THE EMERGING BURDEN OF CHRONIC DISEASES AND ITS IMPACT ON DEVELOPING COUNTRIES

CONFERENCE REPORT
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“WE STAND TODAY WHERE WE WERE WITH HIV IN THE 1980s – WE CAN LOOK AT THE NEXT TWO DECADES AND INTERVENE TO MAKE A HUGE IMPACT ON HUMAN LIVES. ARE WE GOING TO BE DELINQUENT? UNLESS WE HEED THE PARIS DECLARATION AND FOCUS ON SHARED INTERCONNECTED RISKS THAT TRAP HOUSEHOLDS INTO POVERTY AND SICKNESS, WE WILL NOT ACHIEVE BASIC GOALS OF HUMAN DEVELOPMENT.”

Prof David Stuckler, Research Fellow, University of Oxford, United Kingdom
Transforming disease pattern

Non-communicable diseases (NCDs), including cancers, diabetes, injury/violence, mental disorders, cardiovascular and respiratory diseases, account for 35 million deaths each year, corresponding to 60% of all deaths worldwide. The surprising fact is that 80% of these deaths occur in low and middle-income countries (LMICs), which are traditionally thought of as primarily affected by communicable diseases, including malaria, tuberculosis and HIV/AIDS. According to the World Bank, NCDs are now among the most significant causes of illness and death in working-age populations in developing countries. Yet, financing the prevention and treatment of NCDs accounts for less than 1% of official development assistance (ODA) for health. Contrary to popular belief, NCDs do not only impact the elderly in high-income countries: In the developing world, NCDs such as diabetes and hypertension often affect individuals in their mid-forties and early fifties – during the most productive part of their lives – contributing to loss of productivity and higher rates of premature morbidity and mortality. In addition to the ongoing battle against infectious disease, experts believe that the growing burden of chronic diseases in rapidly urbanising LMICs – with inadequate health systems and lack of infrastructure – will negatively impact progress towards the Millennium Development Goals (MDGs).

According to Dr Ala Alwan, Assistant Director General for NCDs and Mental Health at the World Health Organization (WHO), “Health has never enjoyed the priority it has today within the global development agenda. Several health priorities are currently well-established globally, but we are still missing non-communicable diseases as a major health challenge for poverty reduction and sustainable development.”

The gap between burden and commitment

There is an urgent need to bridge the gap between the burden of disease and financial and political commitment if we are serious about poverty alleviation and sustainable development. On the other hand, there has never been a more opportune time to address NCDs effectively. In his opening statement at the International Conference on the Emerging Burden of Chronic Diseases and its Impact on Developing Countries held in Copenhagen, Denmark, on 15 - 16 April 2010, Prof Pierre Lefèbvre, Chairman of the World Diabetes Foundation, stated that “Unless this opportunity is seized by the donors, governments and other partners, the current progress towards the internationally agreed development goals will be undermined and countries will face unbearable costs to their economies and health systems. The world is at a unique tipping point in the history of public health, an opportunity that will rapidly fade if no timely action is taken.” It is this “tipping point” that led Danida in partnership with the World Diabetes Foundation to host the conference, which gathered 140 leading public health and development assistance professionals and high-ranking government representatives from North and South to present and discuss the implications of NCDs in low and middle-income countries – and to address the consequences of not facing up to the reality of the rising pandemic. Participants included the ministers for health from Mozambique, Uganda and Denmark, the Danish Minister for Development Cooperation as well as representatives from the World Health Organization, the World Bank, the Norwegian Agency for Development Cooperation, the International Diabetes Federation, the World Heart Federation and the International Union Against Tuberculosis and Lung Disease. A person living with a chronic disease in Nairobi’s
Viwandani slum also attended the conference and spoke on behalf of the millions of individuals struck by poverty and disease in developing countries. Speakers at the conference noted that while research gaps remain, there is ample evidence and clear knowledge to address the prevention of and care for NCDs in the developing world, including cost-effective interventions that can be implemented immediately.

The objective of the conference was to highlight evidence and experience of and facts on NCDs and their impact in developing countries and to stimulate frank discussion and reflection on the issues presented to bridge the reality-perception and the know-do gaps. This conference was intended to enhance the process of partnership development and create advocacy to address NCDs in development policy, programming and financing urgently and appropriately. This document summarises the conference proceedings through a synthesis of presentations and discussions. The report concludes with a summary of recommendations and suggestions for the way forward.
Not a competition
There is a surging momentum in the recognition that NCDs contribute significantly to the global disease burden – also including in low and middle-income countries. A unique opportunity exists for harnessing this momentum for sustainable international health and development.

According to Dr Gojka Roglic, Medical Officer for the Department of Chronic Diseases and Health Promotion at WHO, “What has happened in the western world in 50 years is happening in 15 years in the developing world.” Yet, never before has health been so highly prioritised on the global development agenda. The fact that three of the eight MDGs are health-related and many of the indicators are correlated with health provides the opportunity to ensure that NCDs are incorporated into the development agenda.

According to the Danish Minister for Development Cooperation, Mr Søren Pind, “Governments should generate conditions in which everyone can be as healthy as possible. Freedom from disease is one of the most fundamental determinants of health. It is important for economic and social progress for families as well as for societies.” This does not imply replacing one set of diseases with another. In fact, according to Dr Alwan, Assistant Director General for NCDs and Mental Health at the WHO, “We should not be talking about competition between the prevention of NCDs and communicable diseases control. They can – and should – mutually reinforce and complement each other. What we need to realise is that NCDs pose enough of a threat to the sustainable development and security of the world that they warrant a large and commensurate response by the international community.”

