Kenyans Come Together against Chronic Diseases

Upon arrival in one of Kenya’s mud-and-thatch villages, a settlement that may lack running water and electricity, you’d never guess that at least a quarter of the subsistence farmers and herders who live here die from chronic diseases that are usually associated with a far more opulent Western lifestyle.

However, no one really knows what the true numbers are because 80 percent of the population lives in rural areas and no whole-country epidemiological data exist.

The illnesses that are killing so many in this East African country—cardiovascular disease, diabetes and hypertension, among others—are rising exponentially, and they stand among the top 10 leading causes of death nationwide. Stroke is number seven on that list, coronary heart disease ranks eighth and Kenya is facing an impending epidemic of chronic diseases.

It’s a hard life for many here. Nearly half of all Kenyans live in poverty, half of those people subsist on under $1 a day and the average yearly per capita income hovers around $780. Health spending is about $27 per person, which is mostly out of pocket. In contrast, the United States spent $8,233 per person in 2012. But with Kenya’s vast economic disparities, the reality is that most people receive little or no health care, and if a villager has a heart attack or stroke, he or she may just die. Current life expectancy is 60.

Traditionally, HIV/AIDS, pneumonia, infectious dysentery and malaria have been among the greatest health concerns, but chronic, noninfectious diseases are now straining the system. The reasons are many: About a quarter of all men over 18 smoke. The country is among the hardest hit by rheumatic heart disease, with 200,000 new cases each year caused by untreated strep infections. Most women prepare meals over smoky indoor cook fires, exposing themselves and their small children to particulate matter and other pollutants that can damage both heart and lungs.

With increasing urbanization and wider availability of processed foods, a nutritional transition is in full swing. Tastes for and attitudes about food are changing rapidly. Traditional staples such as maize, vegetables and the occasional meat or fish that were previously steamed or boiled are now fried in saturated fat. Meals once seasoned with herbs are now heavily salted. People eat more meat, potato chips have arrived in rural shops and kids are clamoring for soda.

The result: High blood pressure is now rampant, found in nearly 50 percent of the population. In 2012, the country tallied about 720,000 diabetes cases; perhaps another 600,000 go undiagnosed, and these numbers are expected to double by 2030. And although malnutrition is still prevalent, obesity...
is spreading, and along with it, heart disease. The 2008–2009 Kenya Demographic and Health Survey found that 25 percent of women were overweight or obese compared with 12 percent that were underweight.

The economic toll of cardiovascular diseases is devastating to individual families who lose income. Patients often cannot afford treatment—even the cheapest blood pressure medication that costs only 50 cents per day—let alone equipment such as walkers or wheelchairs. And chronic diseases also siphon millions of dollars from the national economy in both health care costs and reduced productivity as workers in the prime of life disappear from the workforce.

But if these problems are caught early by screening programs and treated with relatively simple measures, dire outcomes are largely preventable.

THE CHALLENGES

The Kenyan health system is currently struggling to cope with increasing demand, much of it from noncommunicable diseases (NCDs), that exists alongside the same challenges that face other developing countries: spiraling costs, a lack of facilities and equipment—and a shortage of skilled health care professionals. With about 1,500 doctors available in public service, the ratio is one physician for more than 26,000 people. There is a severe shortage of specialists, almost all of whom practice in Nairobi, the capital, which is home to about 12 percent of the population. There are currently no cardiology training programs in East Africa. All five cardiac catheterization laboratories and open-heart surgery options are also in Nairobi; only one of these is a public facility and it opens only intermittently because of inadequate supplies.

Private facilities are too costly for most people, and though some care is available through nonprofit and faith-based organizations, most Kenyans rely on public health services provided by the government. Although these facilities may be able to offer a free diagnosis, they may not have blood pressure machines or other standard medical devices, and probably won’t have basic medicines—not even aspirin. Despite a pledge made
Promoting Cardiovascular Health Worldwide

Infectious and parasitic diseases have traditionally been the largest killers in Kenya, responsible for more than twice as many deaths as noncommunicable diseases. In 2004, cardiovascular disease and diabetes accounted for 9.5 percent of deaths in men and 11.8 percent in women.

**Estimated Proportional Cause of Death in Kenya, 2004 (%)**

**MALE**
- Circulatory 8.5
- Cancers 4.0
- Diabetes 1.0
- Respiratory 2.8
- Other 5.3
- Injuries 9.7
- Nutritional deficiencies 0.7
- Perinatal conditions 10
- Other causes 78.4%
- Infectious/Parasitic 49.3
- Respiratory infections 8.7

**FEMALE**
- Circulatory 10.2
- Cancers 3.6
- Diabetes 1.6
- Respiratory 2.0
- Other 5.0
- Injuries 4.1
- Nutritional deficiencies 0.6
- Perinatal conditions 29
- Maternal conditions 2.9
- Other causes 77.7%
- Infectious/Parasitic 54.6
- Respiratory infections 2.6

**SOURCE:** WHO Global Infobase, Global Burden of Disease: data sources, methods and results

Alongside other African Union countries in 2001 to increase government health spending to at least 15 percent of their national budget by 2015, expenditures have ranged between 5 and 8 percent over the last five years. That money has been almost entirely invested in the treatment of infectious disease, with a heavy emphasis on acute care. The ability to administer long-term care for chronic illness is largely lacking.

