Epidemics without Borders

Cardiovascular and Other Chronic Diseases: The Next Development Assistance Priority

Authors
Gregory Paton, K. Srinath Reddy and Kiti Kajana

It's not every day that presidents and heads of state fly to New York City to discuss a virus. It was September 2001, and governments, charities, corporations and activists took over several city blocks to galvanize action against further spread of the HIV/AIDS virus. Addressing a United Nations Special Session, Nigerian President Olusegun Obasanjo captured the sense of urgency, warning fellow leaders that, “the prospect of extinction of the entire population of a continent looms larger and larger.” At the time, 36 million people were living with HIV/AIDS—25 million in sub-Saharan Africa alone.

News of the meeting was broadcast around the world, showing images of advocates holding quilts in honor of deceased loved ones, celebrities wearing red ribbons and philanthropists pledging billions in aid to assist AIDS-ravaged countries. Images of the devastating impact of the virus went viral—along with growing feelings of injustice that people who lived in poor countries lacked access to lifesaving medicines available in the Western world.

Fortunately, politicians listened. A decade later, nearly 10 million people are alive and healthy, thanks to antiretroviral drugs largely funded by the United States and other Western governments. These medicines transformed AIDS from a death sentence into a chronic, treatable condition, and millions avoided contracting the virus through widespread prevention and education programs. The global solidarity shown in the fight against AIDS sparked dramatic progress and became a landmark achievement in international public health.

A NEW THREAT

The fight against AIDS, as well as tuberculosis and other infectious disease, is far from over—in 2012, three quarters of AIDS cases in low-income countries went untreated and tuberculosis caused 1.3 million deaths. But research by the World Health Organization (WHO) and leading epidemiologists has identified another global epidemic. This one is not contagious, caused instead by a combination of lifestyle and environmental factors. This groundswell of “noncommunicable disease” (NCD) cases—heart disease, stroke, diabetes, cancers and respiratory diseases—all share common risk factors, including a fatty, salty, sugary diet; a sedentary lifestyle; smoking and chewing tobacco; and drinking too much alcohol.

Ten years after the HIV/AIDS meeting in New York, governments recognized that this new crisis warranted a second United Nations health summit. Thirty-five heads of state attended, plus 120 ministers of health and representatives from a host of nonprofit organizations—but all returned home with empty pockets. Some countries questioned the point of the meeting, asking behind closed doors whether weeks of diplomatic negotiations and the voluntary “political declaration” they passed would yield tangible results. Countries were unable to agree on targets for reducing these diseases, and
“The failure to act globally would create a catastrophe, one that we know is coming and have the power to prevent.”
without significant funding from governments or philanthropists, it would be impossible to turn words into action. The media was skeptical. In their reporting, The Economist wrote, “So far, the world’s response has been to have meetings.”

But up until then, these diseases had essentially been neglected by governments, international health organizations and aid organizations. Despite any shortcomings, the summit placed the issue squarely on the table. And people did take notice: A rally organized by the NCD Action Network (a coalition of young health workers, students and concerned citizens) greeted heads of state with megaphones and banners demanding increased access to medicines, action against tobacco companies, and other local and global measures. Their overall message: NCDs are a matter of social justice.

As politicians and ministers flew out of New York, one point was undisputed. They were not doing enough to address these health conditions at home, and almost nothing to encourage cooperation beyond their own borders.

**FROM MYTHS TO ACTION**

Although no one expected one meeting to change the world overnight, the lack of international and domestic commitment is something governments can no longer ignore. Together, heart disease and other noncommunicable diseases kill nearly 36 million people each year. Four fifths of those deaths occur in low-income countries. Contrary to common belief, these diseases do not affect only the elderly; about nine million sufferers don’t live to see their 60th birthday.

For some, vulnerability begins in the womb. Infants who are malnourished in utero and born at low birthweight come into the world with heightened odds of developing heart disease and diabetes later in life, according to a 2010 study published in *BioMed Central Public Health*.

