



Bulletin 106

Medicus Mundi Schweiz

Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All



NOVEMBER 2007

CHRONISCHE KRANKHEITEN

CHRONIC DISEASES
MALADIES CHRONIQUES

IMPRESSUM

MEDICUS MUNDI SCHWEIZ
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

Bulletin Nr. 106, November 2007
Chronische Krankheiten

NETZWERK MEDICUS MUNDI SCHWEIZ
 Die gemeinsame und verbindende Vision der Mitglieder des Netzwerks Medicus Mundi Schweiz ist Gesundheit für alle: ein grösstmögliches Mass an Gesundheit für alle Menschen, insbesondere auch für benachteiligte Bevölkerungen. Medicus Mundi Schweiz vernetzt die Organisationen der internationalen Gesundheitszusammenarbeit, fördert den Austausch von Wissen und Erfahrungen, vermittelt ihnen Impulse für die Weiterentwicklung ihrer Tätigkeit und macht ihre Tätigkeit einem weiteren Publikum bekannt. Das Bulletin von Medicus Mundi Schweiz erscheint viermal jährlich. Jede Ausgabe ist einem Schwerpunktthema gewidmet und enthält aktuelle Hinweise und Informationen. Medicus Mundi Schweiz profitiert in seiner Arbeit von der langjährigen Partnerschaft mit der schweizerischen Direktion für Entwicklung und Zusammenarbeit DEZA, die auch die Herausgabe des vorliegenden Bulletins mit einem grosszügigen Beitrag unterstützt.

GESCHÄFTSSTELLE UND REDAKTIONSSSEKRETARIAT:

Medicus Mundi Schweiz
 Netzwerk Gesundheit für alle
 Murbacherstrasse 34
 Postfach, CH-4013 Basel
 Tel (+41) 061 383 18 10
 info@medicusmundi.ch
 www.medicusmundi.ch

REDAKTIONSKOMMISSION:

Thomas Schwarz, Helena Zweifel,
 Beat Stoll

LAYOUT: VischerVettiger Basel

PRODUKTION: Geschäftsstelle Medicus Mundi Schweiz, Thomas Schwarz

DRUCK: Birkhäuser + GBC

AUFLAGE DIESER NUMMER: 1500 Ex.

ERSCHEINUNGSWEISE: Vier Nummern im Jahr

NÄCHSTE NUMMER:

XXX (Januar 2008)

REDAKTIONSSCHLUSS: 30. August 2007

TITELBILD: XXX Foto: XXX

NETZWERK

Die 46 Mitgliedorganisationen von Medicus Mundi Schweiz:

Aids und Kind
 Aids-Hilfe Schweiz
 AO International
 Association Solidarité avec les Villages du Bénin
 Association Suisse Raoul Follereau
 Basler Förderverein für medizinische Zusammenarbeit
 Bündner Partnerschaft HAS Haiti
 Calcutta Project
 Christoffel Blindenmission (Schweiz)
 CO-OPERAID
 cooperation@epfl
 DM - Echange et Mission
 Enfants du Monde
 FMH Verbindung der Schweizer Ärzte
 Fondation PH Suisse
 Fondation Sociale Suisse du Nord Cameroun
 Fondation Suisse pour la Santé Mondiale
 Förderverein für Otorhinolaryngologie
 Freunde Behindertenintegration Kamerun
 Gemeinschaft der St. Anna-Schwestern GRUHU
 Handicap International (Schweiz)
 IAMANEH Schweiz
 Institut Universitaire d'Etudes du Développement
 INTERTEAM
 Jura-Afrique, Programme Santé
 Kinderhilfe Bethlehem
 Leprophilfe Emmaus Schweiz
 Lungenliga Schweiz
 Médecins du Monde-Suisse
 medico international schweiz
 mediCuba-Suisse
 Mission 21
 Novartis Stiftung für Nachhaltige Entwicklung
 Pharmaciens sans Frontières Suisse
 Schweizerische Gesellschaft für Tropenmedizin und Parasitologie
 Schweizer Hilfsverein für das Albert Schweitzer-Spital Lambarene
 Schweizer Indianerhilfe
 Schweizerisches Korps für humanitäre Hilfe
 Schweizerisches Rotes Kreuz
 Schweizerisches Tropeninstitut
 Secours Dentaire International
 SolidarMed
 PLANeS
 Stiftung Terre des Hommes
 Verein Partnerschaft Kinderspitäler Biel-Haiti

INHALT

Photo: ©MSF



<p>BEAT STOLL Editorial</p>		<p>DREI SCHLÜSSELBEREICHE DER PRÄVENTION</p> <p>WHO Combating the global tobacco epidemic</p>	<p>BETTINA SCHWETHELM ET AL. Improving diabetes prevention and care in Bosnia and Herzegovina</p>	<p>SALOMON KADIRI Control of cardiovascular disease in Africa: Has progress been made?</p>
<p>DIE VERNACHLÄSSIGTE EPIDEMIE</p>	X	X	X	X
<p>GERARD ANDERSON ET AL. The neglected epidemic of chronic disease: Figures and recommendations</p>	X	<p>MICHAEL KRAWINKEL Fehlernährung in den Entwicklungsländern</p>	<p>MICHAEL WILLI Kariesprophylaxe in Afrika, eine Erfolgsgeschichte?</p>	<p>SANIA NISHTAR Pakistan's national Action Plan on chronic disease</p>
<p>DEREK YACH, STIG PRAMMING Emerging support for chronic disease prevention and control in developing countries</p>	X	<p>IRENE ABDERHALDEN The globalisation of alcohol abuse</p>	<p>MARIANNE WIDMER EPEL Braucht es Krebsmedizin in der Entwicklungszusammenarbeit?</p>	<p>JEAN-PIERRE ZELLWEGER VIH et tuberculose: Interactions et prise en charge</p>
<p>BETTINA SCHWETHELM, FRANCISCA MERINO Fighting chronic diseases: A great challenge for NGOs</p>	X	<p>DREI SCHLÜSSELBEREICHE DER PRÄVENTION</p> <p>ELIZABETH LUNDEEN, TOBIAS SCHÜTH Self-help groups - a model for addressing hypertension in rural Kyrgyzstan</p>	<p>MARIANNE WIDMER EPEL Braucht es Krebsmedizin in der Entwicklungszusammenarbeit?</p>	<p>JEAN-PIERRE ZELLWEGER VIH et tuberculose: Interactions et prise en charge</p>
	X	X	X	X

Chronische Krankheiten und primäre Gesundheitsversorgung

Im nächsten Jahr feiern wir 30 Jahre primäre Gesundheitsversorgung. Die «Primary Health Care» bildete 1978 die revolutionär anmutende Antwort der Konferenz von Alma Ata auf die zunehmende Zentralisierung und Hierarchisierung der Gesundheitssysteme, die städtisch orientierte Spitalplanung, die Konzentration der ohnehin knappen Finanzmittel auf die Spitzenmedizin. Die primäre Gesundheitsversorgung setzte ihre Priorität auf den Kampf gegen die Infektionskrankheiten, auf Impfstrategien, Malariakontrolle, einfache Richtlinien zur Behandlung der häufigsten Erkrankungen im Frühkindesalter, gekoppelt mit entsprechender Gesundheitserziehung.