Ultimately, the dearth of tools, facilities and health workers who may not have sufficient training in NCDs is increasing the risk that chronic diseases may remain undetected or be misdiagnosed.

Until now, much of the medical care available for noncommunicable diseases has come through the efforts of nonprofits, including patient advocacy groups. One of the most influential advocates is the NCD Alliance that was formed five years ago, an umbrella for seven organizations including the Kenya Cardiac Society, Kenya Diabetes Association and the Kenyan-Heart National Foundation. They function as part of a larger international alliance that networks over 2,000 organizations in some 140 countries. Their stated mission: To combat the NCD epidemic by putting health at the center of all policies.

One project that has helped diabetes sufferers is the Base of the Pyramid Project. Since 2012, it has provided insulin access to more than 2,600 patients and as a result, the cost of a month’s supply dropped by more than two thirds, down to about $6. Every month, one hundred–plus facilities now host days devoted specifically to diabetes and local patient support groups. This project partners the Ministry of Health and the Royal Danish Embassy with the Kenya Defeat Diabetes Association as well as a number of faith-based health organizations and Novo Nordisk, the world’s largest manufacturer of insulin.

Though such initiatives have made some types of care available and have brought awareness of the growing problem, it’s occurred in a limited, piecemeal way. Over the past five years the NCD Alliance has lobbied the Ministry of Health to address the growing incidence of NCDs. Their efforts have helped to spark new policy and action. Now, the entire health system is about to be revamped, with chronic disease being actively incorporated into a new action plan.

A BRAND NEW FRAMEWORK

Kenya’s adoption of a new constitution in 2010 altered jurisdictions and decentralized many areas of government, changing the framework for the country’s health care system. The national government still runs the large, urban hospitals but county governments are now responsible for the bulk of primary care, including prevention and diagnosis. Community health workers provide much of this “Tier 1” care, along with a few primary and acute care facilities in each of Kenya’s 47 counties.

The new Kenya Health Policy 2012–2030, which is currently under review, provides an overarching strategy for bringing proven interventions to villages, clinics and hospitals. The so-called Kenya Essential Package for Health defines minimum health care requirements. It also outlines ways to prevent disease through education on common risk factors such as poor diet, tobacco, indoor smoke and lack of exercise, and by targeting at-risk populations. Few Kenyans know much, if anything, about these diseases.

A 2008 tobacco control law bans smoking in public places and workplaces and prohibits virtually all advertising, promotion and sponsorship of tobacco products. But implementation has been weak and an enormous economic war is being waged by multinational companies that sell tobacco and unhealthy foods, and their efforts are not being adequately countered by the political will to protect health. There are no laws in Kenya regulating food, including salt content.

The new health plan also recommends that community health workers screen for signs of heart disease, diabetes, obesity and high blood pressure in the small towns and villages they
visit, and that those screenings become standard protocol at district clinics and hospitals as well. These diagnostics are often not available even at high-level provincial hospitals.

But Kenya also needs to quantify the scope of the problem. In 2011, the government launched an eHealth strategy that will help supplement the dearth of health data. But it will also help to address other gaps in the health care system. Digital health records will help extend the reach of health services into remote areas and mitigate some of the disparities between access to care in urban and rural areas. Computerized patient “charts” will facilitate medical referrals and follow-up care.

Digitally available information will go a long way toward educating citizens and allowing medical personnel to investigate new treatment protocols. The eHealth database will also inform policy, investment and research decisions. Electronic data may help communities stock needed drugs and equipment—so that shortages become a thing of the past.

Even if medicines and access to care become widely available, cost remains a huge barrier. In April 2012, then-Prime Minister Raila Odinga expressed his concern in an interview with Capitol Broadcasting Network, a local media outlet. “As we change policy, we must also think about how to make medical care both accessible and affordable to all Kenyans who are living just one disease away from bankruptcy or death.” The reason, he said, is that “a hospital bed is more expensive in Nairobi than a bed in a five-star hotel...” He expressed the need to “develop a universal medical insurance to cushion the least fortunate members of the society.”

There is great competition over scarce resources. Though HIV/AIDS is still the biggest killer in Kenya, and 64 percent of all deaths are attributed to contagious conditions compared with the 26 percent of deaths caused by cardiovascular and other noncommunicable chronic diseases, that will not be the case going forward. As the Ministry of Medical Services and the Ministry of Public Health and Sanitation noted in Kenya Health Policy 2012–2030, “Emerging trends point to the fact that noncommunicable conditions...will increasingly, in the foreseeable future, be the leading contributors to high burden of disease in the country...” If current policies and interventions continue, infectious disease will drop to 39 percent of all deaths by 2030 and chronic disease will jump by 55 percent, becoming the cause of 47 percent of all deaths in Kenya.

Separate national policies for individual diseases are not tenable in a low-income country like Kenya that struggles under a critical shortage of human and financial resources. One all-encompassing national policy on chronic disease is essential to clarify goals and to integrate diagnosis and treatment within existing health and social policies.

The government needs to put a final stamp on a national strategy to prevent new cases of stroke, diabetes, heart attack and the disability they may cause, and to save lives across Kenya. With this overarching framework, the government can integrate this suite of illnesses within a larger, synergistic public health strategy that targets all citizens.

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Kenya Fact Sheets of Health Statistics 2010. WHO.