A high-risk business
The explosive rise of NCDs attributed to aging populations, epidemiological transition, obesity and harmful lifestyles and environments against a background of rapid, unplanned urbanisation and globalisation requires multi-sectoral intervention. The urgency of addressing NCDs in global health and development can be summed up in a question posed by speaker Dr Osborn Tembu, Medical Officer at Kijabe Mission Hospital, Kenya, “How can we save someone’s life only to see the same person die because of a chronic disease?”

CREATING AWARENESS GLOBALLY AND LOCALLY
In December 2006, at its 83rd plenary session, the United Nations General Assembly adopted Resolution 61/225 designating 14 November as World Diabetes Day. This landmark Resolution recognises diabetes as a chronic, debilitating and costly disease with major complications that pose severe risks to families, communities, countries and the world. The Resolution encouraged national governments to develop national plans aimed at preventing diabetes. Following up on the success of Resolution 61/225, the International Diabetes Federation (IDF), in partnership with the World Heart Federation (WHF), the International Union Against Cancer (UICC) and the International Union Against Tuberculosis and Lung Diseases (IUALTD), has called for a United Nations General Assembly Special Session (UNGASS) on NCDs to be held in September 2011. The efforts have been led inside the United Nations by the Caribbean Community Secretariat (CARICOM). On Thursday, 13 May 2010, the efforts bore fruit when the United Nations General Assembly voted in favour of a UN Resolution calling for a UN
Described as “a problem neither the developed nor the developing world can afford,” the 2010 Global Risk Report from the World Economic Forum shows that the risk of severe economic loss as a result of the burden of NCDs is on a par with the global financial crisis.
“WHAT HAS HAPPENED IN THE WESTERN WORLD IN 50 YEARS IS HAPPENING IN 15 YEARS IN THE DEVELOPING WORLD.”

Dr Gojka Roglic, Medical Officer for the Department of Chronic Diseases and Health Promotion at WHO, Switzerland
“IT MAY SEEM THAT WE ARE FOCUSING ON PROBLEMS BEYOND THE DEVELOPMENT DOMAIN, BUT NCDs SHOULD BE INCLUDED IN THE DEVELOPMENT AGENDA IF WE ARE SERIOUS ABOUT IMPROVING THE LIVES OF THE POOR.”

Dr Ala Alwan, Assistant Director General for NCDs and Mental Health at the World Health Organization (WHO), Switzerland

Summit on NCDs in September 2011 to be attended by heads of government.

Dr Alwan highlighted three recent developments at the international level, which contribute to this historic opportunity to take action:

- Growing international awareness that the NCD gap in the health development agenda may derail efforts to improve health and reduce poverty;
- Increasing political momentum exists to include NCDs in global discussions on development;
- Availability and feasibility of low-cost solutions to prevent and treat NCDs in developing countries are viewed as effective economic investments.

Citing important developments at the World Health Assembly over the last ten years, from the Global Strategy for the Prevention and Control of Non-communicable Diseases (2000), the WHO Framework Convention on Tobacco Control (2003), the Strategy on Diet, Physical Activity and Health (2004) to the Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases (2008-2013), he said that the attention on NCDs is growing and the WHO is increasingly urging and encouraging member states to pay close attention to monitoring and evaluating NCDs with special attention paid to poor and marginalised populations.

National action

In addition to the global momentum spearheaded by international organisations and large civil society organisations (CSOs), a repeated call was seen for local and national CSOs to be part of the advocacy and awareness-building campaign to ensure that NCDs are given priority at the national level. According to Dr Paulo Ivo Garrido, Minister for Health of Mozambique, “Everyone needs to understand the issue of NCDs.” Admitting that even in his role as Minister for Health he had been surprised to discover the burgeoning problem of NCDs in his country, Dr Garrido called for focus on health education as well as for development of effective plans, “We need to plan carefully for sustainable prevention, treatment and care of NCDs at all levels – from central to provincial to district levels.” Dr William Maina, Deputy Director of Medical Services and Head of Division of NCDs in the Ministry of Public Health & Sanitation in Kenya, called ignorance of NCDs “a risk factor” in health development. “Over 70% of the population in Kenya have no idea what NCDs are!” exclaimed Dr Maina, in a country where “almost 100% of health financing goes to communicable diseases.” Dr Maina noted that this is strange when you consider that the prevalence of HIV is 6.3% compared to 10.4% for diabetes in urban areas.

Private sector action

There is also an important role for the private sector to play in the prevention and control of NCDs. According to Mr Mads Øvlisen, board member of the United Nations Global Compact, “private-public partnerships are needed for success” in the battle against NCDs. He stated that a successful partnership “requires participation of local communities, local champions and local businesses.” The challenge, according to Mr Øvlisen, is that local communities do not trust corporations. Thus, focus on trust-building through accountability, transparency and legitimacy is needed. “The only way to create legitimacy of corporations,” he said, “is to improve the lives of people.” He called for principles of corporate social responsibility (CSR) which are “not just because it is good for business, but because it is simply the right way to do business.” Ms Lise Kingo, Executive Vice President of Novo Nordisk A/S, reiterated the important role of the private sector in making a difference at local level. “We want to be part of the solution,” she said. “not the problem.”
THE FACE OF NCDS
IN DEVELOPING COUNTRIES

“SOCIAL INJUSTICE IS KILLING PEOPLE ON A GRAND SCALE. IT NOT ONLY MAKES SENSE TO INCLUDE EQUITY IN THE HEALTH AND DEVELOPMENT AGENDA, BUT IT IS IMPERATIVE TO DO SO.”

