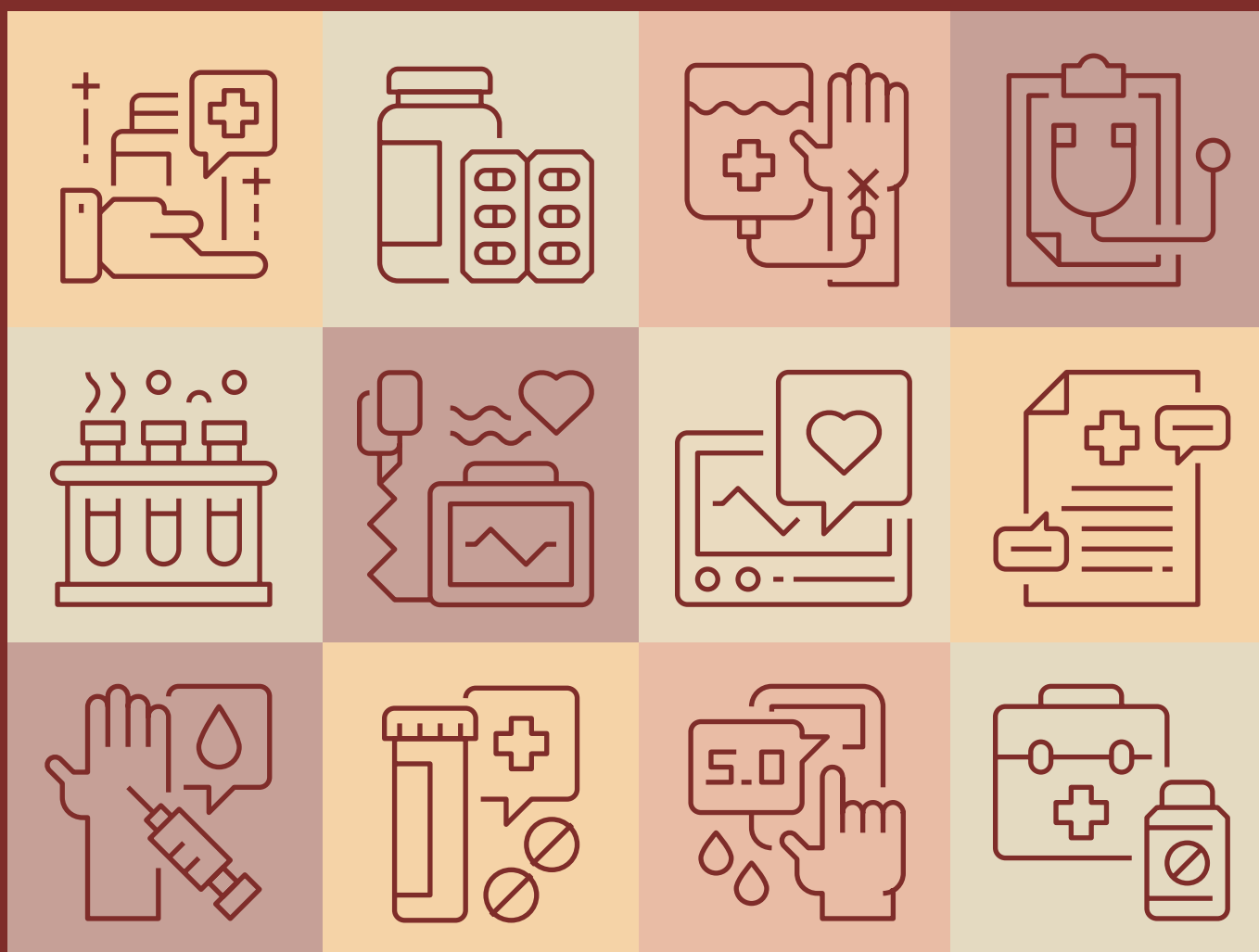


Guidance for Strengthening Non-Communicable Diseases, Injuries and Mental Health Surveillance Systems



Contents

Acknowledgement	3
List of abbreviations and acronyms	5
Executive summary	6
Introduction	8
Purpose, scope and use	11
Recommendations	12
Indicators, data sources and data types	12
Surveillance system capacities	16
Surveillance integration with existing systems	19
Data use	21
Implementation support tools and outlook	23
Continental perspective	25
Definitions	26
Annex	30
Assessment tool	30
Best practices	31
References	35

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List of abbreviations and acronyms

AU	African Union
DHIS2	District Health Information – Software2
HIS	Health Information System
IANPHI	International Association of National Public Health Institutes
MH	Mental Health
MoH	Ministry of Health
MS	Member States
NCDs	Non-Communicable Diseases
NCDI/MH	Non-Communicable Diseases, injuries, mental health
NPHI	National Public Health Institute
SDG	Sustainable Development Goal

Executive summary

Non-communicable diseases, injuries, and mental health conditions (NCDI/MH) are substantial diseases and economic threats across African Union (AU) Member States (MS). The conditions are estimated to disable and prematurely end millions of lives across Africa each year. They constitute a serious impediment to achieving the vision of the Agenda 2063 of building an integrated, prosperous, and peaceful Africa driven by its citizens. The existing data and estimates leave little doubt about the general trajectory of an increasing disease and mortality burden from NCDI/MH on the continent over the next decades. Despite these predictions, recently collected population-based data for NCDI/MH and their risk factors and determinants remain scarce in many AU MS.

This guidance document for Member States was developed in an evidence-based and consultative processes. It aims to support AU MS to progressively strengthen their NCDI/MH surveillance systems in line with national and continental strategies. Furthermore, this document is guided by and seeks to contribute to the realization of the Agenda 2063, the Africa Health Strategy 2016-2030, and Africa's New Public Health Order. Most specifically, this guidance document supports the implementation of the Africa CDC Non-Communicable Diseases, Injuries Prevention and Control and Mental Health Promotion Strategy 2022-26. The guidance also complements existing technical surveillance documents and links to global and regional monitoring frameworks.

This document concerns the surveillance of i) non-communicable diseases, injuries, and mental health conditions, ii) their risk factors and determinants, and iii) the national response to these threats. It also informs the integration of NCDI/MH indicators into the national Health information system (HIS) in order to strengthen the surveillance systems to support evidence-based decision-making for NCDI/MH prevention and control in AU MS. The target audiences for this document include ministries of health (MoH) and National Public Health Institutes (NPHIs) as well as additional ministries and national public institutions with mandates related to NCDI/MH surveillance.

This document has three core sections: Recommendations, Implementation support tools and outlook; Definitions and a complementary annex – a repository of practical documents. The recommendations to Member States are structured under 4 major headings:

- A. Indicators, data sources and data types,
- B. Surveillance system capacities,
- C. Surveillance integration with existing systems, and
- D. Data use. A summary of the key recommendations is highlighted in text box below.

Indicators, data sources and data types

- Decide on a lead agency to coordinate all processes outlined under headings A)-D)
- Identify stakeholders, agree on criteria to prioritize conditions for surveillance and for related health system response
- Develop a (long) list of national NCDI/MH core indicators, based on the consented criteria
- Identify data sources and data types for the (long) listed NCDI/MH indicators
- Prepare for data collection from core NCDI/MH indicators.

Surveillance system capacities

- Develop or strengthen national strategies to include NCDI/MH surveillance
- Cost the prioritized NCDI/MH surveillance activities
- Strengthen the workforce for NCDI/MH surveillance through recruitment, training and support structures
- Improve digital capacities for NCDI/MH data collection, data sharing and data analysis across all levels of the health system.

Surveillance integration with existing systems

- Strengthen integrated national NCDI/MH strategies and surveillance capacities
- Integrate NCDI/MH surveillance into existing systems
- Strengthen multisectoral coordination for NCDI/MH surveillance.

Data use

- Assess and address the quality of NCDI/MH surveillance processes and data regularly, using standardized procedures
- Enhance the impact of NCDI/MH surveillance on policies and decision-making
- Use NCDI/MH data for public health research
- Use NCDI/MH data to inform the general public and increase health literacy
- Share data with other countries and supranational public health agencies for cross-border learning and solutions.