Revolutionär wäre die primäre Gesundheitsversorgung auch heute noch. Allein, ihre Erfolgsbilanz fällt ernüchternd aus. Um die Gesundheit der Menschen nachhaltig zu verbessern und um die Gesundheitsversorgungssysteme auf lange Sicht tragbar zu gestalten, hätte es eine starke sozioökonomische Entwicklung und die deutliche Verbesserung der Wirtschaftslage und der Kaufkraft der Menschen benötigt. Diese Entwicklungen sind aber in vielen Regionen der Welt ausgeblieben. So sind auch die primären Gesundheitssysteme häufig in zaghafte Ansätze stecken geblieben, und die Lücken konnten auch durch internationale Unterstützung nicht gestopft werden.

Das alles ist uns nicht unbekannt und auch nicht primärer Gegenstand dieser Bulletinausgabe, in der wir einen in der primären Gesundheitsversorgung – und in der internationalen Gesundheitszusammenarbeit – zu wenig beachteten Trend in den Mittelpunkt stellen: die Zunahme der chronischen Krankheiten. Eine höhere Lebenserwartung sowie die zunehmende Urbanisierung – rund die Hälfte der Weltbevölkerung lebt in Städten – führten auch in armen Ländern zu Veränderungen im Lebensstil der Menschen und zum vermehrten Auftreten nicht übertragbarer Krankheiten wie etwa Diabetes (Zuckerkrankheit) und Bluthochdruck, aber auch zur Häufung von Problemen im Bereich der psychischen Gesundheit. Als dann in den 80er Jahren mit HIV/Aids eine neue chronische Infektionskrankheit auftauchte, die viel technisches Können und Wissen bei der Langzeitbehandlung erfordert, wurden die Strukturen der primären Gesundheitsversorgung auf eine neue Probe gestellt.

In absoluten Zahlen umfassen die chronischen Krankheiten heute den weitaus größeren Anteil der Krankheitslast als die akuten Krankheiten. Und wie vor 30 Jahren sind die peripheren, der Landbevölkerung nahe stehenden Gesundheitsstrukturen erneut herausgefordert: Welches sind die Bedürfnisse der Bevölkerung? Was bedeutet das Auftreten einer chronischen Krankheit für eine Familie? Wie gehen sie mit einem an einer chronischen Krankheit leidenden Mitglied um? Was bedeutet die Krankheit für die wirtschaftliche Situation einer Familie? Welches neue Wissen müssen Gesundheitsfachleute erwerben?

Chronische Krankheiten erfordern ein langfristiges Begleiten, den Einbezug der Familie und des Umfeldes, eine Neuorientierung der Behandlungskette von der Selbsthilfegruppe bis zum community health worker, von der allgemeinen Krankenpflege zu spezialisierten Fachkräften. Dabei gewinnt auch die Fähigkeit, mit den Patientinnen und Patienten eine vertrauensvolle Beziehung aufzubauen, an Bedeutung.

Die primäre Gesundheitsversorgung bleibt – 30 Jahre nach Alma Ata – eine gültige Antwort auf die Herausforderungen der Zeit, unter der Voraussetzung, dass das Thema der chronischen Krankheiten rasch Eingang in die Planung und Umsetzung der gegebenen Gesundheitsstrukturen findet und dass konkrete Schritte in Angriff genommen werden. Dazu gehören beispielsweise die Ausbildung von Fachkräften, die Erarbeitung von klaren und einfach anwendbaren Diagnostikrichtlinien, der Aufbau von kontinuierlichen epidemiologischen Monitorings sowie das Einbringen der Thematik in die Gemeinschaft.



Ca. 700 Zeichen (inkl. Leerschläge) zuviel...



Seiten 5-31

Die vernachlässigte Epidemie

DISKUSSIONSBEITRÄGE UND GRUNDLAGEN

THE NEGLECTED EPIDEMIC OF CHRONIC DISEASE

In May 2007, the World Health Organization Director General, Dr. Margaret Chan, stated: "Chronic diseases, long considered the companions of affluent societies, now impose their greatest burden in low and middle-income countries ... The distinction between the health problems of rich and poor countries is no longer absolute."¹ Until recently, the prevalence and economic costs of non communicable chronic diseases have remained largely neglected by international aid agencies whose focus has been interventions aimed primarily at preventing and treating infectious diseases.

By Gerard Anderson, Lee Goeddel and Edward Chu*

IN RESPONSE to the shifting burden of disease, the WHO has developed an action plan for non communicable chronic disease (NCD) surveillance, prevention, and control and has urged member states to devote more resources to NCD prevention and treatment. In 2007, the World Bank joined the WHO in calling for more resources devoted to NCD management, a position shared by a small but growing number of international agencies.² A recent article in the *New England Journal of Medicine* argued that private foundations such as the Gates Foundation should devote more resources to NCDs and a billionaire in Mexico just announced that he would devote 500 million US\$ to prevention and treatment of chronic disease in Mexico.³

To respond to the growing burden of non communicable chronic diseases, international health organizations and national governments are beginning to revise their assistance programs to help low and middle income countries cope with the increasing burden of NCDs. Considerably more assistance will be needed in order to achieve the new goals of several in-

ternational agencies of reducing the burden of NCDs by 2 percent per year over the next ten years in a cost effective manner.⁴

THE FIGURES

Recent studies have shown that non communicable chronic diseases represent a significant proportion of the burden of disease in low, middle, and high income countries. The WHO Burden of Disease Project (2002) divides all causes of world wide (*loss of disability adjusted life years* (DALYs)) into four categories – infectious diseases, injuries, the category including maternal, perinatal and nutritionally related diseases, and finally non communicable disease. DALYS were chosen as the burden of disease measure because DALYs take into account both premature deaths and loss of functioning.

Infectious diseases: All infectious diseases, which include infectious, parasitic, respiratory, and all other communicable diseases accounted for 30% of worldwide DALYs in 2002. Infectious diseases posed the most significant burden of disease in Sub Saharan Afri-

ca where they accounted for 61% DALYs and 63% deaths. In all world regions outside of Sub Saharan Africa, all infectious diseases only accounted for 20% worldwide DALYs and 17% of deaths. Furthermore, as the availability of highly active anti-retroviral therapy increases in Sub-Saharan Africa, treatment of AIDS will require a paradigm shift towards chronic disease management.