Dr Rene Loewenson, Epidemiologist and strategic advisor to the WHO Commission on the Social Determinants of Health, Zimbabwe

SHARED RISK FACTORS

Many chronic, non-communicable diseases share risk factors that are largely preventable and can be addressed through social, environmental and structural policies, programmes and interventions. According to Dr Gojka Roglic, Medical Officer for NCDs at the WHO, these risk factors “contribute to a large portion of morbidity and mortality, share common pathologic pathways and create a substantial financial burden on the health care budgets spent on treating complications.” By ensuring that cross-sectoral approaches to prevention, a potential also exists to alleviate the burgeoning burden of NCDs in developing countries. Conference participants highlighted access to safe and adequate shelter, potable water, sanitation, affordable nutritious food, transportation and other basic services as critical to a family’s survival and ability to prevent chronic disease. These interventions go beyond individual responsibility in health and focus on the structural and social/environmental determinants that are embodied as disease, particularly for women and children. Such interventions must include appropriate, local responses that address the daily realities of the struggle for survival. As Dr Samuel Oti of the African Population and Health Research Centre (APHRC) pointed out, when a slum dweller is diagnosed with chronic disease, it is not enough to ask him or her to change his or her diet and exercise routines. Many of the slum dwellers diagnosed with chronic disease lack the ability to choose nutritious food. “How can I ask a diabetic slum dweller,” asked Dr Oti “to change his or her lifestyle when he or she does not have a choice?” Chronic disease in vulnerable populations of the developing world does not “look” the same as chronic disease in the developed world. Focusing on health equity and the social determinants of health is one way of addressing these issues holistically.

SOCIAL DETERMINANTS

Addressing health equity and the social determinants of health, particularly the social determinants of NCDs, is critical if we wish to “Close the gap in a generation” as is the title of a WHO report. In fact, it is critical to understand what Dr Rene Loewenson, Zimbabwean epidemiologist and strategic advisor to the WHO Commission on the Social Determinants of Health, called the “causes behind the causes” of NCDs, or the underlying risks. These include economic and social insecurity, gender discrimination and highly stressful lives focused on survival. Prof Michael Montoya, anthropologist from the University of California-Irvine, added historic and social conditions such as the radical disruption of indigenous lifestyles and urbanisation. Prof Montoya called chronic disease an “embodiment of hardship” suffered by marginalised populations having experienced collective trauma on the road to development. Solutions to the challenge of NCDs cannot be removed too far from the social and historic conditions that impact the lives of the poor in developing countries. Dr Loewenson reiterated the question posed by the late, former Director-General of the World Health Organization, Dr Lee Jong-Wook, who asked “Why do we treat people for disease and send them back to the conditions that made them sick in the first place?” The work on social determinants of health offers us the opportunity to answer this question by addressing health equity and social justice. “Social injustice is killing people on a grand scale,” stated Dr Loewenson. “Addressing equity and equality through the health sector will help other sectors address these issues. There is an opportunity in addressing NCDs to intervene at the level of these social determinants and thus avoid the inequalities in health outcomes that arise from an over-reliance on personal care and curative interventions.”

Health is everyone’s business

In order to ensure social justice and equity, health cannot be seen as the monopoly of the health sector, but must be included in all sectors. While addressing health as an outcome of interventions in other sectors is critical to sustainable development, it is this sector that must lead the efforts to ensure that research and evidence are appropriately communicated both internally and externally. As mentioned by Dr Loewenson, “Health is not just the business of the ministry of health, but everyone’s business – the business of the whole of government.” Prof Srinath K Reddy, President of the Public Health Foundation of India, argued for a new, integrated focus: “A strategy to include health at the centre of all policies should unify sectors across determinants and not diseases. Thus, moving away from a focus on disease and focusing on determinants of disease.”

According to Prof Montoya, “If the incidence and prevalence of diabetes and other chronic diseases are conditions brought on by radical disruptions of lifeways, dispossession, poverty, enslavement, forced migration, famine and, in short, a life without the choices to develop into learning, creative, devoted full members of your community, then merely treating the disease adds insult to injury. What I am advocating, what I think the evidence warrants, is that diseases are no
longer to be treated in isolation, but managed for the complicated entangled ways that life conditions have become embodied.” According to Prof Srinath K Reddy, President, Public Health Foundation, India, “As socio-economic and health transitions advance within each country, the social gradient for NCD risk factors and NCD events progressively reverses till the poor become the most vulnerable, dominant victims.”

**LIVING CONDITIONS**

The nearly one billion slum dwellers worldwide are a testament to the embodiment of life conditions that demand holistic approaches to the prevention and management of chronic disease. Mr Robert Maregwa lives in the Viwandani slum in the Kenyan capital of Nairobi. He was diagnosed with diabetes five years ago, at the age of 40. Informed by his doctor that this is a condition, which requires life-long medication and optimal lifestyle changes, Mr Maregwa shared his reality with the participants at the conference. Working as a welder gives him just two dollars a day, which obviously limits the type of lifestyle he can afford. Once he has paid for housing, affordable food, school fees for his daughter and his own medicine, he has 22 cents left on a daily basis – and whatever is left goes to sustaining his wife who lives in his Kikuyu home community. “I know that I could spend double the amount on food if...

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UN Habitat, State of the World’s Cities 2010/2011: Bridging the Urban Divide

$2,827.6 million in 2010 according to UN HABITAT State of the World’s Cities 2010/2011
"AS SOCIO-ECONOMIC AND HEALTH TRANSITIONS ADVANCE WITHIN EACH COUNTRY, THE SOCIAL GRADIENT FOR NCD RISK FACTORS AND NCD EVENTS PROGRESSIVELY REVERSES TILL THE POOR BECOME THE MOST VULNERABLE, DOMINANT VICTIMS."