Introduction

Non-communicable diseases, injuries, and mental health conditions (NCDI/MH), a substantial disease and economic threat across African Union (AU) Member States (MS), require solid surveillance and response. The conditions are estimated to disable and prematurely end millions of lives across Africa each year.¹

They constitute a serious impediment to achieving the vision of the Agenda 2063 to build an integrated, prosperous, and peaceful Africa driven by its citizens. The existing data and estimates leave little doubt about the general trajectory of an increasing disease and mortality burden from NCDI/MH on the continent over the next decades.

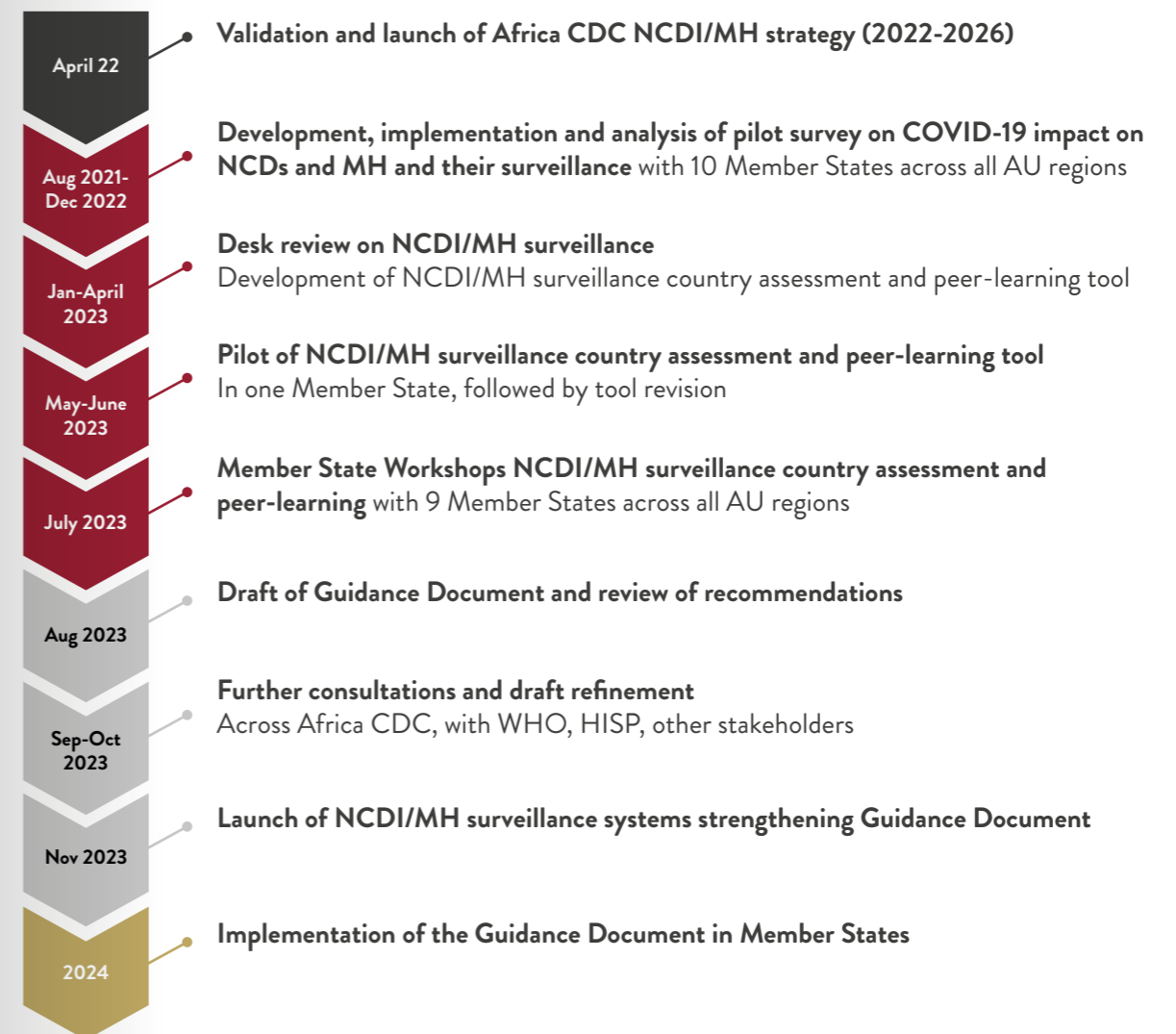
The growing burden can be efficiently and effectively met by data-driven investments and interventions in NCDI/MH prevention and control. The basis for these data is public health surveillance—the ongoing systematic collection, analysis, and interpretation of health-related data, closely integrated with the timely dissemination of the resulting information targeted for public health decisions and action (see also definitions).

Unfortunately, recently collected population-based data for NCDI/MH and their risk factors and determinants remain scarce in many AU-MS. Decision-makers sometimes only have extrapolated NCDI/MH data from neighbouring countries or decades-old representative NCDI/MH data from their own country at hand. Such data gaps can inhibit contextualized evidence-based interventions and disincentivise investments to curb NCDI/MH in countries and across the continent. At the same time, some countries have already advanced NCDI/MH surveillance activities, leading the way for the continent.

This document aims to support AUMS to progressively strengthen their NCDI/MH surveillance systems in line with national and continental strategies. It is guided and seeks to contribute to the realization of the Agenda 2063, the Africa Health Strategy (2016-2030), and Africa's New Public Health Order. Most specifically, this guidance document supports the implementation of the Africa CDC Non-Communicable Diseases, Injuries Prevention and Control and Mental Health Promotion Strategy 2022-26. The first of its six objectives is to 'Enhance the capacity of Ministries of Health (MoH) and/or National Public Health Institutes (NPHI) to develop, integrate and implement national and supranational frameworks and policies for the prevention and control of NCDs & injuries and the promotion of mental health'. A priority intervention for this objective is to 'Support MoH/NPHI to integrate NCDI/MH surveillance into national surveillance systems and develop system interoperability'. As thus foreshadowed, the document emphasizes leveraging already existing systems as opposed to creating new ones that would run parallel. Further, it seeks to promote data-sharing for cross-border solutions and learning, practices that were already harnessed for the creation of the document.

This guidance document for Member States was developed in an evidence-based and consultative process. A phased approach saw frequent and substantial participation and input by Member States from all AU regions (Figure 1). The first phase, following the Africa CDC NCDI/MH strategy launch, served to gather evidence and assess gaps through a pilot survey (10 MS), desk review, the development and piloting of the NCDI/MH Surveillance Country Assessment and Peer-Learning Tool, and its application in two Member State workshops (with a total of 9 MS in attendance). Based on the results of the first phase, the next phase co-created options for surveillance systems strengthening and the draft guidance document. This phase also included extensive consultations with various key stakeholders to ensure no duplication but rather complementarity.

Figure 1 – Phased approach to developing the guidance document.



As part of this process, ten Member States self-assessed the maturity of their NCDI/MH surveillance system along predefined domains. On average, the Member States, which were from all AU regions, were at a developing stage for NCDI/MH surveillance at this point (Figure 2). NCD surveillance was generally stronger than injury or mental health surveillance. There was also extensive variation in the capacities of Member States.

Figure 2 – Self-assessment of NCDI/MH surveillance by six domains, across 10 AU MS.

Stage Domain	Basic			Developing			Advanced			Leading Edge		
	1	2	3	4	5	6	7	8	9	10	11	12
Strategic Direction	●		Injuries MH NCDs						●			
Systems	●		Injuries/ MH			NCDs			●			
Resources	●			Injuries/ MH		NCDs				●		
Quality	●		MH		Injuries/ NCDs				●			
Engagement	●				Injuries/ MH		NCDs			●		
Impact	●				Injuries/ MH	NCDs			●			

Grey bar indicates the average self-assessed stage (range) across countries, “NCDs”, “Injuries” and “MH” indicates the distinct rating for the respective disease group. Orange and red dots show the minimum and maximum score by a MS, for each domain.

The discussions and findings which developed around the peer-learning workshops highlighted innovative Member State practices and common NCDI/MH surveillance challenges. This in turn reveals the potential for advancing NCDI/MH surveillance through continental cooperation, coordination, and commitment. The guidance document is a product and an effort to that end.

Purpose, scope and use

Purpose

This guidance document shall support AU MS in strengthening their surveillance systems to support evidence-based decision-making for NCDI/MH prevention and control.

Scope

The document focuses on surveillance—the ongoing systematic collection, analysis, and interpretation of health-related data closely integrated with the timely dissemination of this information for public health decisions and action. Ideally, the surveillance system is linked to the national health information system (HIS).

