analyze, and implement finds from data (WHO, 2017).

➢ Recognize the need for surveillance to identify and evaluate risk factors for NCDs.

➢ Plan for the administration of the surveys and other tools for data collection, as well standardize the approach for examining and implementing the surveillance of these major risk factors.

➢ Conduct data analysis.

➢ Translate data from surveillance into recommended policies and programs for intervention.

- Depending on the resources available, it is recommended that this survey collection is done every 5 years (WHO, 2017).

Senegal

NCD POLICY BRIEF

EXECUTIVE SUMMARY

➢ Though NCDs are responsible for fewer deaths than communicable diseases, NCDs are on the rise while the latter are decreasing

➢ There are no minimal policies in place right now to address NCDs

➢ Opportunities exist to strengthen policy in areas such as tobacco prevention, high blood pressure screening, and cancer surveillance and treatment.

OVERVIEW

➢ The 2014 Census by the World Health Organization (WHO) estimates that non-communicable diseases (NCDs) account for 34% of Senegal's mortality rate. Cardio- vascular disease and cancer are the primary contributors to this figure, whereas individual risk factors – tobacco abuse and high blood pressure – conflate to intensify the situation.

RECCOMENDATIONS

Tobacco Control Policy

➢ Tobacco consumption is a public health concern in Senegal. This is a significant issue among the male population in which 22.4% of them use tobacco products (WHO, 2013). Cigarettes are the most widely used form of tobacco (WHO, 2013). Although most places in Senegal are under the smoke-free legislation, there is minimal data on compliance to these regulations. Restaurants still have designated smoking rooms which continues to expose people to some amount of second hand smoke (WHO, 2013).

➢ Dedicate funds for the enforcement of smoke-free legislation (WHO, 2013). These funds could come from an increased excise tax and has the potential to positively influence compliance.

➢ Health warnings on tobacco products is a key area to focus on in order to curb down the amount of tobacco consumption. Currently the health warnings on packages are not written in the principal language(s) of the country, do not describe the harmful effects of tobacco use, and also are allowed to be obscured by required markings (WHO, 2013).

➢ Create to ensure that warning labels are visible, accurately describe risks, and are available in the principal language of the country (WHO, 2013).

➢ Currently there is minimal support for tobacco dependent users in some communities and the cost is not covered by the national/federal health insurance or the national health service (WHO, 2013).

➢ Enhance Tobacco dependency support.

➢ Further, ban tobacco products from display at the point of sale to further help Senegal to reduced tobacco consumption rates (WHO, 2013).

Senegal

NCD POLICY BRIEF

RECOMMENDATIONS

Outreach Strategies to Reduce High Blood Pressure

- High blood pressure (HBP) is common in both urban and rural Senegal, affecting 32.1% of the population (WHO, 2014). A national strategy for the prevention, monitoring, and treatment of hypertension led by the Ministry of Health is crucial in the long term. Also, short-term strategies for mitigating HBP can be undertaken by the public and private sectors. Notably, a large proportion of Senegalese citizens with hypertension are unaware of their condition, which can be attributed in large part to a lack of medical supervision.

1. Target NCD screening activities towards private workers. This can be accomplished during the mandatory occupational health visits at private companies, and can be used to increase awareness in socio-professional populations. (Seck, Gueye, Tamba, and Ba, 2010)
2. Grant access to a free medical consultation once a year. This can substantially increase awareness rates in rural populations (Duboz, Boetsch, Gueye, and Macia, 2016).

Population Based- Cancer Registry and Palliative Care

➢ In Senegal cancer accounts for 5% of the mortality rate (WHO, 2014). Among men, liver (21.5%) and prostate (17.1%) cancer have the highest mortality rates, and among women, cervical (30%) and breast (15.5%) cancer have the highest mortality rates (WHO, 2014). A common issue is that diagnosis is often too late, and accessibility to medical care is challenged by the availability of treatment options and cost of care (Chung, 2013). Access to palliative care such as pain medication is very limited (Chung, 2013). In 2012 and 2013, morphine was only available to 194 patients with cancer (Chung, 2013).

➢ Create policies to mandate the availability of palliative care and essential medicines at the national and community level (Chung, 2013).