Prof Srinath K Reddy, President, Public Health Foundation, India

I were to live healthily – now I try my best with beans, vegetables and a little meat," he says. "The majority of people with diabetes in the slum are very poor. Most of them have witnessed the death of their colleagues." Describing the lack of security, sewage, health facilities and food in Nairobi’s slums, Mr Maregwa described first-hand the double burden of infectious and chronic disease rampant in his home community. Mr Maregwa called “ignorance” the biggest “killer” in poor communities.

Dangerous myths

Many participants mentioned that the most frustrating barriers to linking chronic and infectious disease are the perpetuation of myths and the medical paradigms that currently exist in the health community. One such myth is that NCDs are not really an issue in Africa. Prof Ib Bygbjerg of the Copenhagen School of Public Health at the University of Copenhagen said that “the most dangerous myth perpetuated by experts is ‘that you can look at someone and tell if they have diabetes’. Just as you cannot see HIV – it is a myth that you have to be overweight to have hypertension or diabetes.” Prof Bygbjerg pointed out that 30-70% (depending on the country) of the cases of type II diabetes in the developing world are not related to obesity.

In Danish, the historic phrase for diabetes is “gammelmands sukkersyge”, which literally translates into English as “old man’s sugar disease.” This myth of diabetes being a disease of the elderly in rich societies is being challenged by research and reality on the ground. For example, Prof CS Yajnik, Director of the Diabetes Unit at the King Edward Memorial Hospital in Pune, India, discussed how his country went from having a low prevalence of diabetes in 1907 to becoming the “diabetes capital of the world” in 2007. According to Prof Yajnik, “India is a land of paradoxes,” where malnutrition and obesity exist side by side. “Migration is a strong risk factor for diabetes as are rapid urbanisation and poverty, which are affecting younger and poorer populations.” These have led to the “thin-fat” Indian phenotype, who is thin on the outside, but has fatty organs on the inside, putting the individual at great risk of chronic disease. The “myth” of diabetes merely being a problem in the wealthy countries is being challenged by realities on the ground where double burdens of addressing both malnutrition and obesity are often found.

Underweight and overweight in the same household

Dr Meera Shekar, Lead Health & Nutrition Specialist at the World Bank, gave an example of high maternal overweight rates co-existing along with high child malnutrition rates in the same countries - and sometimes in the same households. She provided the example of Mauritania where 40% of mothers are obese, yet 30% of children are underweight. “We often see the double burden of underweight and overweight in the same household,” continued Dr Shekar, “and the solution is to tie them together; we cannot address one problem without addressing the other because there is increasing evidence that low birth weight and under-nutrition in the first two years of life pre-disposes these children to overweight and obesity later in life. In many developing countries this produces ‘short-fat adults’ who are more prone to cardio-vascular diseases and diabetes.” Prof Peter Damm from the Centre for Pregnant Women with Diabetes at the Copenhagen University Hospital, Rigshospitalet, noted that “over-nutrition” in pregnant women increases the prevalence of type II diabetes in the population. This is due to an increased prevalence of gestational diabetes (GDM), which in addition to increased maternal and neonatal morbidity, is followed by a high risk of type II diabetes in both mother and offspring later in life. “This is a vicious circle,” stated Prof Damm. "Targeting children of women with GDM is an urgent preventive strategy that can have a positive impact on the lives of the children. The first step in this is to diagnose GDM and treat the women with GDM appropriately.”

Foetal programming and early life development

In his presentation “Nutrition, Foetal Programming & Diabetes and CVD”, Prof Yajnik established links between the rapidly growing NCD epidemic in the world and foetal programming and early life development. According to Prof Yajnik, there is ample evidence linking maternal malnutrition and child malnutrition with increased risk of diabetes, impaired glucose tolerance, arterial hypertension, coronary heart disease, lipid abnormalities
and stroke in adult life. Moreover, undiagnosed or poorly managed hyperglycaemia during pregnancy is associated with maternal and pre-natal morbidity and poor pregnancy outcomes. “Without adequate resources and health systems, women in low-income countries and their children are far worse off than their wealthy counterparts in the developed world. A combination of as yet unaddressed micronutrient undernutrition and increasing hyperglycaemia in the young mothers has caused ‘dual’ programming of Indian babies to increase the risk of non-communicable disease manyfold. There is an urgent need to address these NCDs risk factors in maternal and child health if MDG goals are to be met successfully,” said Prof Yajnik.

Many speakers highlighted the critical link between gender, empowerment and NCD prevention and control for sustainable health and development. Using evidence from anthropology, Prof Montoya argued that “the idea that women’s lives only impact the domestic and family sphere is a fiction of the first order. We imagine that only those in the board room or in our central programme offices have ‘real’ influence. But, and especially when it comes to managing the daily burdens of living in resource scarce environments, we must create approaches that recognise the fact that women’s lives, their work, their capabilities, their roles in their families and communities are central parts of the way the world works. Increase women’s ability to impact their communities (economically, socially, culturally, and politically) and you increase their capacities to make a healthy community and to manage the multiple burdens of inequities of all kinds.”

**An unintended paradox**

Dr Shekar mentioned that part of the problem in not addressing such issues holistically may have been the development community itself. “It is possible,” she said, “that the development community could contribute to increasing obesity while trying to reduce the undernutrition rates. This is why development policies and interventions must address health in a much more holistic and cross-sectoral manner.”