The document covers the surveillance of i) non-communicable diseases, injuries, and mental health conditions, ii) their risk factors and determinants, and iii) the national response to these threats. It also informs the integration of NCDI/MH indicators into the national the HIS.

The document targets the national level. However, it has implications for NCDI/MH surveillance system strengthening at the subnational, regional, and continental levels.

Target audience

Target audiences for this guidance document are ministries of health (MoH) as well as other ministries, such as the transport ministries (for e.g. road traffic accidents) or the home/interior ministries (e.g. dealing with suicide prevention and control), national public health institutes (NPHIs) and national public institutions with mandates related to NCDI/MH surveillance, such as national statistics and road safety agencies.

The document may also inform entities of Regional Economic Communities (RECs) and continental public organizations, such as the Africa CDC. Further, the

broader stakeholder community engaged in NCDI/MH surveillance, prevention and control at various levels on the continent (including public, private, faith-based and other non-governmental healthcare providers, universities/ research institutes, public health agencies, civil society organizations, development banks, foundations, insurance companies, amongst others) may find the guidance useful.

Use

Professionals at MoH/NPHI and other national public organizations can use the document to guide national NCDI/MH surveillance activities and interventions to strengthen the surveillance system. Expectedly, this leads to improved decisions, actions, funding, and outcomes of NCDI/MH prevention and control. The document can assist in further defining, developing, funding, implementing, coordinating, integrating, and evaluating national NCDI/MH surveillance activities and systems.

The guidance complements existing technical surveillance documents and relates to global and regional monitoring frameworks. It does not seek to duplicate or replace these but can be used alongside. Examples of existing technical surveillance documents include the WHO Integrated Diseases Surveillance and Response (IDSR) strategy and technical guidelines, the Africa CDC Mortality Surveillance Framework, the Africa CDC Events-Based Surveillance Framework, and the African Union Health Information Exchange Guidelines and Standards. Further to this, the document relates to the monitoring frameworks of the Sustainable Development Goals (SDG) especially target 3.4, the UN’s Road Safety Decade plan, the WHO Mental Health as well as the NCD Action Plan, and the WHO AFRO PEN-Plus strategy.

Structure

This document has three core sections: Recommendations, Implementation support tools and outlook; and Definitions. These are complemented by annex/a repository of practical documents.

Recommendations

Effective planning, resourcing and implementation of NCDI/MH health promotion, disease prevention and control hinges on the availability of timely and adequate data, structured by indicators.

Additional factors include capacities for data collection and analysis as well as dissemination and uptake of health information. The following recommendations to Member States are structured under these 4 major headings: A) Indicators, data sources and data types, B) Surveillance system capacities, C) Surveillance integration with existing systems, and D) Data use. The recommendations are both cross-cutting and specific for NCDs, injuries, and mental health. This serves to support systems strengthening in an integrated manner while preserving distinctions for the surveillance of each of the three disease areas.

A) Indicators, data sources and data types

Member States are encouraged to identify and develop core indicators, data sources and data types. The following 5 steps are suggested:

1. Decide on a lead agency to coordinate all processes outlined under headings A)-D). The lead agency shall specifically

- Analyze, map and recruit potential stakeholders
- Prepare and set up consultative meetings
- Coordinate scientific and political partners (technical and implementation partners) and their input into the process
- Keep stakeholders / partner informed of processes and outcomes.

Expected outcome: A standing consultative national expert body on NCDI/MH surveillance.

2. With the identified stakeholders, agree on criteria to prioritize conditions for surveillance² and for related health system response.

- Consider criteria such as burden or severity of disease, disability (DALY/YLD) or equity
- Consider the broad range of NCDs, many of which are not yet under surveillance but may be very burdensome to the general population
- Include criteria for common MH conditions as well as for conditions in conflict areas and for health sector responses such as psychology services
- Map the diverse field of injuries, including road traffic injuries, violence, unintentional injuries such as falls or burns, and others, and decide on focus areas for surveillance
- Include criteria for risk and protective factors across each of the three disease areas
- Include health system response topics such as access to and use of health care services.

Expected outcome: A list of consented criteria to prioritize NCDI/MH topics for surveillance.

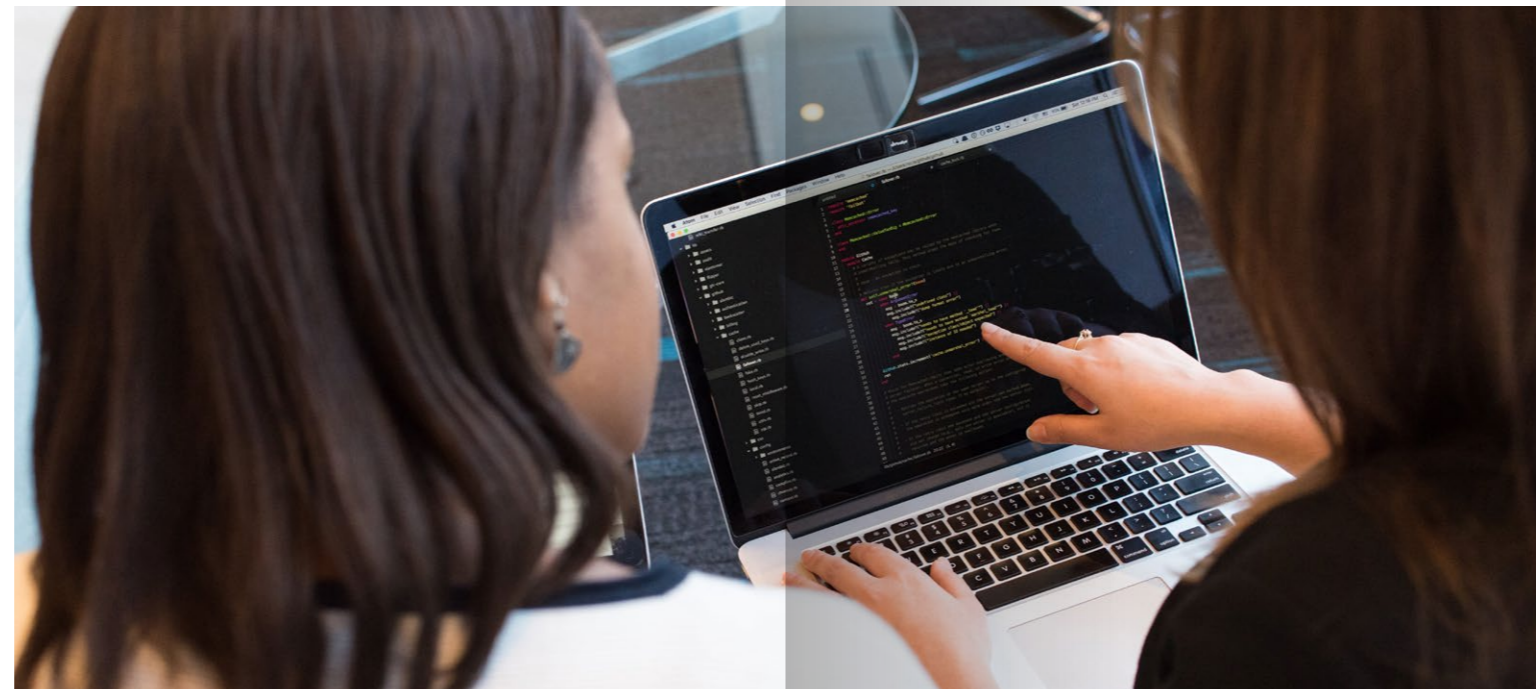


Image credit: Pexels, Christina Morillo

3. Based on the consented criteria, develop a (long) list of national NCDI/MH core indicators

- Define NCDI/MH core indicators and develop meta data for each of them
- Ensure that the (long) list contains disease-specific indicators as well as indicators on risk and protective factors and on defined injuries
- Capture indicators in other sectors which could be used and explore opportunities for their integration with health data or interoperability across systems (E.g. does any crime reporting include whether alcohol was a factor in the incident)
- Include demographic data in the (long) list to contextualize health indicators
- Respect regional, continental and global indicator standards (e.g. WHO Noncommunicable Diseases Global Monitoring Framework) to promote data-sharing, cross-country learning and use of core indicators for international reporting requirements.