➢ Train healthcare workers to provide palliative care and pain management (Chung, 2013).

➢ Currently there is not a population-based cancer registry (WHO, 2014). Create a sustainable and effective registry that:

1. Identifies every case of cancer within designated area, and distinguishes between resident and non-resident cancer cases that seek treatment in the area and outside the area.
2. Actively tracks down cancer information directly from health records and facilities to ensure accuracy and completeness (Bray et al., 2015).
3. Ensures completion and validity by collecting data from multiple sources (Bray et al., 2015).
4. Timely reports data (Bray et al., 2015)
5. Establishes a fruitful working relationship and active engagement with respective health authorities both regionally and nationally (Gakunga & Parkin, 2015).
6. Creates an advisory committee for the registry that includes members from the public health, clinical, and academic communities (Bray et al., 2015).

Cape Verde

NCD POLICY BRIEF

EXECUTIVE SUMMARY

➢ Most deaths in Cape Verde are caused by non-communicable diseases, particularly cardiovascular disease and cancer

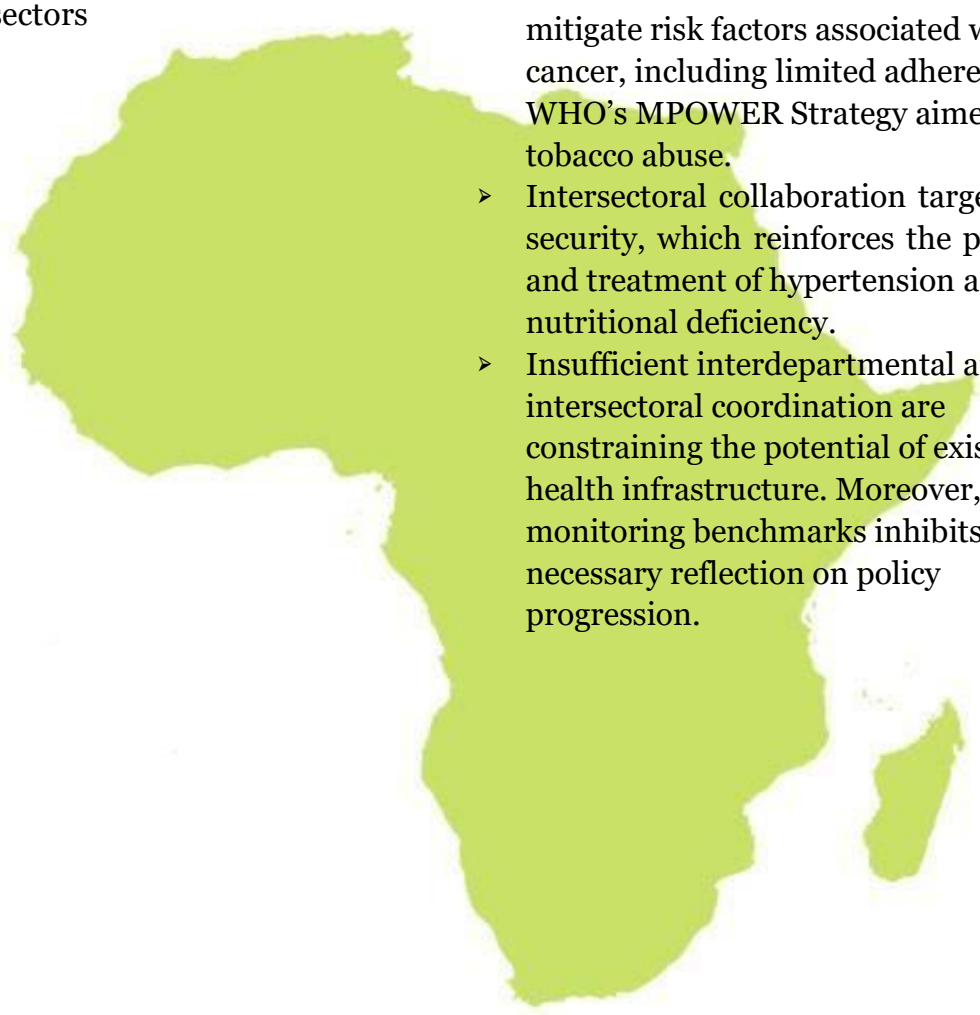
➢ NCD mortality rates can be mitigated by addressing individual and shared risk factors