Injuries: Injuries also contributed a significant global burden of disease in 2002 with 12% global DALYs. In all regions road traffic accidents were most prevalent while poisonings, fires, falls, and drownings contributed differently across regions. In Middle East and North Africa, for instance, falls played the second most important role while poisonings ranked second in Europe and Central Asia. Injuries were particularly prevalent in the European and Central Asian region where they were responsible for 17% of total regional DALYs.

Maternal, perinatal and nutritional disease: The fourth category of disease, maternal, perinatal and nutritional disease, accounted for 11% worldwide DALYs in 2002. Maternal hemorrhage, maternal sepsis, low birth weight, birth asphyxia and birth trauma, protein-energy malnutrition, and iron-deficiency anemia all played significant global roles with no significant differences across regions.

Non communicable diseases: In 2002, non communicable chronic diseases were the leading cause of DALYs in all regions of the world except for Sub Saharan Africa. NCDs accounted for 47% DALYs and 53% worldwide deaths in 2002 and the prevalence of NCDs is projected to increase considerably over the next 20 years.⁵ As shown in the studies, NCDs affect the regions of Latin America and the Caribbean, South Asia, Middle East and North Africa, Europe and Central Asia, and East Asia and Pacific significantly more than injuries, all infectious diseases, and the fourth major disease category (perinatal, maternal, and nutritional diseases).

Across the regions specific non communicable chronic diseases are important targets of opportunity because of their high burden of disease and the potential for low cost prevention and treatment methods. Cardiovascular disease was responsible for 26% of all deaths and 10% DALYs in 2002. Recent data from 2005 suggests that 30% of all deaths are now attributa-

ble to cardiovascular disease.⁵ The lower-middle and low income countries (countries with a per capita gross national product of less than 3,255 US\$ in the year 2004) demonstrated a similar burden of disease for cardiovascular disease in 2005 (27% of all deaths and 9% of all DALYs). Chronic respiratory diseases were responsible for over 7% of global deaths and 4% of all disability adjusted life years in 2002. 80% of the deaths attributable to chronic respiratory diseases, most notably chronic obstructive pulmonary disease and asthma, occurred in middle and low income countries.⁵ Diabetes accounted for over 5% of all worldwide deaths and 2% of DALYs in 2002.

NO RISK OF CONTAGION ...

In recent history, international aid agencies have given little attention to the prevention and treatment of non communicable chronic diseases. Tuberculosis, human immunodeficiency virus (HIV) infection, and malaria have garnered the most attention and money from international donors.⁶ As this article will show there are good and less compelling reasons for this orientation. However, these three infectious diseases together only account for 10% of deaths worldwide (12% in low income countries) and 11% of the disability adjusted life years (13% in low income countries).⁶ The burden of these three diseases does not warrant the resources they receive across the world except in Sub Saharan Africa where they collectively result in 33% of all deaths and 31% DALYS. International aid agencies attempting to reduce the burden of disease in the world in the most cost effective manner may want to reassess their funding strategies. This does not mean spending less on infectious diseases, simply using any additional resources to prevent and treat chronic diseases.

The current focus on infectious diseases can be traced back to the early 1900's, when infectious diseases caused the highest burden of disease in rich and poor countries alike. As the 20th century progressed, significant improvements in medicine and public health occurred. Improvements in sanitation, living conditions, immunizations, and antibiotics dramatically decreased the burden of infectious disease in high income countries. With this evidence of success in reducing the burden of infectious disease, it is logical that the leaders of



Photo: WHO/Marko Kotic

high income countries used their international aid money to target infectious diseases in low income countries.

Some infectious diseases have become known as neglected diseases because they no longer exist with any significant prevalence in high income countries. When directing funds, policymakers in wealthy countries are drawn to treating diseases like leprosy or lymphatic filariasis because of success in eradicating these diseases in their own countries. Public health leaders are sympathetic to neglected diseases like onchocerciasis (river blindness) and human african trypanosomiasis (sleeping sickness) because of their horrific pathologies and recognition that the populations they affect lack sufficient purchasing power to attract investment in research and treatment.

Funding from international donors has created a market for investing in treatments for these neglected diseases that would not otherwise exist and it has also maintained a market for treatments that have proven efficacious

against these diseases. The pharmaceutical industry bases their research, development, and production on treatments that will return a profit. Since these treatments usually target diseases in those countries that will pay high prices, diseases that no longer exist in high income countries might not have a sufficient profit margin to generate the necessary research and development in spite of the high burden of disease.

Some public health leaders have focused attention and resources on infectious diseases that can cause major epidemics, especially those that could spread to their own country. A current example is the global focus to prevent a pandemic of avian influenza, AIDS, and TB. In contrast, the current epidemic of obesity and consequently of diabetes poses no risk of contagion.

The possibility of a “permanent fix” also makes preventing and treating infectious diseases attractive to those responsible for dispersing international aid, especially those like Bill Gates who have a technology background.

Vaccination programs, for instance, may only require a single investment with the promise of permanent eradication of the disease (for example smallpox). Tackling NCDs, however, is unlikely to have the possibility of a quick fix and treatment can require ongoing care that may last a patient’s lifetime.

Sympathy also influences policymaking and funding. Pictures of celebrities visiting HIV positive children in low income countries are increasingly common. These images capture the public’s awareness and appeal to our conscience. In contrast, an obese 40 year old man with poorly controlled hypertension who is at high risk of stroke would not be nearly as photogenic. The image is less compelling to the public, even though the well being and happiness of his son, his daughter, and his wife might depend on his health and ability to work.

CONFRONTING THE MYTHS

Certain myths about non communicable chronic diseases have may be responsible for decreased interest in NCDs.

The first myth is that chronic conditions only affect affluent nations. As shown a substantial burden of disease occurs in low and middle income countries. Even in Sub Saharan Africa where infectious diseases exert the greatest impact, non communicable chronic diseases contribute substantially to the disease burden, an impact that is growing rapidly.