**WHEN DISEASES INTERSECT**

In addition to the importance of a cross-sectoral approach to health and prevention of disease, it is important to recognise the link between communicable (infectious) and non-communicable diseases. This intersecting provides further evidence for a unified approach to communicable and non-communicable diseases, and indicates why a lack of focus on NCDs might derail the control of communicable diseases. According to Prof Anthony Harries, Senior Advisor at the International Union Against Tuberculosis, the links between diabetes and tuberculosis (TB) were recognised more than two thousand years ago.

Citing various studies since 2007 and 2008, Prof Harries stated that “diabetes increases TB risk by two or three times.” The association between TB (an infectious disease) and diabetes (a non-communicable disease) “is not in doubt.” The limitation, according to Prof Harries, is that most recent studies have focused on the developed world. “As a result of this limitation, in November 2009, we conducted an expert meeting with international partners to identify knowledge gaps, develop a prioritised research agenda and make policy recommendations,” he noted.

**NCDs crucial for meeting health MDGs**

The limitation that NCD interventions focus on the developed world is not restricted to research. It also impacts interventions, treatment and health equity. Prof Harries pointed out that there is a
“IT IS POSSIBLE THAT THE DEVELOPMENT COMMUNITY HAS CONTRIBUTED TO INCREASING OBESITY WHILE TRYING TO REDUCE THE MALNUTRITION RATES.”

Dr Meera Shekar, Lead Health & Nutrition Specialist, World Bank, USA
Sharing scarce resources

An important aspect of strengthening health systems is the development of national health plans that address NCDs. That this is possible is demonstrated by the experience from the treatment of HIV/AIDS. The antiretroviral treatment (ART) medication distribution programme has provided life-saving assistance to people suffering from HIV/AIDS in the developing world. A comparable programme does not yet exist for chronic and non-communicable diseases, which could potentially save millions of people from death, disability and poverty. According to available data based on analysis of Official Development Assistance (ODA), quoted by Dr Ala Alwan in his talk, health ODA commitments in 2007 were over USD 22 billion, but the contribution to non-communicable disease prevention and control was minimal. Dr Tembu Osborne, Medical Officer at Kijabe Mission Hospital in Kenya, pinpointed the disproportionate health care spending and priorities in his presentation “Realities on the ground: when people with diabetes wish they had AIDS instead.” He compared the care between HIV/AIDS patients and diabetes patients at the Naivasha Rural District Hospital. The former receives heavy funding and attention translating into improved quality of care. “Because of the many resources allocated to HIV treatment and care, the reality is that people who are diagnosed with diabetes lament that they did not get an HIV diagnosis instead,” he said.

Strengthening health systems is a key objective

“Health systems in low-income countries are unable to respond effectively to the increasing magnitude of NCDs,” said Dr Alwan. “As a result, health inequities are increasing. Thus, strengthening health systems is mandatory if we are to address health concerns in the 21st century and beyond.” Strengthening health systems was reiterated throughout the conference as an important pathway to disease prevention and health-for-all. Yet, as Dr Alwan noted, “The challenge is that this is a long-term goal. What we need to do in the short run while working on this long-term goal is to identify low-cost interventions – such as salt reduction in processed foods – that are cost-effective and appropriate at the local level.”

Lack of health care workers

Highlighting the experience of Mozambique, Dr Paulo Ivo Garrido, Minister for Health since 2005, noted that his government has had an NCD Department within the Ministry of Health since 2000. Since the creation of this department, a National Strategic Plan for Prevention and Control of Communicable Disease (NSTPPCCD) has been prepared, which included NCD components. “Our task now,” he stated, “is to implement what we have planned. NCDs are included in key government documents and policies such as Mozambique’s 2006-2009 Poverty Reduction Strategy Papers. The biggest challenge we face in implementing the NCD component in the NSPPCCD is lack of health care workers and specialists.” According to the WHO, the minimum number of health workers per population needed to maintain an adequate infrastructure is 2.28 health care professionals per 1,000 population. In Mozambique, according to the Minister, it is currently 1.3 per 10,000 people with only one medical doctor for each 20,000 people. “With this shortage, when we talk about health systems strengthening, we must also talk about human resources. We still have a long way to go to convince international donors to think of NCDs and not just of HIV/AIDS,” Dr Garrido stated.

Addressing the participants after listening to Dr Garrido, Dr Richard Nduhuura, Minister of State for Health from Uganda, expressed his appreciation to the conference organisers for providing an opportunity to link up with his Mozambican colleague. “Immediately after this session, we can see how, in the spirit of African brotherhood, we in Uganda can also have a national plan,” he said. Dr Nduhuura concluded his remarks by stating, “We know what to do to deal with the double burden of disease in our country, but we have no budget. We have not been able to raise the USD 300,000 to complete the Uganda NCD risk factor survey during the 2009/2010 financial year, so we shall have a delay in obtaining the NCD-related data information so badly needed to produce the evidence demanded by our donors. The key question here remains: How can we ensure that we have enough evidence to shift donor financing paradigms if we do not have the funds to conduct research to generate that evidence?

WHO Global Health Observatory http://apps.who.int/ghodata/

WHO World Health Report, 2006
Costly inaction

Dr Michael Engelgau, Senior Public Health Specialist at the World Bank, highlighted the impact of NCDs on poverty reduction efforts that are part of the global development agenda. He focused on the “micro” realities of out-of-pocket (OOP) costs related to NCD care and treatment in the developing world. Dr Engelgau noted that inaction enhances the risk of increasing poverty: “Out-of-pocket expenses for an individual in a low-income country are 50-75% of health care costs and for high-income countries, the percentage is 30%. Financing catastrophic expenses in the form of prolonged hospitalisation for an event related to NCD comes from borrowing or selling household assets. This can drive families in a low-income country into an endless poverty-disease-debt trap cycle,” he said.