Expected outcome: A (long) list of fully defined national core health indicators.

4. Identify data sources and data types for the (long) listed NCDI/MH indicators

- Map available data sources and data types, including census data, vital statistics (e.g. for mortality surveillance), population health surveys, facility-based individual-level data or service records (e.g. patient data at health and other facilities), or resource records such as on health commodities
- Include and engage traditional healers and faith-based institutions (churches, mosques, etc.) as key data sources as many mental health clients seek help from these sources before turning to clinical reviews
 - Retrieve injury data from non-health sectors (e.g. the transport ministry, home ministry, and police among others)
- Advocate against MH stigmatization and decriminalize suicide to promote MH data availability
- Group the (long) list into core indicators with readily available data sources / data types (Group 1) and those indicators for which data are not (yet) available (Group 2)
- Finalize meta data sheets for each core indicator with information of data sources and data types.

Expected outcome: Overview of implementable indicators and of indicators with data sources/data types under development.

²Burden of disease = overall health impact of condition, severity = severity of the condition in terms of premature mortality, disability = the extent of disability caused by the condition on each individual, equity = inequity of health outcomes from the condition as compared to other countries.

5. Prepare for data collection from core NCDI/MH indicators

Develop quality assurance mechanisms for each stage of NCDI/MH surveillance to ensure that indicator development, data collection and data use are fit for purpose.

Define the frequency and timing for data collection from each source.

- For population health surveys:
 - Integrate core NCDI/MH indicators including their risk/protective factors into broad national surveys, such as the Demographic and Health survey (DHS)
 - Develop national plans for regular NCDI/MH-focused surveys based on a recommended minimum sample size and available resources.
- For health facility data
 - Provide clear guidance on NCDI/MH facility level data collection (i.e. standard case definitions, frequency and facility type)
 - Train health workers across health system levels to enhance the diagnostic and surveillance capacity for NCDI/MH
 - Adopt specialized models of clinical management and data collection for NCDI/MH, such as PEN-Plus
 - Decentralize NCDI/MH data collection across all levels of healthcare in the country (especially at community level) to promote coverage beyond specialized centres and for timely prevention and control
 - Emphasize on accurate recording of poorly captured cases (e.g. suicide cases, which may often be hidden under other diagnoses).
- Mortality surveillance (in addition to the interventions noted for health facility data)
 - Strengthen the Cause of Death (CoD) registration for NCDI/MH deaths occurring in health facilities
 - Strengthen the CoD registration for NCDI/MH deaths especially for community deaths, standardizing and enhancing verbal autopsies.
- Screening
 - Integrate NCDI/MH screening into existing national screening programs
 - Prioritize other NCDI/MH conditions (beyond cancers and their risk factors) into existing national screening programs
 - Scale up and ensure sustainable screening programs at national and subnational levels.
- Registries
 - Strengthen existing registries (e.g. on cancer) and introduce additional registries (e.g. on injuries, suicide)
 - Link registry data with other data sources e.g. lab data, screening data etc.
- Standard Operating Procedures (SOPs)
 - Develop/update, disseminate, and implement NCDI/MH surveillance SOPs for the national, provincial and district level, in line with the NCDI/MH surveillance strategy
 - Standardize, validate, and implement NCDI/MH data collection tools for facilities and communities across the country.

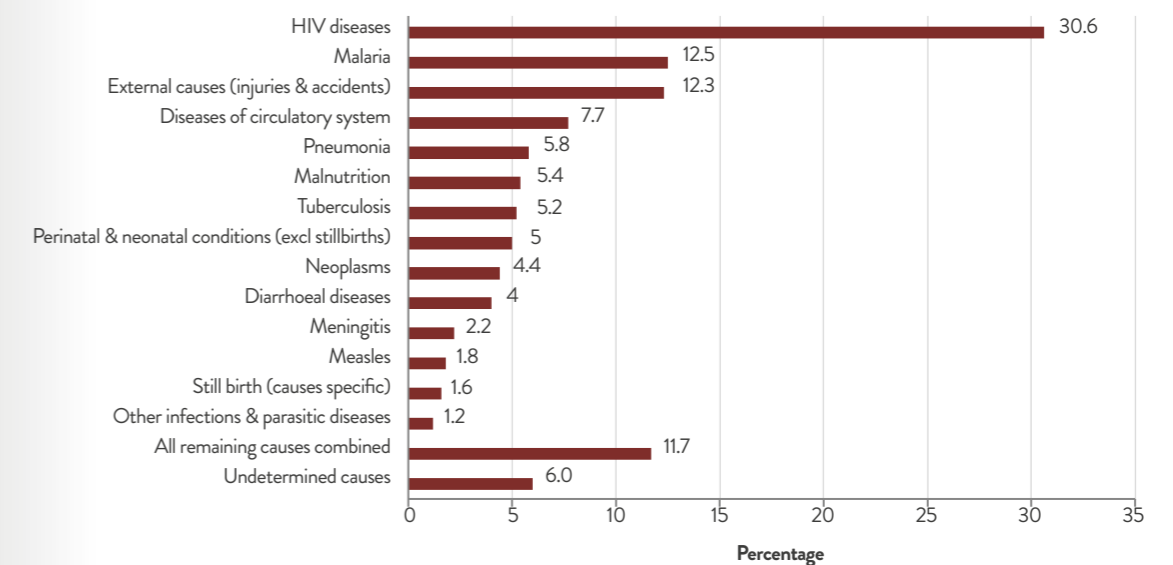
Expected outcome: A comprehensive national NCDI/MH surveillance plan.

Box 1 – Country best practice example: National Statistics NCDI/MH Mortality Surveillance integration: Case of Zambia

The Ministry of Health and Zambia National Public Health Institute (ZNPPI) with the Zambia Statistics Agency (ZamStats) in using household surveys, community-based surveillances and administrative sources to strengthen the surveillance system for NCDI/MH. Zamstats was established by the Statistics Act of Parliament No. 13 of 2018, to be responsible for collection, coordination and management and development of official statistics in the country. The Agency is the authoritative source and custodian of official statistics in Zambia. ZamStats collects data from primary sources in periodic socio-economic censuses and surveys.

Examples of indicators include percent women ever tested for breast cancer, cervical cancer, percent of respondents with the following conditions; Diabetes, High Blood Pressure, Heart Disease or chronic heart condition, kidney Disease, percent of respondents with depression and anxiety at national level. Zambia has utilised a multisectoral approach and linked multiple stakeholders (Road Traffic Safety Agency, District Councils, Health Information management system, Ministry of Education, Faith based institutions, traditional leaders and the national pension scheme) through ZNPPI which coordinates to strengthen mortality surveillance and guide policy on NCDI/MH direction in the country.

Causes of Death among Males in Four Provinces, SAVVY, 2010



Box 2 – Country best practice example: Improving health facility data through specialized care model, PEN-Plus: Case of Kenya

The introduction of PEN-Plus in the country led to development of diseases specific tools that were not previously available in the country. This is specifically for cardiovascular diseases and Sickle cell diseases. The process of developing the tools was consultative

incorporating specialist, health facility staff and professional association bodies. Though the tools are only used in the two PEN Plus health facility there are plans to scale them up and adopt them into the Kenya Health information system.

B) Surveillance system capacities

Member States are encouraged to develop well-performing NCDI/MH surveillance systems that run on robust governance, sustainable finance, a strong workforce, and increasingly digital capacities. The following 4 steps are suggested:

1. Develop or strengthen national strategies to include NCDI/MH surveillance

- Ensure that national strategies (on NCDI/MH, on HIS, on surveillance) include NCDI/MH surveillance by updating existing strategies or by including NCDI/MH surveillance into new strategies
- Embed NCDI/MH surveillance objectives and activities in pertinent national documents, such as policies, strategies, strategic plans, and laws (e.g. mental health, NCD or injury legislation)
- Undertake regular exercises to assess the country's current and desired maturity on NCDI/MH surveillance and develop strategic objectives and activities to strengthen it (see assessment tool in Annex).

Expected outcome: Integration of NCDI/MH surveillance in relevant strategic and operation documents.