A second myth is that NCDs only affect the elderly. Data from a 2005 WHO report estimates that one quarter of all people worldwide who died from chronic disease were younger than 60 years of age. These data also suggest that NCDs have an important impact on the workforce, and, as a result, on economic productivity of low and lower middle income countries. The chronic nature of these diseases amplifies their consequences on families. Long term treatment depletes savings and often requires a family member to leave school or work to function as a primary caregiver. The WHO projects that China, Russia, and India may lose from \$200 billion US dollars to \$550 billion over the next 10 years from the effects of heart disease, stroke, and diabetes on patients and their families.⁵

A third myth contends that treatment and prevention programs that target chronic diseases are significantly more expensive than

programs aimed at infectious diseases. Recent reports, however, outline low cost and cost effective NCD interventions that have been implemented in countries with high, middle, and low incomes.^{5,8} Unfortunately some lower middle and low income countries continue to invest in infectious disease programs with relatively high cost effectiveness ratios. One example is the ongoing treatment of latent tuberculosis in patients without HIV (4,129 to 5,506 US\$ per DALY), while more cost effective intervention programs to treat cardiovascular disease with beta-blockers and aspirin (9 to 273 US\$ per DALY averted) struggle for funding.⁸

A WHO report documents these and other myths in its report on widespread misunderstandings about the reality of chronic diseases. Other myths are that NCDs primarily affect men, are always the consequence of unhealthy lifestyles, and only affect the rich in poor countries.⁵

COST EFFECTIVE INTERVENTIONS

We have recently started a review of the interventions in Latin America that have targeted NCDs to help USAID identify the most cost effective programs, an effort we recently completed for Eastern Europe. Most of the examples of cost effective interventions we will use will be drawn from these studies.⁷ Our objective is to identify programs that were clinically efficacious, cost effective, and were sustained beyond the initial funding.

Interventions for cardiovascular disease have been successfully applied in Latin America. The most simple treatment with beta-blocker and aspirin has been shown to substantially reduce cardiovascular events and blood pressure while demonstrating high cost effectiveness (less than 25 US\$ per disability adjusted life year (DALY averted)).⁸ During 2000-2002 an international team established a hypertension treatment program with a surveillance and education component in rural Ecuador. The results demonstrated clinical effectiveness, cost effectiveness and have been sustained once the original demonstration program ended. An evaluation of the program found that after 18 months in a population of 4284 adult patients the percentage of grade II hypertensive patients dropped from 34% to 25% and the percentage of grade III hypertensives dropped from 35% to 29%.⁹



Photo: WHO/Chris de Bode

Chronic respiratory disease: Tobacco is the single most important determinant of chronic respiratory disease and a major risk factor for many other chronic diseases. Levying a 33% tax increase on tobacco is highly cost effective in improving health (13 to 195 US\$ DALY averted) while simultaneously generating tax revenue, especially in low income countries.⁸ Despite a plethora of evidence linking tobacco control legislation around the world to reduced tobacco consumption, lower income countries have been reluctant to enact these policies citing concern about negative economic impact and smuggling. Cost effective programs have also dealt with asthma, a chronic respiratory disease affecting 300 million people worldwide. In 2002, the Brazilian ministry began providing free drug therapy to asthmatics. Economic analysis after the first year demonstrated that the province of Salvador experienced 55% fewer hospital submissions, and families of severe asthmatics experienced a 10% increase in income.⁵

Diabetes programs focusing on glycemic control, blood pressure control, and foot care have all demonstrated the potential to be both effective and viable.⁸ In 2000, an intervention named PENDID-LA started in Argentina and became a partnership program in hospitals across nine other Latin American countries. It included patient education and treatment programs that targeted lifestyle, glycemic control, and blood pressure management. The program succeeded in decreasing fasting blood glucose, body weight, systolic blood pressure, and blood triglycerides. The savings in future drug therapies and glucose monitoring of the participants were estimated to be approximately 160 US\$ per person per year.¹⁰ This figure does not capture the savings from avoiding more extensive medical care and DALYs averted by preventing further diabetic complications. Similarly, in the Costa Rican primary healthcare system, public health officials used a methodology to evaluate patient education on diabetes in El Guarco, Costa Rica. Based upon the pilot results, they designed and implemented a dia-

betes education program for patients at primary care centers. After one year, the average fasting blood glucose of the patient population decreased from 189 mg/dl to 157 mg/dl.¹¹

Lifestyle interventions: In many middle and low income countries worldwide and in Latin America, specifically, there has been a recent broad based push to broaden the scope of NCD intervention to population based primary prevention. Recent programs have sought to decrease NCD risk factors through lifestyle interventions. For example, from 1999 to 2002, the Brazilian program, Agita Sao Paulo, used extensive media campaigns; built strong community partnerships; and held public events to successfully integrate physical activity and health awareness into Brazilian popular culture. At an estimated 1 cent per person, the program been implemented as a cost effective model to promote physical activity and has served as the model for similar programs in eleven other Latin American countries.

ESTABLISH AND SUSTAIN AN EFFECTIVE RESPONSE

As international health agencies and national governments begin to recognize and confront the substantial global burden of NCDs, more resources must be directed to cost effective NCD interventions. Cost effective programs must be designed that will work in low and lower middle income countries. For the continued improvement of these programs, international aid agencies must draw on the successes of current examples in the low and lower middle income countries and more work must be done to introduce chronic care interventions from high income countries to low and lower middle income countries. Additionally, training in leadership and technical assistance for governments, if pursued, will be the foundation on which to establish and sustain an effective response to the growing burden of chronic non communicable disease.

* **GERARD F. ANDERSON**, PhD is a professor of health policy and management and professor of international health at the Johns Hopkins University Bloomberg School Public Health, professor of medicine at the Johns Hopkins University School of Medicine, director of the Johns Hopkins Center for Hospital Finance and Management, and co-director of the Johns Hopkins Program for Medical Technology and Practice Assessment. Dr. Anderson is currently conducting research on chronic conditions, comparative insurance systems in developing countries, medical education, health care payment reform, and technology diffusion. He has directed reviews of health systems for the World Bank and USAID in multiple countries. Contact: ganderson@jhsph.edu

LEE GOEDEL is a second year medical student at the Johns Hopkins University School of Medicine. Edward Chu is Chief of Medical Oncology at Yale Cancer Center.

EDWARD CHU, MPH, MD Candidate is a medical student at Johns Hopkins University School of Medicine. Prior to coming to Hopkins, Edward was the Deputy Director for the Robert Wood Johnson Community Health Leadership Program. Contact: echu@jhmi.edu

REFERENCES

- 1 WHO sixtieth Health assembly transcripts. Dr. Margaret Chan. 15 May, 2007. Geneva, Switzerland.
- 2 World Bank. Public Policy and the Challenge of Non Communicable Diseases. June 27, 2007. Washington, DC.
- 3 Braine, Theresa Mexican billionaire invests millions in Latin American health. Bulletin of the World Health Organization. Volume 85, Number 8, August 2007. Geneva, Switzerland.
- 4 WHO. Eleventh General Programme of Work. May 2006. Geneva, Switzerland.
- 5 Preventing chronic diseases: a vital investment - WHO global report. Geneva: World Health Organization, 2005.
- 6 Anderson, GF, Chu, E. Expanding Priorities - Confronting Chronic Disease in Countries with Low Income. New England Journal of Medicine. January 2007. 357: 209-211.
- 7 Anderson, Gerard F., Hyder, Adnan A. Non Communicable Disease and Injuries in Eastern Europe and Eurasia. USAID. October 2006.
- 8 Disease control priorities in developing countries. 2nd ed. Washington, DC: World Bank, 2006.
- 9 Anselmi, M, Avanzini, F et. Al. Treatment and control of arterial hypertension in a rural community in Ecuador. Lancet. April 5; 361 (9364): 1186-7.
- 10 Gagliardino, JJ, Etchegoyen, G et. Al. A Model Educational Program for People with Type 2 Diabetes. Diabetes Care. 24: 1001-1007, 2001.
- 11 Arauz, AG, Sanchez G, Padilla G. A community diabetes educational intervention at the primary care level. Revista Panamericana Salud Publica.