Dispelling myths and getting facts right

Even when this evidence is available “Why do donors not invest in NCDs?” asked Dr Brown. “Because of the prevailing myths surrounding chronic disease?” According to him, many donors do not believe that diabetes is a problem in sub-Saharan Africa. “In truth, incidence in sub-Saharan Africa is high. If you look at mortality data on Africa, you see that people do not survive long once they get diabetes. Prevalence would be much higher, and people with diabetes in Africa would be much better off and more productive, if they had access to the cheap essential drugs that prevent its deadly complications. In fact, the cheapest and easiest way to lower mortality in Africa would be to treat diabetes and hypertension.”

Another myth that must be dispelled is the conventional wisdom that infectious diseases are more deadly than chronic diseases. According to Mr Esben Sønderstrup, Chief Health Advisor at Danida, “This is easier said than done. Prevention is better than cure – especially when we talk about NCDs – but prevention has no constituency. There is more pressure on politicians to deal with ‘sick’ patients who have HIV than people who ‘are not sick yet.’” He called for a continued need for research in NCDs and their relationship with poverty. “NCDs compete for attention; politicians still see infectious diseases as a problem because they are guided by the MDGs and popular sentiment.

Decisions on political actions are not always made on rational grounds. We can help inform policymakers to make better choices through research and appropriate communication of evidence.” Mr Sønderstrup concluded by stating that “there are many challenges in fighting NCDs – but challenges are always there. Donors cannot solve the problem alone, but we can start somewhere – and getting the facts right is a good place to start.”

The call for increased funding for NCD research and surveillance, not to mention treatment and care, was reiterated throughout the conference by speakers and participants alike.
The risk of experiencing catastrophic spending or impoverishment is between 2.5 and 5.5 times higher among people with NCDs than without NCDs in the same socio-economic strata.

Mahal et al.: National Sample Survey, 2010

“OUT OF USD 20.6 BILLION IN OFFICIAL DEVELOPMENT ASSISTANCE TO HEALTH IN 2006 PROVIDED BY 24 OECD/DAC COUNTRIES AND THE EU, ONLY USD 0.1 BILLION WENT TO BASIC NUTRITION AND THERE WAS NO SPECIFIC INVESTMENT IN THE PREVENTION AND CONTROL OF CHRONIC NON-COMMUNICABLE DISEASES.”

Kaiser Family Foundation. Health ODA Commitments by Major Sub-Sector, 2006. Analysis of data obtained via online query of the OECD Development Assistance Committee
Why are we hesitating?

With all of the evidence highlighting the threat of NCDs to social and economic development, why are donors and governments not investing more in their prevention and treatment? Dr Brown from the IDF attributed it to the continuing ignorance of the importance of chronic illness, the continuing bias of donors towards political priorities and fears in the donor countries rather than the needs on the ground, and the dominance of the institutions already in place to combat HIV and other infectious diseases. Robert Maregwa, the chronic disease patient from Nairobi's slum, claimed that ignorance is killing his people. Many people are still not convinced that NCDs are a threat in the developing world. While data exist, more data and research need to be presented to policymakers and donors until they are able to balance the priorities to also address NCDs at the local level. As Prof Jean-Claude Mbanya, President of the IDF, put it in a panel discussion, “We tend to talk a lot and present all the solutions, but we never ask ourselves why we are not doing anything.” Prof Mbanya highlighted the important role of civil society organisations (CSOs) in the battle for HIV/AIDS treatment and called on CSOs to “lead by example” in the advocacy of the emerging burden of NCDs. This point was reiterated by many of the participants.

Elizabeth Gatumia, CEO of the Kenyan Heart National Foundation, asked, “Why are we not doing what we already know?” Highlighting that rheumatic heart disease has been nearly eliminated in developed countries yet persists in the developing world because of lack of infrastructure and health promoting environments. She said, “We have worked in slum populations in Nairobi for the last four years and we see it is not a lack of money, but a lack of prioritisation that is preventing us from eliminating chronic disease.”

In his talk, Prof Srinath K. Reddy quoted the famous pathologist Rudolf Virchow who asked, “Do we not always find the diseases of the populace traceable to defects in society? If disease is an expression of individual life under unfavourable circumstances, then epidemics must be indicative of mass disturbances.” Prof Reddy’s point was that “healthy development is possible when there is a convergence of concerns and we start to focus on sustainable development.” Providing a link between environmental protection and NCD prevention, he pointed to urban environments which reduce vehicular congestion and promote physical activity and energy efficiency. Such environments also include appropriate nutrient intake through sustainable consumption patterns, which again reduce pollutants and toxic chemicals in the environment. Such steps address both health and environment issues at the same time.

Walking the talk

Prof David Stuckler, Research Fellow at the University of Oxford, emphasised that donors must walk the talk in implementing the Paris Declaration and Accra Agenda for Action in global health and development aid. He admitted that the global recession had squeezed commitments in development assistance, but that there is a need to recognise the growing rhetoric that the existing aid is not working. “Donors are being criticised for skewing priorities away from needs, which is precisely why the principles in the Paris Declaration and Accra Agenda for Action are critical and urgent at this point in human history,” he said. The true test of commitment to prioritising NCDs, according to Stuckler, “can only be judged by the decision to spend money.” Rhetorically, he asked, “How can we raise the priority of NCDs in the global development agenda?”

Prof Stuckler recommended that the NCD community learn from the HIV/AIDS community and social movements to reframe the debate on NCDs. He concluded, “We stand today where the HIV community stood in the 1980s – we can look at the next two decades and intervene to make a huge impact on human lives. Are we going to be delinquent? Unless we heed the Paris Declaration and focus on shared interconnected risks that trap households into poverty and sickness, we will not achieve basic goals of human development.”