2. Cost the prioritized NCDI/MH surveillance activities

- Conduct economic analyses of national NCDI/MH surveillance strategies to ensure their continued feasibility
- Explore mechanisms to earmark routine public domestic resources for NCDI/MH surveillance, considering a specific national budget line allocated to NCDI/MH surveillance

- Explore public resource mobilization mechanisms, such as from sin tax incomes (e.g. tobacco levies) and others
- Seek additional sustainable resources from other organizations as needed, e.g. from international development banks, NGOs, foundations, public health agencies, and others.
- Explore funding options from the committed domestic private sector, such as companies and foundations
- For all of the above, develop and apply ethical standards of financing to ensure that no direct funding for NCDI/MH surveillance comes from health-harmful products and actions
- Advocate vis à vis policy makers for sustainable financing of NCDI/MH surveillance to ensure long-term data collection and trend analyses for health care planning and evidence-informed policy advise.

Expected outcome: Overview of costs and resources for national NCDI/MH surveillance to enable sustainable planning and advocacy.

3. Strengthen the workforce for NCDI/MH surveillance through training, support structures, and recruitment

- Consider a committee at the MoH/NPHI level to enhance leadership and coordination of NCDI/MH surveillance staff
- Map and strengthen capacity building needs among national focal points and other staff in charge of NCDI/MH surveillance in the areas of data collection, analysis and use; devise and implement adequate capacity building programs, or identify existing international programs and make these available to focal points and relevant staff

- Enhance health workers' diagnostic and surveillance capacities for NCDI/MH
 - Develop curricular content to ensure health workers' technical qualification and awareness for NCDI/MH and their surveillance (targeted to specific health worker groups – e.g. community health workers, nurses, doctors)
 - Build health worker capacity to accurately diagnose, enter, analyze, and use data on NCDI/MH across health system levels (i.e. inclusion of respective modules in routine curricula, for example in nursing, and through regular targeted training)
- Reinforce data quality through support structures, such as supervision, and on-site monitoring for health information and surveillance staff in different facilities
- Establish regular training and mentorship programs for health information and surveillance staff on specificities of NCDI/MH surveillance
- Communicate the public health importance of NCDI/MH surveillance to health information and surveillance staff across levels
- Explain/re-iterate the needs and expected deliverables for NCDI/MH surveillance from health information and surveillance staff across levels
- Develop/strengthen NCDI/MH modules or contents in Field Epidemiology Training Programs (FETP), Field Epidemiology Laboratory Training Programs (FELTP), and other epidemiology or biostatistics training programs.

Expected outcome: Overview of national NCDI/MH surveillance workforce needs and capacities to enable capacity building.

4. Improve digital capacities for NCDI/MH data collection, data sharing and data analysis across all levels of the health system

- Advocate for the provision of IT infrastructure to the community and district levels of the health system across the country
- Digitize NCDI/MH data collection and processing at the community and district level as much as possible. Recommended pathways include:
 - Piloting/scaling up direct digital data collection and analysis of NCDI/MH surveillance indicators with the DHIS2
 - Strengthening community-level health information management systems, including improving data collection and reporting tools as well as the development of an electronic health information system as a basis for community surveillance
 - Promoting interoperability of existing data systems used regarding NCDI/MH, such as between health facilities and national HIS and surveillance platforms
 - Developing/updating dedicated tracker modules (eTracker) for NCDI/MH through existing electronic HIS and surveillance platforms and emerging electronic medical records system
 - In line with the digital transformation strategy of Africa CDC, develop practical national data sharing strategies while adhering to data protection laws
 - Engage government and partners to invest in the development and use of data sharing platforms.

Expected outcome: Overview of digitalization needs and capacities of the broader health information system, and for NCDI/MH surveillance.

Box 3 – Country best practice example: Funding population-based survey through sin taxes: Case of Botswana

Whilst most countries tend to depend on external funding to conduct these population-based surveys, Botswana has come up with an innovation to fund the WHO STEPS survey from domestic resources. Botswana had last conducted the STEPs survey in 2014 making the next one due in 2019. This was not achieved due to lack of funding. In 2022, the NCD unit had to explore other alternatives to address the STEPS survey funding challenge. The main priority was to look for domestic funding.

The NCD unit had to use evidence to show the burden of NCDs and their socio-economic impact; how STEPS survey can assist in tobacco and alcohol

programmes by provide up to date population level data. The data was presented to the Tobacco Levy implementing Committee. Support was requested from the tobacco as tobacco is one of the leading causes of preventable death. Botswana introduced a 30% tobacco levy in 2014. The proposal was accepted and the committee agreed to cover the total budget as submitted. During the country case studies in Zambia, the Botswana representatives reported that they are now at an advanced stage to conduct the STEPS survey using domestic resources from the tobacco tax. A total of USD 580,000 have been made available to conduct STEPS survey this year.

Image credit: Pexels, Keegan Checks



C) Surveillance integration with existing systems

Member States are encouraged to integrate health data with a view to generating an accurate view of the health status of the population and of the risk and protective factors and determinants affecting them.

The following 3 steps are suggested:

1. Strengthen integrated national NCDI/MH strategies and surveillance capacities

- Address challenges such as varying indicator definitions, interoperability of components of health information systems, preparedness of systems to include (new) indicators on NCDI/MH, or access to health-related data from non-health sectors
- Harmonize NCDI/MH data from distinct data sources to enable a thorough assessment and use
- Strengthen integrated surveillance to reveal and appropriately respond to co-morbidities, such as between diabetes and depression and/or tuberculosis
- Include integrated surveillance objectives and activities in any national NCDI/MH surveillance strategic or operational documents, such as workforce development and capacity building plans, SOPs, data collection tools.

Expected outcome: Overview of opportunities and challenges concerning the integration of NCDI/MH health information.

2. Integrate NCDI/MH surveillance into existing systems

- Integrate core NCDI/MH indicators into the national health information system
 - Develop and implement a roadmap for the inclusion of NCDI/MH indicators in the DHIS-2 platform
 - Explore options for the integration of NCDI/MH within existing infectious disease systems

- Foster inclusion and access of NCDI/MH indicators in surveillance platforms for chronic infectious diseases (such as HIV, TB) for national NCDI/MH surveillance
- Implement NCDI/MH indicators designated for active surveillance in the national Integrated Disease Surveillance and Response (IDSR) system.
- Integrate NCDI/MH surveillance into health facility information systems
 - Link NCDI/MH data collection tools with the overall (electronic) medical / health records (EMR / HER) system at health facilities
 - Advocate for unique patient identifiers in specialized NCDI/MH facilities and more broadly across the health system to avoid parallel patient registration and enhance surveillance along the care cascade
 - Advocate for integrated NCDI/MH surveillance vis à vis key stakeholders such as statistics agencies, ministries, health insurance authorities, healthcare providers, non-governmental organizations, community actors, international partners amongst others as well as actors at the supranational, national, and subnational level (same as below on multisectoral coordination)
 - Develop and implement regulatory frameworks to secure data inputs from private sector and private healthcare providers, faith-based, traditional, university, and non-governmental organizations or programs into a central public data system for national NCDI/MH surveillance to prevent parallel systems
 - Advance the in-country storage, accountability, and security of NCDI/MH / health sector data.

Expected outcome: Overview of opportunities and challenges concerning the NCDI/MH integration with communicable disease surveillance data and systems.

3. Strengthen multisectoral coordination for NCDI/MH surveillance

- Ensure national NCDI/MH strategies are multisectoral and outline how data from different sectors will be collected and used for surveillance
- In the framework of overall stakeholder management for NCDI/MH surveillance, establish a national multisectoral committee on NCDI/MH to oversee and coordinate surveillance activities across various stakeholders including the private sector
- Raise awareness among staff from non-health sectors for the importance of collecting and sharing accurate data for health surveillance. In this context,
 - On NCDs: liaise e.g. with the ministries of agriculture, environment, sports, labour, industry/trade, interior, roads and transport, NGOs engaged in NCD research and advocacy, as well as traditional and religious leaders/healers
 - On mental health: liaise with the ministries of justice (which houses police, correctional services) and of the interior, NGOs engaged in mental health research and advocacy, as well as traditional and religious leaders/healers
 - On injuries: liaise with the ministry of transport, interior, with the police, road safety commission, mortuary services, national ambulance services, NGOs engaged in injury research and advocacy, as well as traditional and religious leaders / healers.

Expected outcome: Roadmap of multisectoral stakeholders and required action to strengthen multisectoral collaboration for effective NCDI/MH surveillance.