THE TIDE MIGHT BE TURNING ...

This article highlights significant recent developments that suggest the tide might be turning in favour of sustainable support for chronic disease prevention and control. Developments include publication of significant new reports by the World Bank, WHO and the U.S. National Institutes of Health; establishment of new alliances and partnerships such as the Oxford Health Alliance and the Global Alliance for Prevention of Obesity and Chronic Disease; and the announcement of funding by players previously not involved in global health, including support for tobacco control by the Bloomberg Foundation and support for broader aspects of chronic diseases by United Health Care and the PepsiCo Foundation.

By Derek Yach and Stig Pramming*

OVER THE LAST two years, signs have steadily emerged that chronic diseases in developing countries are at last being taken seriously. For decades, evidence has shown that the epidemiological transition was well under way in low- and middle-income countries but that it was taking a form not seen in developed countries. Julio Frenk, former Mexican Minister of Health, characterised this almost 20 years ago as “protracted polarised epidemiological transition” to emphasise that these countries suffered simultaneously from infectious and non-infectious chronic diseases as well as from injuries.¹ However, the problem of chronic diseases has historically received little attention from governments and even less from those funding health research and interventions.

Many reasons for the neglect have been proposed² and are addressed elsewhere in this edition. This article highlights significant recent developments that suggest the tide might be turning in favour of sustainable support for chronic disease prevention and control. They include publication of major new reports; es-

tablishment of new alliances and partnerships; and the announcement of significant funding for chronic disease prevention by players previously not involved in global health.

SOLID AND INDISPUTABLE EVIDENCE

There has been a steady production of academic journal articles since 2004 that have provided new global and national estimates of the burden of disease attributable to the risk factors – poor diet, tobacco use, lack of physical activity – driving the epidemic of chronic disease. The evidence has been used in three major reports: the WHO report *Preventing Chronic Diseases: A Vital Investment* (2005)³; the report of the *Developing Country Priorities project DCP2* (2006)⁴; and the World Bank report on *Public Policy and the Challenge of Chronic Noncommunicable Diseases* (2007).⁵ Between them, these reports now provide solid and indisputable evidence of the epidemiological and economic impact of chronic diseases in developing countries. Each report was subject to intense review within agencies with complemen-



Photo: WHO/Marko Katic

tary roles in addressing the problem: the WHO has lead responsibility for policy and strategy development; the World Bank is key to providing financial support and economic advice to governments; and the U.S. National Institutes of Health (one of the primary players in the Developing Country Priorities project work) and more particularly its International Fogarty Center, has a key role in setting priorities for, and supporting, global health research.

It is anticipated that these reports will stimulate these agencies to step up their investment, advocacy and general support for chronic disease prevention and control. This is evident within WHO with the increased focus on implementation of the WHO Framework Convention on Tobacco Control⁶ and the development of an action plan for the Global Strategy for Diet, Physical Activity and Health.⁷ The latter is to be discussed at the World Health Assembly in May 2008.

In addition to these global reports, there has been progress at country level, a recent example being the publication by the South Afri-

can Medical Research Council of an extensive national effort to quantify the contribution of major risks to health. In the Medical Research Council report, 17 major risks were analysed, with hypertension, tobacco use, increased body mass, physical inactivity and other risks for chronic diseases ranking among the top-ten contributors to the burden of disease.⁸ This is particularly significant in a low-middle-income country beset with HIV/AIDS and high levels of violence.

ADVOCATING FOR FUNDING AND ACTION

While these research and policy documents are necessary, without supportive financial investment and the creation of human and institutional capacity there can be no action at country level. This has been recognised by non-governmental organisations that have started to work together to advocate for funding and action. An example of this is the establishment of the Global Alliance for the Prevention of Obesity and Chronic Disease, which includes the World Heart Federation, the International

Obesity Task Force, the International Diabetes Federation, the International Association for the Study of Obesity, the International Pediatric Association and the International Union of Nutritional Science.⁹

Three new investments were recently announced with the potential to have global impact:

First, in mid-2006, Michael Bloomberg, mayor of the city of New York and head of the Bloomberg Foundation, announced the award of 125 million US\$ for global tobacco control to be administered through a web of NGOs and the WHO.¹⁰ This grant will significantly contribute to accelerated action in implementing the provisions of the Framework Convention on Tobacco Control in selected countries. If

programmed wisely, it will also lead to the development of a stronger cadre of tobacco-control policy experts within those countries.

Secondly, Lois Quam announced in 2006 that Ovations, a UnitedHealth Group company, would provide 15 million US\$ to support development of centres of excellence to address chronic diseases in developing countries.¹¹ The hope is that these centres will work with established groups in developed countries to create a much-needed pool of expertise in developing countries, capable of leading development of chronic disease prevention and management systems. Ms Quam's announcement was made during the 2006 Clinton Global Initiative in a special session devoted to chronic diseases – in itself an important milestone in the growing acceptance of the need for action.¹²

Thirdly, the PepsiCo Foundation announced a grant of 5.2 million US\$ in September 2007 to support an Oxford Health Alliance community-based research initiative to be initiated by groups in India, China, Mexico and the United Kingdom. The project, Community Interventions for Health, will evaluate how best to reduce chronic disease risks (tobacco use, poor diet and physical inactivity) through interventions in schools, workplaces, communities and health-care centres in developing countries and communities.¹³

These are not the only ongoing chronic disease initiatives – they build on years of work undertaken by Salim Yusuf from McMaster University in Canada, Stephen MacMahon from the George Institute in Sydney, Sir Richard Peto from Oxford University and Stig Wall from Umeå University in Sweden. Further, it should be recognised that these are still only modest investments when compared to the size of the burden of disease today and the emerging burden based on current levels of risk, or the level of financial and political support given to AIDS, malaria or tuberculosis. But they represent an important start.

NEW PARTNERSHIPS AND ALLIANCES

The development of new partnerships and alliances is the third major development. As mentioned above, the Oxford Health Alliance (OxHA) is the first private-public partnership with resources to convene major players and to carry out the strategic research required to provide clear evidence for why chronic diseases demand more attention.¹⁴ It receives its core funding from Novo Nordisk – a Danish-based global pharmaceutical company with a deep and proven commitment to tackling diabetes and related health conditions globally. OxHA's annual meetings have brought together people from a range of NGOs, international health agencies, private food, pharmaceutical and insurance companies and academia to foster a better understanding of each group's role in addressing chronic diseases. What has emerged is a growing sense that profits and public health goals can coincide, and that market forces could be a far more effective tool in tackling chronic diseases than previous models of philanthropy or public-sector actions.