These diseases were once highly common only in wealthy countries. But over the last decades, rural dwellers have streamed off the land into rapidly industrializing cities, with new, low-income urban communities across the globe adopting unhealthy lifestyles. It’s one of the driving forces behind this global epidemic. New evidence is emerging that the poorest members of society are most at risk.

Another myth is that Western countries haven’t made progress against these conditions. The combination of prevention and treatment over the last 20 years is paying off in places like Finland, where deaths from heart disease have dropped by 80 percent, largely because of healthy lifestyle changes.

**IT IS ABOUT THE ECONOMY**

The rapid rise of the health burden of chronic diseases is compelling on its own, but economic development is another reason for donor governments, along with philanthropic and international organizations to shift some of their efforts to global noncommunicable diseases. A recent study led by David Bloom, a professor at Harvard School of Public Health, found that the cumulative price tag for heart disease and other noncommunicable diseases in developing countries could surpass $7 trillion by 2025.

That study was commissioned by the World Economic Forum (WEF), a nonprofit organization that engages the world’s leading business and political leaders on key issues. Another WEF study unearthed equally shocking statistics: Brazil, China, India and the Russian Federation currently lose more than 20 million productive life years annually to these diseases. In an increasingly interconnected global economy, productivity losses of this magnitude reverberate far beyond individual borders. In a forum survey, Fortune 500 companies identified NCDs among the top global threats to economic growth.

With effective solutions, the fight against HIV/AIDS and other infectious diseases made dramatic gains. Similarly, there are known effective solutions to reduce the burden of chronic diseases, but commitment is needed to implement them. The inventor of the first oral polio vaccine, Albert Sabin, said that a vaccine that sits on the shelf is useless. Not all interventions are as simple as vaccinating children. But if fully implemented, cardiovascular disease interventions could avert some three million premature deaths a year in low- and middle-income countries—and save billions of dollars in treatment costs and lost productivity.

**AID THAT SUPPORTS HEALTH FOR ALL**

There is intense competition over the $28 billion that high-income governments and philanthropists donate each year to combat disease in developing nations. One pressure on how that money is spent is the need to find quick-win initiatives like vaccine programs where governments and organizations can easily demonstrate short-term results to taxpayers and sponsors.

While demonstrating success is crucial, effective aid also needs to finance change that benefits every patient who seeks health services. That means building a strong health system...
with well-trained health care workers, readily available primary care and a monitoring system that reveals what’s happening on the ground, quantifying the burden of disease. All are crucial components of a coordinated response. But revamping a nation’s health care system is a costly, long-term investment that many donors aren’t willing to sign on for.

Primary care centers in rural settings suffer the most, lacking basic equipment like blood pressure cuffs, heart and blood pressure medicines and needed staff. Such centers are a community’s first line of defense, not only offering screening, diagnosis and health counseling, but early treatment that will prevent future complications—or death—so creating and supporting these facilities is key.

In these difficult economic times, it is understandable that Western governments may have difficulty prioritizing non-communicable diseases within their international health agendas. But if some part of the $28 billion they spend each year fighting disease in developing countries builds sustainable health systems, huge gains will be made in the coming years.

**ASSISTANCE BEYOND THE HEALTH SECTOR**

Several years ago, health and development organizations (including WHO) began focusing efforts beyond the health sector, recognizing that there were wider issues driving the exponential rise in chronic diseases. Among them were food systems, migration patterns, growing urban slums and increased tobacco use. The health system is left to pick up the pieces and absorb high treatment costs, becoming a victim to policies outside its control. In 2013, at the 66th World Health Assembly in Geneva, health ministers agreed on actions that would, if properly implemented and monitored, cut early deaths from noncommunicable diseases by 25 percent. But trying to lower epidemic levels of heart disease, stroke, obesity and diabetes without proper policies in place to prevent them is akin to patching a hole in a pipe with infinite leaks. No amount of financial aid will stop the endless flow of patients created by weak policies on tobacco, unhealthy food and exercise—and their huge effect on health systems and the economy.