Box 4 – Country best practice example: Integration of data from the private sector: Case of Ghana

Ghana, like most countries has a significant sector of the population who benefit from the private sector for health provision. The country has also been experiencing challenges getting data from the private sector, both for profit and not for profit. To mitigate on the loss of important health service data from the public sector, the Ghana Ministry of health came up with an innovation to ensure that the data from the private sector gets into the mainstream national data repository. The ministry engaged the medical and dental practice regulatory authority which agreed to enact a policy for data collection from the private sector.

Within this policy, all private health care providers are required to provide their data directly into the DHIS2, which is then verified by the Center for Health Information Management of the Ghana Health Service (CHIMS) and relayed to the responsible regulatory authorities. Failure to submit will result in non-renewal of the licence for the facility. Like all other service providers in the public sector, the private sector is required to report service data to the district level monthly. This has assisted in ensuring that data from both for profit and non-profit private players are collected and hence the surveillance system does not leave out this very important data source.

D) Data use

Member States are encouraged to create actionable and targeted information from NCDI/MH surveillance to improve the population's health, public health research and public health decision-making.

The following five steps are suggested:

1. Assess and address the quality of NCDI/MH surveillance processes and data regularly, using standardized procedures

- Define quality standards in line with regional or global standards
- Conduct regular data quality assessments and develop improvement plans.

Expected outcome: Outline of data quality needs for NCDI/MH surveillance.

2. Enhance the impact of NCDI/MH surveillance on policies and decision-making

- Use NCDI/MH surveillance data to identify and communicate emerging public health threats to political decision-makers (agenda-setting) and to influence political outputs such as national policies, laws, and taxes for enhanced NCDI/MH prevention and control (agenda-keeping)
- Develop strategies and products to empower decision-makers with the right data and policy options to strengthen NCDI/MH prevention and control
- Advocate vis à vis political decision-makers for the use of surveillance data to prioritize NCDI/MH, including the president's/prime minister's office, ministers, parliamentarians, high-level ministry officials, regional and local government leaders

- Link NCDI/MH surveillance data with economic and socioeconomic data to support effective planning of prevention and control policies.

Expected outcome: Visible and documented use of NCDI/MH data in political decision-making

3. Use NCDI/MH data for public health research

- Make NCDI/MH surveillance data easily accessible for research and vice versa
- Exchange and cooperate with the research community, including academic institutions, to identify trends in NCDI/MH burden or care in the country.

Expected outcome: Increasing number of scientific publications and updated clinical guidelines based on NCDI/MH data.

4. Use NCDI/MH data to inform the general public and increase health literacy

- Create information products and activities aimed at informing the general public of health risks in the area of NCDI/MH, increasing health literacy and informed decision-making in the population to avoid health risks. Such products shall be developed for different target groups along the life-course, i.e. children/teachers, adults and the elderly, and for groups within society, e.g. for men/women, persons with special needs
- Provide information to the general public about the availability of services for health promotion, prevention and care/treatment.

Expected outcome: Visible and documented use of NCDI/MH data for national health campaigns along the life course, included improved uptake of health promotion and prevention programs.

5. Share data with other countries and supranational public health agencies for cross-border learning and solutions.

- Ensure compatibility of indicators with international reporting requirements to avoid double reporting burden
- Support efforts towards establishing continental core health indicators to allow regional and cross-country comparisons.

Expected outcome: Improved data completeness for international reporting requirements and contribution to continental NCDI/MH core indicator development.



Image credit: Pexels, Alberto Iteriteka

**Box 5 – Country best practice example:
Using data to influence policy:
Case of Nigeria**

In 2008, Nigeria conducted the Global Youth Tobacco Survey (GYTS) to determine the level of use of tobacco amongst young people.

This survey managed to provide information on tobacco and tobacco products access by the youth in the country. The findings established that the policy and legal framework for tobacco and tobacco products access by the youths has been the driving force behind the increase to tobacco use.

Based on the findings of the GYTS, Nigeria started the conversation of the formulation of policies to reduce tobacco use. The National Tobacco Control Act, 2015 which regulates all aspects of tobacco control including smoking-free places, tobacco advertising, promotion, and sponsorship, tobacco packaging and labelling, prevention of tobacco industry interference, tobacco product disclosures, the creation of a National Tobacco Control Committee was enacted. This has helped to regulate both the commercial activities promoting tobacco use and the use of tobacco and tobacco products. This policy has also helped Nigeria to make steps to be compliant with the Framework convention for tobacco control (FCTC).

This indicates that data can be used to influence policy.

Implementation support tools and outlook

To ease the implementation of the above recommendations, target audiences find in the ANNEX to this guidance several supporting documents.

Ready-to-use documents include:

- an assessment tool for the NCDI/MH surveillance system
- best practices of Member States

Documents under development include:

- a list of core continental NCDI/MH surveillance indicators,
- an outline for a national NCDI/MH surveillance SOP and health facility data collection tool,
- a sample prioritization procedure for national NCDI/MH surveillance indicators,
- a costing template for NCDI/MH surveillance activities,
- an NCDI/MH surveillance question battery for the selection of pertinent items for existing national population-based surveys, such as the DHS,
- a roadmap for inclusion of NCDI/MH indicators in National Health Information Systems
- a sample training procedure and curriculum in line with the SOP and data collection tool templates, and
- an adaptable policy brief template for using NCDI/MH data to impact key national decisions and documents positively for NCDI/MH prevention and control.

While Member States are primarily in charge of implementing the recommendations and strengthening their NCDI/MH surveillance systems, Africa CDC seeks to bilaterally support ministries of health and NPHIs in this effort.

This could include:

- assistance for assessing the maturity of the surveillance systems and revealing strengthening opportunities,
- high-level advocacy visits to promote the implementation of national NCDI/MH surveillance (strengthening) activities,
- technical support for the development and implementation of NCDI/MH surveillance (strengthening) activities, and
- resource mobilization support amongst others.

Member States are encouraged to mobilize in-country partners to support national plans.

Member States could work together to strengthen their surveillance systems and Africa CDC is dedicated to facilitate cross country peer-learning processes and formats. The hitherto NCDI/MH surveillance country assessment and peer-learning workshops (see introduction) showcased the value of mutual exchange and deliberation among focal points for NCDs, injuries, mental health, and surveillance from various Member States. Besides additional workshops of this kind, communities of practice for specific NCDI/MH surveillance areas, for example, cancer registries, are conceivable based on the needs of Member States. Further, Africa CDC may assist in facilitating bilateral study visits of focal points of one Member State to another to learn about NCDI/MH surveillance.



Image credit: Pexels, Blue Ox Studio

Cross-country data sharing is a priority element of continental cooperation and will be pivotal to advance public health across Africa, including for high-burden diseases such as NCDI/MH. Continental data can be especially effective to promote public health action when it is used in high-level political processes. As part of the implementation of the NCDI/MH Strategy (2022-2026), Africa CDC is committed to supporting Member States on NCDI prevention and control and MH promotion and advocacy at the highest level at the African Union. Robust surveillance data are a prerequisite for the success of these processes and can help to unlock policy space for prevention and control. Therefore, to support continental

coordination for NCDI/MH surveillance more broadly, Member States are encouraged to cooperate in cross-border NCDI/MH data sharing. Africa CDC will harness its existing platforms and work with partners to provide the appropriate mechanism and support Member States in data sharing.

Strengthening national NCDI/MH surveillance systems and sharing data across borders is thus expected to result in at least two major benefits for Member States: enabling effective and efficient public health actions on NCDI/MH and widening the policy space for their implementation.

Continental perspective

Complementary to the strengthening of surveillance systems through national and subnational guidance is a continental perspective to be kept in focus. This is to ensure a well-coordinated, streamlined and efficient continent-wide NCDI/MH surveillance.

An overarching guidance for supranational agencies to ensure a coordinated effort towards the realization of this agenda is paramount.

These include:

1. Indicators, data sources and data types

- Develop a set of high-level continental indicators for NCDI/MH
- Develop continental SOPs for NCDI/MH data collection and data management
- Oversee and ensure the compatibility of data for cross-country comparison
- Supranational agencies (e.g. NGOs, specific programs) who deal with NCDI/MH data should coordinate with and make data available to national NCDI/MH data collection platforms.