A major article in *The Economist* very recently called for a greater focus on chronic disease.¹⁵ The same publication not too long ago opposed action, saying that chronic diseases are due to a failure of personal responsibility, are mainly the concern of the affluent and the old, and do not warrant special attention.¹⁶ This reversal of attitude may well represent a realisation that failure to address chronic diseases is bad for profits – a theme so well documented in recent World Bank and Oxford Health Alliance reports¹⁷, and discussed in depth at the first-ever meeting between the World Health Organization and the World Economic Forum in Dalian, China during September 2007. That meeting highlighted the cost-effectiveness of workplace interventions to address chronic diseases and called for implementation of what works – with a greater focus on adapting knowledge from developed countries to workplaces in developing countries.

Future progress will require that serious investment be made by governments; that corporations carefully review how they could contribute more tangibly to the health of their employees and, where their core business involves products or marketing practice that influence public health, that they seek ways of advancing both their profitability and public health.

The initiatives described here are, on the whole, modest and fragmentary. If they work together and are able to attract funding and political support, there is great potential to scale up these efforts.

* **DR. DEREK YACH** is Director Global Health Policy PepsiCo in New York. Until 2004, he worked at the World Health Organisation where he established the Tobacco Free Initiative and where he was responsible for developing a new global "Health For All" policy, which was adopted by all governments in May 1998. From 2005 to early 2007, he was at the Rockefeller Foundation, heading its global health programmes. Prior to that, he was Professor of Global Health at Yale University. Contact: derek.yach@pepsico.com.

DR. STIG PRAMMING is Executive Director Oxford Health Alliance in London. He worked in the Danish National Health Service and also in Norway and Sweden. He is a widely published author with over 50 papers to his name, and several coauthorships of professional textbooks. He is a fellow of Harris-Manchester College, Oxford, an honorary consultant to the UK NHS, and a professor of the University of Oxford. Contact: stig.pramming@oxha.org

REFERENCES

- 1 Frenk et al. (1989) Health transition in middle-income countries: new challenges for health care. *Health Policy Plan* 4(1): 29-39.
- 2 Yach D, Hawkes C, Gould CL, Hofman KJ (2004). The global burden of chronic diseases: overcoming impediments to prevention and control. *JAMA* 291(21): 2616-2622.
- 3 World Health Organization (2005). Preventing Chronic Diseases: A Vital Investment. Geneva.
- 4 World Bank (2006). Disease Priorities in Developing Countries. Washington, DC.

- 5 Adeyi O, Smith O, Robles S (2007). Public Policy and the Challenge of Chronic Noncommunicable Diseases. World Bank. Washington, DC.
- 6 World Health Organization (2003). Framework Convention on Tobacco Control. Geneva.
- 7 World Health Organization (2004). The Global Strategy on Diet, Physical Activity and Health. Geneva.
- 8 South African Comparative Risk Assessment. *SAMJ* 2007; 97 (8), Part 2: 635-790.
- 9 Global Alliance for the Prevention of obesity and related chronic disease. www.preventionalliance.net/index.htm
- 10 WHO named as one of five partners to implement Michael Bloomberg's 125 US\$ million initiative to promote freedom from smoking': www.who.int/mediacentre/news/statements/2006/s16/en/index.html
- 11 Quam L, Smith R, Yach D (2006). Rising to the global challenge of chronic diseases. *The Lancet* 368(9543): 1221-1223.
- 12 See "Request for proposals announced" (24 July 2007), www.oxha.org/alliance-alert/
- 13 Community Interventions for Health: www.oxha.org/initiatives/cih
- 14 See www.oxha.org and www.3four50.com.
- 15 The maladies of affluence/ *The Economist*, 11 August 2007: www.economist.com/world/international/displaystory.cfm?story_id=9616897
- 16 Less Mary Poppins *The Economist*, 9 Nov 2006: www.economist.com/opinion/displaystory.cfm?story_id=8139883
- 17 Adeyi et al., op cit. Suhrcke et al. (2006), Chronic Disease: An Economic Perspective. Oxford Health Alliance.

A GREAT CHALLENGE FOR NGOs

Building on existing expertise and commitment to vulnerable populations, non-governmental organizations must become advocates and active participants in the fight against chronic diseases in low and middle income countries. Donor agencies, governments, and the public must recognize NGOs as strong partners and allies that will play a key role in countering this epidemic.

By Bettina Schwethelm and Francisca Merino*

CARDIOVASCULAR diseases, cancer, chronic respiratory diseases, diabetes, and other chronic diseases are responsible for most deaths and much of the disease burden in the industrialized world. Due to globalization, urbanization, life style changes, and overall population aging, chronic diseases are also increasing at epidemic rates in low and middle income countries, straining health care budgets and competing with acute infectious diseases for limited resources. In 2005, 60% of the approximate 58 million deaths were from chronic conditions, compared to only 30% due to infectious diseases, even when including HIV/AIDS, TB and malaria¹. The proportion of deaths from chronic diseases exceeds that of infectious diseases in all regions of the world, except Africa.

Global life style changes are more threatening “infectious agents” than many bacteria and viruses known to-date. With the aggressive marketing of western fast foods, tobacco, and sedentary life styles, low and middle income populations are at great risk of becoming “infected.” At the same time, they lack the necessary information, tools, and alternatives for the behavior change needed to protect their health and well-being.

OPPORTUNITIES FOR COMBATING CHRONIC DISEASES

Lifestyle factors are causally related to many chronic disease deaths. Therefore, life style changes, combined with basic treatment can save many lives and reduce premature death and suffering. Because it generally takes years for chronic diseases to establish themselves and for symptoms to appear, there are opportunities to intervene along the prevention continuum²:

Primordial prevention approaches generally target large populations and are long-term investments to reduce the number of chronic disease cases, the burden of disease, and health care costs. Benefits may be reaped decades after the initial investment has been made. For example, smoking, alcohol consumption, and diet during pregnancy have been associated with increased rates of several chronic diseases decades after the child is born. Therefore, primordial intervention approaches can be integrated already into prenatal care in low and middle income countries. Similarly, nutrition education, exercise promotion, and substance abuse education during the school years may counter the increasing rates of teens and pre-teens smoking and childhood obesity, with benefits accruing during the adult years.



Kosovo cardiovascular program (funded in 2003-04 by the SDC) – to diagnose adult patients with heard diseases

Primary prevention targets individuals with already known risk factors (for example: smoking, overweight) and provides them with special interventions (for example: smoking cessation and nutrition counseling, sports clubs) that can substantially reduce chronic diseases and premature death, while improving the quality of life. At-risk groups can be targeted through focused Behavior Change Communication approaches, empowered patient associations, and provider in-service training.