NEED FOR A PARADIGM SHIFT IN THINKING

"IT IS NOT A QUESTION OF IF BUT WHEN DONORS WILL ENGAGE IN NCDs."

Dr Paul Fife, Director, Department of Global Health and AIDS, Norad, Norway
TOP TEN LEADING CAUSES OF DEATH IN LOW-INCOME COUNTRIES

2004
- Lower respiratory infections: 11.2%
- Ischaemic heart disease: 9.4%
- Diarrhoeal diseases: 6.9%
- HIV/AIDS: 5.7%
- Cerebrovascular disease: 5.6%
- Chronic Obstructive Pulmonary Disease: 3.6%
- Tuberculosis: 3.5%
- Neonatal infections: 3.4%
- Malaria: 3.5%
- Prematurity and low birth weight: 3.2%

2030
- Ischaemic heart disease: 13.4%
- HIV/AIDS: 13.2%
- Cerebrovascular disease: 8.2%
- Chronic Obstructive Pulmonary Disease: 5.5%
- Lower respiratory infections: 5.1%
- Perinatal conditions: 3.9%
- Road traffic accidents: 3.7%
- Diarrhoeal diseases: 2.5%
- Diabetes mellitus: 2.1%
- Malaria: 1.8%

TOP TEN LEADING CAUSES OF DEATH IN MIDDLE-INCOME COUNTRIES

2004
- Cerebrovascular disease: 14.2%
- Ischaemic heart disease: 13.9%
- Chronic Obstructive Pulmonary Disease: 7.4%
- Lower respiratory infections: 3.8%
- Trachea, bronchus, lung cancers: 2.9%
- Road traffic accidents: 2.8%
- Hypertensive heart disease: 2.5%
- Stomach cancer: 2.2%
- Tuberculosis: 2.2%
- Diabetes mellitus: 2.1%

2030
- Cerebrovascular disease: 14.4%
- Ischaemic heart disease: 12.7%
- Chronic Obstructive Pulmonary Disease: 12.0%
- HIV/AIDS: 6.2%
- Trachea, bronchus, lung cancers: 4.3%
- Diabetes mellitus: 3.7%
- Stomach cancer: 3.4%
- Hypertensive heart disease: 2.7%
- Liver cancer: 2.2%

(Text in red indicates NCDs)

**CONCLUSION:**

**ACTION POINTS, RECOMMENDATIONS AND THE WAY FORWARD**

**Recommendations and the way forward**

Throughout the conference, there was a call for increased partnership and collaboration among all stakeholders, sectors and donors to advocate increased awareness and prioritisation for NCDs at global, national and local levels. The general call for focus on equity and health at the centre of all policies was also echoed during the conference as an entry point to address NCDs, as was focus on locally appropriate interventions and treatment options for NCDs in developing countries. This was enhanced by a recommendation for all stakeholders to bridge both the rhetoric-reality gap and the know-do gap regarding sustainable development, poverty reduction and their link with NCDs. Throughout the conference, participants were quick to point out that increased awareness and prioritisation of NCDs in the global development agenda are not intended to reduce focus on the global burden of infectious disease. In fact, the need to address health holistically – to include both communicable and non-communicable diseases as well as address the weak health systems – was an often repeated recommendation during the two days of the conference. In addition, calls for increased public awareness and advocacy were made throughout the conference, especially in the need to communicate evidence effectively to policymakers. Finally, a commitment to the pivotal role of women in healthy development was a consistent theme throughout the conference.

There was an overriding sentiment that the NCD agenda lacked the “outrage” that has often sparked important access to life-saving medicine for patients in the developing world. There was an expressed desire to learn from both the HIV/AIDS community and the TB-DOTS interventions to apply lessons learned to the NCD campaign so the world does not repeat the mistakes of the past.
TO THE DONORS


• RAISE THE LEVEL OF ODA FOR NCDs AT A LEVEL COMMENSURATE WITH SEVERITY OF THE BURDEN OF DISEASE AND ITS POTENTIALLY NEGATIVE IMPACT ON ACHIEVING THE MDGs.

• IN DIALOGUE WITH PARTNER COUNTRIES, PRIORITISE PREVENTION AND PROMOTE SAFE, AFFORDABLE AND ACCESSIBLE PROVISION OF TREATMENT AND CARE FOR NCDs AS A LESSON LEARNED FROM HIV/AIDS.

• INVEST IN HEALTH SYSTEMS STRENGTHENING AND CAPACITY BUILDING FOR ADDRESSING NCDs AND THEIR RISKS IN ORDER TO FURTHER POVERTY REDUCTION AND DEVELOPMENT.
TO NATIONAL GOVERNMENTS

• STRENGTHEN HEALTH SYSTEMS TO ADDRESS INFECTIOUS AND NON-COMMUNICABLE DISEASES HOLISTICALLY; FOCUS ON STRENGTHENING HEALTH SYSTEMS AS PART OF A HOLISTIC NATIONAL PLAN AND NOT IN “PIECE-MEAL” PROJECTS.

• ENCOURAGE CROSS-SECTORAL COLLABORATION FOR HEALTH AND DEVELOPMENT.

• PLACE HEALTH AND EQUITY AT THE CENTRE OF ALL POLICIES AND INTERVENTIONS.

• DEVELOP NATIONAL HEALTH POLICIES AND PLANS THAT INCORPORATE NCD LINES OF ACTION, PREVENTION, PROMOTION, RESEARCH AND FINANCING.

• BUILD PUBLIC AWARENESS CAMPAIGNS THAT DISPEL MYTHS OF NCDs AND EDUCATE POPULATIONS ON RISK FACTORS.