2. Surveillance system capacities

- Support countries with capacity building programs (e.g. peer exchanges), trainings, and mentorship
- Develop a centralized digital platform to collect NCDI/MH data across the continent and ensure system interoperability with country HIS
- Develop continental NCDI/MH score cards for monitoring the indicator performance
- Donor agencies should consider increasing funding for NCDI/MH surveillance activities.

3. Surveillance integration with existing systems

- Establish multisectoral coordination mechanisms for NCDI/MH surveillance at the supranational level. For example, agencies engaged in infectious disease surveillance should be open to the integration of NCDI/MH into their existing surveillance systems.

4. Data use

- Promote the use of NCDI/MH data for global health research
- Ensure international and intercontinental data sharing through standard data sharing platforms.

Definitions

Noncommunicable diseases (NCDs)¹: Describe a group of medical conditions or diseases that by definition are non-infectious and cannot be passed from person to person. NCDs may be chronic diseases of long duration and slow progression, or they may result in more rapid death such as sudden stroke. According to the World Health Organisation, the four main types of non-communicable diseases are cardiovascular diseases (like heart attacks and stroke), cancer, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma), and diabetes. Many NCDs are driven by modifiable risk factors (smoking, unhealthy diet, unhealthy living conditions) and can be prevented through behavioral or environmental change.

Injury^{2, 3}: Physical harm or damage to the body resulting from an exchange, usually acute, of mechanical, chemical, thermal, or other environmental energy that exceeds the body's tolerance. In some cases (eg. drowning, strangulation, freezing), injury occurs as the insufficiency of a vital element. The two main injury categories, intentional and unintentional injuries are defined in terms of a series of external cause codes; unintentional injuries are subdivided into road traffic injuries, poisoning, falls, fires, drowning, and "other unintentional injuries". Unintentional injuries also include exposure to animate and inanimate mechanical forces (including firearms); exposure to electric current, radiation, and extreme ambient temperature and pressure, and to force of nature; and contact with heat and hot substances, and venomous plants and animals. Intentional injuries are subdivided into self-inflicted injuries (eg. suicide), interpersonal violence (eg. homicide), war-related violence, and "other intentional injuries".

Mental health⁴: As defined by the World Health Organization (WHO), is "A state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities.

A mental health condition⁵: according to WHO, is "[a] broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning, or risk of self-harm.

Surveillance⁶: Is the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of health-related practice, closely integrated with the timely dissemination of these data to those who need to know.

Passive Surveillance describes the routine submission of data from health facilities to a health institution⁷

Active surveillance involves the search for cases in the community or health facilities⁷.

NCDI/MH surveillance⁸: Noncommunicable diseases, injuries and Mental health surveillance is the ongoing systematic collection, analysis, interpretation, and dissemination of data to provide appropriate information regarding a country's NCDI/MH disease burden, including the main causes of NCDI/MH mortality, the population groups at risk, morbidity, risk factors, and determinants, coupled with the ability to track NCDI/MH-related health outcomes and risk factor trends over time.

Routine surveillance /Indicator-based surveillance (IBS)⁶: Defined by WHO as the systematic (regular) collection, monitoring, analysis, and interpretation of structured data, i.e., of indicators produced by a number of well-identified, mostly health facility-based, formal sources. It can be realized in different approaches, including facility-based or case-based surveillance⁷.

Event-based surveillance (EBS)⁶: The organized collection, monitoring, assessment, and interpretation of primarily unstructured ad hoc information regarding health events or risks, which may represent an acute risk to human, animal, plant, or environment health.

Indicators⁹: Indicators are summary measures, that can, in a simple way, reveal (or measure) a situation that is not obvious when considered by itself. A health indicator, then, is a way of measuring specified health characteristics in a given population. Indicators can be categorized according to their mathematical measurement (indicators based on absolute and relative measures), their epidemiological interpretation (prevalence and incidence); and the type of indicator (indicators of behavioral risk factors, morbidity, and mortality, as well as those used for evaluation of health services). The reference period for the indicator is essential and should be explicitly stated when a health indicator is interpreted and disseminated; this is particularly important for comparability. The definition of the period depends on the event being monitored and on the indicator's purpose.

Monitoring and Evaluation¹¹:

Monitoring is a continuous process of collecting and analyzing information about a program and comparing actual against planned results to judge how well the intervention is being implemented. It uses the data generated by the program itself (characteristics of individual participants, enrolment and attendance, end-of-program situation of beneficiaries, and costs of the program) and it makes comparisons across individuals, types of program, and geographical locations.

Evaluation is a process that systematically and objectively assesses all the elements of a program (e.g. design, implementation, and results achieved) to determine its overall worth or significance. The objective is to provide credible information for decision-makers to identify ways to achieve more of the desired results¹¹.

Performance evaluations focus on the quality of service delivery and the outcomes (results) achieved by a program. They typically cover short-term and medium-term outcomes (e.g. student achievement levels, or the number of welfare recipients who move into full-time work). They are carried out based on information regularly collected through the program monitoring system. Performance evaluation is broader than monitoring. It attempts to determine whether the progress achieved is the result of the intervention, or whether another explanation is responsible for the observed changes¹¹.

Impact evaluations look for changes in outcomes that can be directly attributed to the program being evaluated. They estimate what would have occurred had beneficiaries not participated in the program. The determination of causality between the program and a specific outcome is the key feature that distinguishes impact evaluation from any other type of assessment¹¹.

Health Information Systems¹³: Systems that manage healthcare data and facilitate the flow of information between healthcare providers, patients, and other stakeholders. HIS includes electronic health records, clinical decision support systems, telehealth systems, and other technologies that support the collection, analysis, and sharing of health information. HIS can improve the quality of care, increase efficiency, and reduce costs by enabling better decision-making, reducing duplication of services, and improving communication and coordination among healthcare providers.

Electronic health records (EHR)¹³: Digital records of a patient's health information, including medical history, medications, allergies, test results, and treatment plans. EHRs provide healthcare providers with instant access to patient data, enabling more efficient and coordinated care. They also improve patient safety by reducing the risk of errors and duplication of services. EHRs are more comprehensive than EMRs and accessible across healthcare organizations.

Electronic medical records (EMR)¹³: Digital records of a patient's medical information created and stored by a single healthcare organization, such as a hospital or clinic. EMRs typically include patient demographics, medical history, medications, allergies, test results, and treatment plans. EMRs allow healthcare providers within a single organization to access and share patient data more efficiently, reducing the risk of errors and improving patient safety. They also facilitate electronic prescribing, appointment scheduling, and other administrative tasks.

Health information Exchange¹⁴: Is defined as the electronic transfer of clinical and/or administration information among the organizations, people, and technology that hosts the defined ecosystems.

Interoperability^{8,14}: refers to the capability of digital technologies to exchange and make use of data amongst each other based on common standards and norms⁸. Involves the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged.¹⁴

Health Commodity¹⁵: A collective term to include pharmaceuticals, consumable medical supplies, and durable medical equipment.

Verbal Autopsy¹⁶: A verbal Autopsy is a process used to describe the causes of death at the population level for deaths which occur in the community, and for which there is no medical certification of the cause of death.