Training of primary health care providers and chronic disease specialists can reduce the burden of severe disease and premature death (for example: assist diabetic patients to control their blood glucose levels through regular testing, nutrition and exercise, foot care). Often health care providers in low and middle income countries lack protocols, basic equipments, tests, reagents, and medications, as well as the skills to counsel and actively involve patients as partners in the control of their chronic condition.

NOT IN LINE WITH THE “INNOCENT VICTIM” PERCEPTION ...

Despite the significance of chronic diseases and multiple opportunities to intervene, non-governmental organizations are not yet significant

players in countering the chronic disease epidemics. Several factors contribute to this low level of involvement:

Blaming the victim: There is a pervasive perception that chronically ill individuals are “less deserving” because they are to a large degree responsible for their disease and could have prevented it with greater control over food intake, tobacco, alcohol, drugs, and exercise.

Public health threat: With some exceptions (HIV), chronic diseases are generally not “communicable” in the traditional sense. The “infectious agents”, as for example life styles, are considered individual and not a public health issues.

Financial considerations: Closely related the above points are financial considerations. NGOs have to be able to raise funds for their activities. Pictures and stories of malnourished or critically ill children, refugees, and pregnant women engender more feelings of human empathy and willingness to help than pictures and stories of overweight children, insulin-injecting adults, or individuals on heart monitors. Exceptions are chronic conditions, for example visual impairments, which are more in line with the “innocent victim” perception (for example river blindness, severe vitamin A deficiency), with the result that NGOs have been more actively involved.



Children with chronic respiratory diseases – Kozle Institute

Low political commitment: The political commitment, particularly to the prevention of chronic diseases is emerging very slowly in low and middle income countries, where governments and health services are under pressure to prioritize emergency and acute care for the patients lining up at public health centers and hospitals. Low political commitment is also still evident in the donor community. Few foundations and bilateral donors are channeling resources to NGOs to deal with heart disease, diabetes, and cancer prevention and treatment programs in these countries, making it a great challenge for NGOs to contribute to chronic disease prevention and care efforts.

NGOS MUST BECOME INVOLVED

Non-governmental organizations can make critical contributions to counter chronic diseases in low and middle income countries, building on their particular strengths and expertise. Delivery of targeted services: While it is im-

portant to strengthen the public sector, there is a clear role for NGOs to deliver services in geographic regions with severe human resources constraints or to populations with special needs (homebound patients, visually impaired, etc.). Governments may also decide to contract NGOs, because they represent or have special knowledge of special-needs populations (for example diabetes patient associations, cancer survivors, etc.) as well as can deliver services with greater efficiency through their existing community-based networks.

This unique access and understanding of vulnerable populations has been critical to the success of many health interventions. DOTS for TB treatment and prevention, integrated management of childhood illnesses, reproductive health, malaria and HIV prevention and treatment would not have reached the community and household level without the leadership role of NGOs in the design, planning, implementation, and monitoring and evaluation. In-

creasingly, donors, such as The Global Fund, have recognized the value added by NGOs and are formalizing NGOs participation in addressing infectious diseases. This involvement must be extended to chronic illnesses.

Development of human resources: NGOs can leverage technical resources through creative partnerships with universities, medical centers, consultancy firms and individuals. Such partnerships can assist in the introduction of efficient, evidence-based approaches to chronic illnesses, the transfer and adaptation of international protocols, assistance in the development of local training capacity, and direct training, mentoring and coaching of local partners in program design, marketing, financing, program implementation, quality assurance, and monitoring and evaluation.

Resource mobilization: For sustainability reasons, NGOs have developed an expertise in resource mobilization with various types of donors to finance new projects. In addition, they have leveraged in-kind assistance of volunteers and products for infectious diseases. Such resource mobilization skills are key to success in countering chronic diseases in resource constrained environments.

Innovation and research: NGO staff often work in environments that encourage innovation and operational research. The NGOs commitment to make a difference in the lives of their target groups, combined with organizational flexibility, capabilities to raise resources, and understanding of program design provide a fertile environment for piloting new approaches that can, if successful, be scaled up by the public sector. Innovative partnerships entered by NGOs, linking the public and private, for-profit and not-for-profit sectors have contributed to innovation (for example Rollback Malaria) in communicable diseases. Such innovative approaches and partnerships are particularly needed to counter the chronic disease epidemics.

Advocacy role: NGOs have served as primary advocates for vulnerable and at-risk populations in maternal and child health, women's health, HIV, and visual and mental impairments in low and middle income countries. They have worked with governments to better meet the needs of some of these target groups, increased access to care, pushed for changes in laws and regulations, and introduced new pro-

ocols for service providers. These advocacy skills need to be extended to chronic diseases.

Given the global, societal, community and family impact of chronic diseases, NGOs must seize the opportunity to become involved at a time when their role in advocacy, public health and service delivery is essential in saving lives and reducing health care costs. Whenever feasible, chronic disease prevention and treatment can and should be integrated into existing NGO programs. The donor community can support NGOs in taking this step, as well as provide support to the development of new innovative approaches.

* **BETTINA SCHWETHELM**, PhD, MPH, is the Executive Director of Fondation Partnerships in Health, a Swiss NGO working in chronic and infectious diseases advocacy, prevention and care in the Western Balkans and Central Asia. As a founding member of the CORE Group, Inc., a US NGO umbrella organization, and a member of the Medicus Mundi Switzerland Board, she promotes NGO involvement and multi-sector linkages in new disease initiatives. Contact: bsch@partnershipshealth.ch

FRANCISCA MERINO, MD, a family physician from Chile, is the Medical Advisor of Partnerships in Health. She is involved in the conceptualization of chronic disease initiatives, including the diabetes prevention and care project in Bosnia and Herzegovina. Contact: fm@partnershipshealth.ch

REFERENCES

- 1 WHO Global report. Preventing Chronic Diseases: A Vital Investment.
- 2 Gaziano, T.A. (2007). Ovations Option Paper: Clusters of Excellence for Chronic Disease:

www.oxha.org/knowledge/publications/ovations-option-paper-final-010507.pdf



Seiten 5-31 Drei Schlüsselbereiche der Prävention

«MANCHE INDIGENEN GEMÜSE- UND KRÄUTERARTEN KÖNNTEN ZUR PRÄVENTION UND BEHANDLUNG VON ZUCKERKRANKHEIT UND HERZ-KREISLAUF-KRANKHEITEN BEITRAGEN.»