• ENGAGE DONORS IN THE FIGHT AGAINST NCDs.
TO CIVIL SOCIETY ORGANISATIONS

• PARTNER UP WITH HEALTH AND DEVELOPMENT CIVIL SOCIETY ORGANISATIONS IN ADVOCATING INCREASED AWARENESS AND PRIORITISATION OF NCDs AT ALL LEVELS AND IN ALL SECTORS.

• ADVOCATE THE DEVELOPMENT OF LOCAL, CONTEXT-APPROPRIATE INTERVENTIONS FOR PATIENTS SUFFERING FROM NCDs IN DEVELOPING COUNTRIES.

• URGE GOVERNMENTS AND PRIVATE INDUSTRY TO PRIORITISE THE EMERGING BURDEN OF NCDs, THEIR PREVENTION AND PROMOTION AND THE SAFE, AFFORDABLE PROVISION OF TREATMENT OPTIONS FOR RESOURCE-POOR SETTINGS.

• IMPLEMENT PUBLIC AWARENESS CAMPAIGNS TO DISPEL MYTHS OF NCDs AND EDUCATE VULNERABLE POPULATIONS ON RISK FACTORS.

• ADVOCATE ALTERNATIVES TO MARKET SOLUTIONS, WHICH ARE OFTEN TOO NARROW TO ADDRESS HEALTH HOLISTICALLY.
APPENDIX A

CONFERENCE SPEAKERS

Alderson, Ms Helen
CEO, World Heart Federation, Switzerland

Alwan, Dr Ala
Assistant Director General for NCDs and Mental Health, WHO, Switzerland

Brown, Dr Jonathan Betz
Vice President, International Diabetes Federation, USA

Bygbjerg, Prof Ib
Copenhagen School of Public Health, University of Copenhagen, Denmark

Courten, Prof Maximilian De
Copenhagen School of Public Health, University of Copenhagen, Denmark

Cooper, Mr Quentin
Moderator and Presenter, BBC, United Kingdom

Damm, Prof Peter
Copenhagen Centre for Pregnant Women with Diabetes, Copenhagen University Hospital, Denmark

Engelgau, Dr Michael
Senior Public Health Specialist, World Bank, USA

Fife, Dr Paul Richard
Director, Global Health and AIDS Department, NORAD, Norway
Pind, Mr Søren
Minister for Development Cooperation, Denmark

Reddy, Prof K. Srinath
President, Public Health Foundation, India

Roglic, Dr Gojka
Medical Officer, Department of Chronic Diseases and Health Promotion, WHO, Switzerland

Tembu, Dr Osborn
Medical Officer, Kijabe Mission Hospital, Kenya

Shekar, Dr Meera
Lead Health & Nutrition Specialist, World Bank, USA

Stuckler, Dr David
Research Fellow, University of Oxford, United Kingdom

Sønderstrup, Mr Esben
Chief Health Advisor, Danida, Denmark

Yajnik, Prof C.S.
Director, Diabetes Unit, King Edward Memorial Hospital, Pune, India, and Vice President, Society of Natal Effects on Health in Adults

Øvlisen, Mr Mads
Board Member, United Nations Global Compact, Denmark
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>APHRC</td>
<td>African Population and Health Research Council</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral drugs</td>
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<tr>
<td>CARICOM</td>
<td>Caribbean Community Secretariat</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisations</td>
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<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
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<tr>
<td>Danida</td>
<td>Danish International Development Agency</td>
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<tr>
<td>DM</td>
<td>Diabetes mellitus</td>
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<tr>
<td>GDM</td>
<td>Gestational diabetes</td>
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<td>IDF</td>
<td>International Diabetes Federation</td>
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<tr>
<td>IUALTD</td>
<td>International Union against Tuberculosis and Lung Disease</td>
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<tr>
<td>LIC</td>
<td>Low-income country</td>
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<tr>
<td>LMIC</td>
<td>Low and middle-income country</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease, also referred to as chronic diseases</td>
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<tr>
<td>Norad</td>
<td>Norwegian Development Agency</td>
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<tr>
<td>NSTPPCCD</td>
<td>National Strategic Plan for Prevention and Control of Communicable Disease</td>
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<tr>
<td>ODA</td>
<td>Official development assistance</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Papers</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TB-DOTS</td>
<td>TB-Directly Observed Treatment Short Course</td>
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<tr>
<td>UICC</td>
<td>International Union Against Cancer</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>WDF</td>
<td>World Diabetes Foundation</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WHF</td>
<td>World Heart Federation</td>
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The conference was supported by:

Norad

International Diabetes Federation

WORLD HEART FEDERATION

UICC - global cancer control

Helsedirektoratet - Norwegian Directorate of Health

Sundhedsstyrelsen - National Board of Health
CHRONIC DISEASES ARE CURRENTLY THE CAUSE OF 35 MILLION DEATHS EACH YEAR – OR 60% OF ALL DEATHS WORLDWIDE – OF WHICH 80% OCCUR IN LOW AND MIDDLE-INCOME COUNTRIES.

In order to address these facts, Danida, in partnership with the World Diabetes Foundation, hosted the International Conference on the Emerging Burden of Chronic Diseases and its Impact on Developing Countries in Copenhagen, Denmark, on 15 - 16 April 2010.

The conference gathered 140 leading public health and development assistance professionals and high-ranking government representatives from North and South to present and discuss the implications of NCDs in low and middle-income countries – and to address the consequences of not facing up to the reality of the rising pandemic.

For more information about Danida, please visit: [www.um.dk](http://www.um.dk)