Annex

Assessment Tool*

	Basic (Level 1)	Developing (Level 2)	Advanced (Level 3)	Leading Edge (Level 4)
Strategic Direction	The MoH/NPHI conducts NCDI/MH surveillance based on WHO guidance or donor interest but collected data not analysed or used.	The MoH/NPHI attempts to use NCDI/MH surveillance data but there is often a mismatch between what is needed and what is collected.	The MoH/NPHI's NCDI/MH surveillance is designed to provide data to guide policies and programs. All aspects of NCDI/MH surveillance are considered in designing systems.	The MoH/NPHI uses multiple approaches, including engaging decision-makers, to ensure NCDI/MH surveillance systems are maximally useful.
Systems	The MoH/NPHI has NCDI/MH surveillance SCPs and guidelines but these are hard to use and not widely distributed.	The SCPs for NCDI/MH surveillance are sometimes outdated or not comprehensively reviewed. Reporting entities sometimes do not have them.	All reporting entities receive SCPs and these are generally followed. NCDI/MH surveillance systems are regularly reviewed using standard indicators (e.g. timeliness completeness).	The MoH/NPHI's NCDI/MH surveillance SCPs are models for other organisations. The MoH/NPHI routinely reviews system for quality and relevance and data use. Evaluations usually lead to improvements in the system.
Resources	The MoH/NPHI has few resources to conduct NCDI/MH surveillance, and limited capacity exists to analyse and use NCDI/MH surveillance data.	The MoH/NPHI has some resources to improve data collection by reporting entities but these are inadequate.	The MoH/NPHI has resources and staff have the skills and resources to collect and analyse data, including sophisticated analyses and to use data to make recommendations.	The MoH/NPHI invests substantially in all aspects of its NCDI/MH surveillance systems. It consistently updates staff skills, infrastructure and technology to meet current and expected future demands.
Quality	The MoH/NPHI's NCDI/MH collected data, and analyses, if performed, are often of poor quality and are incomplete.	The quality of the MoH/NPHI's NCDI/MH collected data is variable. Some data analysis occurs in a timely manner, but much of the data are not analysed.	The MoH/NPHI's NCDI/MH surveillance data collection and analysis of generally high quality and reports are complete in a timely manner.	The MoH/NPHI's NCDI/MH data collection and analyses meet high international quality standards. The MoH/NPHI regularly develops and tests innovative approaches to improving the quality of its surveillance.
Engagement	Decision-makers and other stakeholders are not involved in defining questions for data collection and analysis.	The MoH/NPHI sometimes involves decision-makers and other stakeholders when prioritising data collection and analysis, usually at the stakeholder's request.	Decision-makers and other stakeholders routinely provide input to the MoH/NPHI ensures that they have access to results.	The MoH/NPHI actively seeks input from a range of stakeholders to inform its data collection and analysis efforts and also proactively shares results.
Impact	The MoH/NPHI's NCDI/MH surveillance data are rarely used in-country for decision-making.	The MoH/NPHI can provide few examples where NCDI/MH surveillance data have informed policies or programs or have been used to identify acute issues.	Decision-makers often rely on the MoH/NPHI's NCDI/MH surveillance data for informing programs and policies.	The MoH/NPHI's NCDI/MH surveillance has a proven major impact on the policies and programs of the MoH and many other organisations. Some of its findings have global impact.

*Adapted from: https://ianphi.org/_includes/documents/sections/tools-resources/sdt/discussion-guidelines/en/16.pdf

Best practices

Improving health facility data through specialised care model, PEN-Plus: Case of Kenya

The use of electronic health systems has greatly enhanced the quality and availability of data. The Ministry of Health has partnered with Medtronic Labs to introduce an electronic system that collects patient level data known as SPICE. The inbuilt quality checks ensure completeness and accuracy of the data. With continuous mentorship, the health care workers including clinicians, pharmacists, laboratory personnel and health records officers have become comfortable using the system hence are motivated to regularly send the monthly reports as required. An added advantage is that the SPICE system is integrated with the Kenya Health Information System which contains aggregated data that is reported on a monthly basis. This therefore means that there is no need for double entry of data.

The Division of Non-Communicable Diseases have prioritized data quality audits to improve the quality of data at health facility. The division together with PATH, developed an electronic tool that assess attributes such as completeness and concordance between paper-based data and the electronic data. Among the areas looked at is also the availability of the data tools which is a major challenge in the public health facilities. The feedback sessions after the data quality audits are tailored as solution seeking dialogues to enable health facilities and sub-national entities improve on data collection, reporting and data translation. A key lesson learnt from this experience is that strategic partnerships are vital in efforts aimed at improving health facility data.

The introduction of PEN Plus in the country led to development of diseases specific tools that were not previously available in the country. This is specifically for cardiovascular diseases and sickle cell diseases. The process of developing the tools was consultative incorporating specialist, health facility staff and professional association bodies. Though the tools are only used in the two PEN Plus health facility there are plans to scale them up and adopt them into the Kenya Health information system.

Integration of data from the private sector: Case of Ghana

Facility based data collection is one of the most important sources of data. This entails collecting data from the point of service delivery, compiling it, analysing and reporting the data to the national level through the established channels. Whilst most AU MS are making efforts to collect data for NCDI/MH from all service providers in their countries, the biggest challenge remains with the private sector. The private sector provides services to an average of 55.9% in urban areas in the AU MS. The biggest challenge with the private care providers is that they don't provide data to the ministries of health for surveillance systems. Money countries reported that challenge during the case studies. This extract describes how Ghana as managed to create a policy framework that enforces reporting of data from the private sector.

Ghana, like most countries has a significant sector of the population who benefit from the private sector for health provision. The country has also been experiencing challenges getting data from the private sector, both for profit and not for profit. To mitigate on the loss of important health service data from the public sector, the Ghana Ministry of health came up with an innovation to ensure that the data from the private sector gets into the mainstream national data repository. The ministry engaged the medical and dental practice regulatory authority which agreed to enact a policy for data collection from the private sector. Within this policy, all private health care providers are required to provide their data to the Center for Health Information Management of the Ghana Health Service (CHIMS). Failure to submit will result in non-renewal of the licence for the facility. Like all other service providers in the public sector, the private sector is required to report service data to the district level monthly.

This has assisted in ensuring that data from both for profit and not for profit private players is collected and hence the surveillance system does not leave out this very important source of data. This has enabled data collection for NCDI/MH among other disease conditions.

Funding population-based survey through sin taxes: Case of Botswana

Creating an effective national surveillance system requires resources. Health information needs multiple sources of data to be able to be triangulated to get the accurate national situation. One of the most important sources of NCDI/MH data is the population-based surveys like the WHO STEPS survey and the demographic health survey (DHS) supported by the USAID. These surveys are supposed to be conducted every 3- 5 years. Most countries in the AU region are not able to fund the 5-year population-based surveys due to limited financial capacity resulting in surveys like DHS and STEPS surveys not being regularly done. There is need for AU MS to come up with innovative domestic funding models to carry out these surveys regularly. In this extract the experience of Botswana in securing domestic funding for the STEPS survey is described.

Whilst most countries tend to depend on external funding to conduct these population-based surveys, Botswana has come up with an innovation to fund the WHO STEPS survey from domestic resources. Botswana had last conducted the STEPs survey in 2014 making the next one due in 2019. This was not achieved due to lack of funding. In 2022, the NCD unit had to explore other alternatives to address the STEPS survey funding challenge. The main priority was to look for domestic funding. The NCD unit had to use evidence to show the burden of NCDs and their socio-economic impact; how STEPS survey can assist in tobacco and alcohol programmes by provide up to date population level data. The data was presented to the Tobacco Levy implementing Committee. Support was requested from the tobacco as tobacco is one of the leading causes of preventable death. Botswana introduced a 30% tobacco levy in 2014. The proposal was accepted and the committee agreed to cover the total budget as submitted. During the country case studies in Zambia, the Botswana representatives reported that they are now at an advanced stage to conduct the STEPS survey using domestic resources from the tobacco tax. A total of USD 580,000 have been made available to conduct STEPS survey this year. This approach is also being adopted to target alcohol levy as well as sweetened beverages for obesity prevention.

Botswana is hence using sin taxes to strengthen NCDI/MH surveillance. This should be a best practice example that can be cascaded across the MS if there is political will. Domestic funding allows for sustainable funding of the population-based surveys.

Using data to influence policy: Case of Nigeria

Surveillance has been defined as the systematic collection, analysis and use of data. Data use revolves around knowledge sharing and evidence-based decision making. One of the challenges in data management is that data is collected and not used for decision making. There has been very little evidence that most AU MS are using NCDI/MH health data for decision making especially in the area of policy. Below we describe how Nigeria has managed to turn data into policy.

In 2008 Nigeria conducted the Global Youth Tobacco Survey (GYTS) to determine the level of use of tobacco amongst young people. This survey managed to provide information on tobacco and tobacco products access by the youth in the country. The findings established that the policy and legal framework for tobacco and tobacco products access by the youths has been the driving force behind the increase to tobacco use.

Based on the findings of the GYTS, Nigeria started the conversation of the formulation of policies to reduce tobacco use. The National Tobacco Control Act, 2015 which regulates all aspects of tobacco control including smoke free places, tobacco advertising, promotion, and sponsorship, tobacco packaging and labeling, prevention of tobacco industry interference, tobacco product disclosures, the creation of a National Tobacco Control Committee was enacted. This has helped to regulate both the commercial activities promoting tobacco use and the use of tobacco and tobacco products. This policy has also helped Nigeria to make steps to be compliant with the Framework convention for tobacco control (FCTC).

This indicates that data can be used to influence policy.

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