➢ Opportunities exist to strengthen policy in areas such as cancer surveillance and prevention, food security and dietary programs, and coordination between/within sectors

OVERVIEW

The 2014 Census by the World Health Organization (WHO) estimates that noncommunicable diseases (NCDs) account for 69% of Cape Verde's mortality rate. Cardiovascular disease and cancer are the primary contributors to this figure. Individual risk factors – tobacco and alcohol abuse, high blood pressure, and food security – conflate to intensify the situation. While the policy team at EAF understands the limited resources available to Cape Verde with respect to health reform, transparency about ongoing issues is important for stakeholders' capacity building efforts. The primary areas of concern include:

- A lack of enforced control measures to mitigate risk factors associated with cancer, including limited adherence to the WHO's MPOWER Strategy aimed at tobacco abuse.
- Intersectoral collaboration targeting food security, which reinforces the prevention and treatment of hypertension and nutritional deficiency.
- Insufficient interdepartmental and intersectoral coordination are constraining the potential of existing health infrastructure. Moreover, a lack of monitoring benchmarks inhibits necessary reflection on policy progression.



Cape Verde

NCD POLICY BRIEF

RECOMMENDATIONS

Cancer Control & Surveillance

➢ To reduce the risk of cancer and cardiovascular disease, Cape Verde must implement stricter adherence to the WHO's MPOWER strategy. Tobacco policies enforceable through the Food and Product Regulation and Supervision Agency (ARFA) is a significant step toward achieving MPOWER's mandate.

➢ Creation of a national quit-line is both a feasible and effective solution for the Ministry of Health to implement within its current capacity. The Ministry of Health's planning and development team must also establish a long-term outline to introduce hospital and clinic-based cessation programs (Politica Nacional De Saude, 2007). Raising the excise tax on cigarettes will both increase government revenue for healthcare-based programming and act as a smoking deterrent, particularly for young males.

➢ Given its small population and a centralised healthcare system, it is feasible to implement a national population- based cancer registry (PBCR) within the next policy target deadline, without significant constraint on the Ministry of Health's existing budget. PBCR's provide an excellent platform for cancer surveillance and management, and can be established with minimal financial and human resources (AFCRN, 2015).

Dietary Risks & Food Security

➢ Policies that control food insecurity and promote healthy diets are needed to curb rates of high blood pressure and cardiovascular disease. Tax increases von processed foods and other products with little n utritional value will encourage the population to adopt healthier diets. The additional revenue from increased taxation should be allocated to local farming stimulus programmes to reduce the associated costs of healthy diets.

➢ Programmes such as 'Purchase from Africans for Africa', which involve local producers and farmers, must be promoted in lieu of imported alternatives. In combination with the additional stimulus, reduced cost associated food production, and greater access to fresh food, will stabilize food security.

➢ The Feeding for Schools Programme must also be improved, as many children are suffering from preventable conditions such as anemia. The Ministry of Health will benefit from utilizing its coordination efforts with Vitaferro and Unicef to promote healthy diets within the primary school system. Stronger coordination will serve as a springboard to reduce malnutrition and stabilize food security (UNICEF, 2017).

Interdepartmental & Intersectoral Coordination

➢ Stronger coordination infrastructure must work within Cape Verde's existing institutional capacity. With respect to the WHO's 2016 Cooperation Strategy, recommendations include:

- Creating a more cohesive framework for monitoring and enforcement between ARFA and the Ministry of Health will improve the response to alcohol, tobacco, and food safety risks. Decree-Law No. 89/92 must be reviewed in order to allow a platform for stronger coordination between both agencies (FAL, No. 44)
- Transparency between the Department of Research and Planning (DRP) and community-based institutions (regional health units, educational institutions, local governance) is vital for communication of NCD risks and developments. This includes, but is not limited to, the creation of web-based resources that outline and coordinate community-based strategies for reducing NCD risks.
- A multi-stakeholder approach to health reform between the DRP, regional health units, and CSOs. A "Lessons Learned" approach to monitoring NCD risk reduction will ensure participation of all actors in addressing community-specific barriers to NCD prevention

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