This raises an important question: How much impact will U.N. goals forged in Geneva bring, when at home some countries have not established even basic health policy measures? At the 2011 Summit on Noncommunicable Diseases, all 194 U.N. members promised to develop national NCD action plans by January 2013, but the date passed with little attention to who had met this commitment.

The focus of external health assistance needs to continue to expand beyond health services. It also must provide technical cooperation and policy support that, working with strong national leadership, will result in countries enacting policies that nurture healthier populations, with fewer sick people for hospitals to treat. Enacting and implementing policy measures that impact cardiovascular diseases can cost less money than individual interventions or changes to the health system. Tax hikes on tobacco, alcohol and unhealthy foods are a great example: They drive down consumption while raising cash for health services. Modifying existing initiatives is also relatively easy and less costly—for example, adding a quit-smoking component to a tuberculosis program.

A huge roadblock to progress is the fact that health ministers hold limited influence compared with their counterparts in trade, agriculture, transportation and finance—and vested interests wield immense power. Trying to enact health policies that negatively impact local incomes or corporate profits—even when those measures will save countless lives—are difficult, if not impossible to push through.

Tobacco is a case in point. By 2014, 177 nations had ratified the WHO Framework Convention on Tobacco Control, the world’s first...
global public health and corporate accountability treaty. They committed to reducing tobacco use by raising taxes on tobacco products and banning advertising, creating smoke-free public spaces and workplaces, publicizing health warnings and preventing industry interference in health policies.

Guidelines require signatories to treat the industry differently from others because tobacco is perhaps the only legally available consumer product that kills people when used as intended: It kills someone every six seconds. But global tobacco lobbies exert powerful influence. In India, industry pressure successfully delayed implementation of pictorial warnings on tobacco products for two years. The government ultimately weakened and reduced the size of those warnings. Some 275 million Indians use tobacco, with over one million tobacco-related deaths each year.

In Uganda, a proposed tax increase on cigarettes ignited a huge industry outcry, although levies in neighboring countries are far higher. At the end of 2013, no final decision had been made.

A 2008 WHO report calculated that the world's governments collect five times more money from tobacco taxes each year than they spend trying to curb use. Meanwhile, governments often accept money from the industry under the corporate "social responsibility" umbrella. "These policy makers need to realize how the industry manipulates the system to interfere with public health policy—and ‘charitable donations,’ which only serve to open doors for the industry to expand their businesses, provide legitimacy to their actions and block effective tobacco control policies," said Ehsan Latif, director of tobacco control at the International Union Against Tuberculosis and Lung Disease. An example: In 2004, tobacco manufacturers spent seven million Kenyan shillings (about $90,000) on a luxurious "workshop" in Mombasa for members of parliament in an attempt to weaken their Tobacco Control Act.

International business interests also come into play. For 13 years, Samoa was denied entrance into the World Trade Organization (WTO), in part because they held a firm import ban on "turkey tails." Turkey tails are poor quality, high-fat off cuts meat sold mainly to Third World markets. Only when Samoa lifted the ban in 2011 were they admitted to WTO. Nick Wilson, an expert on the health of Pacific nations, called the move "highly problematic" in the Samoan press. "From a public health perspective the decision to allow turkey tails...will fuel the epidemics of obesity, diabetes and cardiovascular disease that are hitting Pacific Island nations," he said.

ASSISTANCE IN BUILDING LOCAL KNOWLEDGE

Another way that donor assistance can help is by supporting collaborative research. To date, there have been few long-term studies of these diseases and interventions to address them in developing nations. To counter that, institutions from high-income countries are partnering with public health agencies and university health departments, collaborating on first-class research.

One such study is helping diagnose children with rheumatic heart disease in Uganda. Without antibiotics, strep throat can progress to rheumatic fever, damaging heart valves. Cardiologists from Children's National Medical Center, in partnership with the World Heart Federation, ran echocardiograms on some 5,000 children. "What we found is that there were many children who had clinically silent RHD [rheumatic heart disease], which would have gone undetected without an echocardiogram," said Andrea Beaton, the study's lead author. This type of screening proved to be three times more effective than a normal examination with a stethoscope. Rheumatic fever affects more than 15 million people, mostly in poor countries.

When establishing these partnerships, Western researchers need to consider whether their protocol or technology will work in small, remote villages in Asia or Africa or Latin America—places that may be fairly inaccessible, may lack electricity and refrigeration or may have strict religious or cultural traditions. They also must make sure to translate their findings in...
an understandable, accessible way for health ministers and other policy makers.

And funding must be targeted. Large international non-profits and philanthropists must ensure that the billions they spend on health projects each year include screening and treatment for coronary heart disease and other NCDs.

GLOBAL SUPPORT—AND LOCAL COMMITMENT

Change must begin at home. A commitment will be more likely from donors and international organizations—and the resources will go further—if that commitment is paired with national commitment in low- and middle-income countries. Despite limited resources, governments must prioritize the health of their citizens. Achieving that goal sometimes takes pressure from advocates and concerned citizens that prods governments to take action. The average citizen suffering from heart disease may be unaware of commitments and targets created in New York and Geneva, but they do know what is happening in their own countries. The role of national patient groups and activists is critical in forcing politicians to translate rhetoric and resolutions into services.

Those efforts sometimes come at a price. The public protests that characterized the AIDS movement sparked action—but persecution of people living with HIV/AIDS became widespread and remains a major challenge in some countries today. Likewise, the stigma associated with cardiovascular disease and diabetes has prevented many from going public and making their case to politicians.

Without advocacy and partnerships, voluntary international commitments may be little more than paper tigers, never becoming high priority domestic issues. For example, pressure from advocates and patients prompted Uganda’s elected officials to create the Parliamentary Forum on Noncommunicable Diseases. In 2012, the forum wrote, “Uganda faces a real threat of an epidemic of NCDs within the next few years if immediate practical steps are not taken to reverse this dangerous trend.” The forum characterized these stigmatized diseases as “silent killers,” hidden because they are considered by many to be “some kind of witchery.” They noted that the only way to avoid overstretched already strained health systems is prevention—and education.

Toward that end, the Uganda NCD Alliance, a national coalition of groups, offers integrated services to patients. One initiative sends volunteers, many of whom live with these conditions, into villages. They train health workers to educate community members and counter the common myths that prevent people from seeking treatment. There is also a global NCD Alliance that unites more than 2,000 organizations in the fight against noncommunicable diseases.

In his work at the Uganda Cancer Institute, Uganda NCD Alliance Chair Jackson Orem has demonstrated that millions of lives could be saved if doctors, governments and medical companies work together to facilitate affordable access to the latest technologies and medicines.

Across the globe, advocacy groups are pushing politicians to draft new laws and increase government health budgets. For but for now, the political leadership shown by Uganda’s elected officials remains the exception rather than the rule.

TOWARD A HEALTHY FUTURE

These health problems are far from solved in the U.S., Europe and other Western countries. But the failure to act globally would create a catastrophe, one that we know is coming and have the power to prevent. Let’s start by creating a sense of urgency and pushing our governments to protect people from the tragedy of shortened lives and disability. Non-communicable diseases have gone global, and looking beyond our own borders is the right course of action.

ABOUT THE AUTHORS

Gregory Paton has worked with the Uganda Cancer Institute, International Diabetes Federation and the Commonwealth Secretariat. He has a lead role in creating the NCD Alliance and managed the international campaign for a U.N. Summit on NCDs.

K. Srinath Reddy is president of the Public Health Foundation of India and also serves as president of the World Heart Federation.

Kiti Kajana is a director at Global Health Strategies in New York City. She works on a variety of global health advocacy and communications projects.

MORE TO EXPLORE

Chronic Diseases in Developing Countries: Growing Pains. The Economist, Sep. 24, 2011.