Photo: WHO/K. Sridhar Reddy

COMBATING THE GLOBAL TOBACCO EPIDEMIC

The statistics surrounding tobacco continue to speak for themselves. While many developed nations have begun to slow and even reverse the tide of tobacco use and disease by implementing effective tobacco control policies, low and middle-income countries continue to see strong growth in tobacco consumption. The battle to combat the tobacco epidemic has not been won, but has clearly shifted to a larger and more challenging arena. Without focused interventions on tobacco control, an estimated one billion people are likely to die from tobacco in the 21st century.

By WHO, Tobacco Free Initiative*

GOVERNMENTS representing over 80% of the world's population are now party to the World Health Organization Framework Convention on Tobacco Control, WHO's first global public health treaty and one of the most widely embraced treaties in UN history. Governments around the world clearly understand the burden of the tobacco epidemic whose impact hits hardest in those countries that can least afford it. With the funding available for global tobacco control only a fraction of that being spent by tobacco companies looking to exploit the vast marketplace of developing countries, it is essential that the Framework Convention on Tobacco Control is implemented in a manner that leverages to a maximum the limited resources available to reverse the tobacco epidemic. WHO believes that as many as 200 million lives could be saved by the middle of this century through the implementation of a core package of cost effective demand reduction measures and, to this end, the Organization's Tobacco Free Initiative, working with partners from the public and private sectors, is taking unprecedented steps to scale up its technical assistance at country level.

AN INCREASING BURDEN FOR DEVELOPING COUNTRIES

5.4 million people die every year due to diseases caused by tobacco, a figure that will rise to 8.3 million a year by 2030 unless urgent action is taken. Of these deaths, an estimated 84% will occur in developing countries. It is the poor and the poorest who smoke the most and the large majority of tobacco users now live in developing and transitional economy countries with tragic consequences for the public health and economies of those nations. In Bangladesh male smokers spend more than twice as much on cigarettes as on clothing, housing, health and education combined, while in countries such as China, Egypt, Indonesia and Russia, people spend 5-6% of their household income on tobacco.

Meanwhile the world's largest tobacco companies are wasting no time in targeting the vulnerable new clientele of the developing world spending billions of dollars each year on marketing and promotion in these markets. Campaigns aimed at women and girls, often portraying smoking as a key to emancipation and liberation, threaten a huge rise in the



number of women smokers even in cultures where tobacco use has traditionally been a male preserve.

In August this year, Altria/Philip Morris announced plans to spin off Philip Morris International as a separate company, a move that financial analysts see as an effort to expand more aggressively in developing nations. Responding to the announcement, Dr Douglas Bettcher, Director of WHO Tobacco Free Initiative said: “An effort to boost long-term shareholder value is presented as the logic of the relentless drive into the developing world by multinational tobacco companies. The reality for their shareholders is that their investment yields millions of additional deaths every year, chronic and crippling illness, and suffering for millions of the poorest families worldwide.”

The role for tobacco control in the achievement of the Millennium Development Goals is clear. Chronic diseases due to tobacco use exacerbate poverty in developing countries, imposing huge public health costs as well as im-

pacting on the workforce. Tobacco use kills workers at the height of their productivity, robbing families of their key breadwinner and rendering workers less productive due to illness.

A SUCCESSFUL WAY FORWARD FOR TOBACCO CONTROL

However, the picture on tobacco control is not all bleak. The political momentum that has built up around tobacco control in the past decade is a clear signal that governments globally understand the negative health, budgetary and broader development impacts of tobacco use. The success of the WHO Framework Convention on Tobacco Control in securing parties is, in some ways, the “end of the beginning” in the battle to make tobacco control more effective worldwide. The challenge now is to see the political success of the Framework Convention transformed rapidly into practical and effective mechanisms enabling governments, notably those in the developing and transition economies, to roll back tobacco use amongst their

citizens. This requires a rapid scaling-up of technical assistance at country level, a goal that WHO Tobacco Free Initiative has placed at the top of its agenda for the next few years.

One of the most important developments and a cornerstone of WHO’s efforts to both scale up and transform the global impact of tobacco control measures is the recently launched Bloomberg Global Initiative. Set against the background of the Framework Convention on Tobacco Control, the innovative new initiative brings WHO into a five way partnership that gathers together UN legitimacy, private foundation financing, and world recognized health expertise to implement a core package of cost effective demand reduction measures for tobacco control.

The initiative targets 15 developing countries where two thirds of the world’s smokers live and promotes evidence-based approaches to tobacco control, namely, tobacco tax increases, advertising bans, anti-tobacco advertising and mandatory health warning labels,

smoking bans and cessation support. The initiative also rigorously monitors the status of global tobacco use and the progress of countries in implementing the core package. New York Mayor, Michael Bloomberg, has injected an initial 125 million US\$ to capitalize the two-year collaboration with the WHO Tobacco Free Initiative and four partner organizations.¹

With its unparalleled regional and country network, WHO is uniquely placed to facilitate tobacco control activities throughout the world. In July this year 146 Parties to the WHO Framework Convention on Tobacco Control met in Thailand for the Second Conference of the Parties, the governing body which oversees, monitors and evaluates the progress of the Treaty and works to develop protocols, specific guidelines and requirements for countries to implement tobacco control measures. The tobacco epidemic and its contribution to the chronic disease burden has been exacerbated by globalization and the Conference of the Parties provides a multilateral forum to address

this challenge, highlighted this year by its decision to launch negotiations for the first protocol to the Framework Convention, a new international treaty on illicit trade in tobacco products.

Recognizing the scope and scale of the challenges facing successful scaling up of its technical assistance to developing countries worldwide, WHO works with a range of partners on activities to effect this transformation. These activities include:

World no tobacco day, celebrated on the 31 May each year, providing a launch pad for tobacco control initiatives worldwide. In 2007 activities ranged from a high-level tobacco control conference in Moscow organized by the Russian Duma to an extensive television campaign by Brazilian broadcasters;

The global youth tobacco survey, a joint WHO and Centers for Disease Control and Prevention initiative, a school-based survey that monitors tobacco trends amongst 13-15 year olds. The data gleaned from the Global Youth Tobacco Survey is used to plan and develop comprehensive tobacco control programmes for adolescents;

Tobacco regulatory, an international scientific advisory group whose work is based on cutting edge research on tobacco product issues and which advises WHO as it develops effective regulatory frameworks governing the design and manufacture of tobacco products;

The WHO tobacco laboratory network created to facilitate transnational and regional testing and research into tobacco products of all forms;

Use of evidence-based training materials to enable countries to develop and implement tobacco control measures tailored to local needs.

LEARNING FROM TOBACCO – A KEY TO NON-COMMUNICABLE DISEASE CONTROL

WHO believes that the innovative approach to tobacco control it is now implementing together with partner organizations could offer a key to its broader work in combating noncommunicable diseases by scaling up control and prevention strategies at a country level. "It is projected that by 2015, tobacco will kill 50% more people than HIV/AIDS and be responsible for 10% of all deaths globally. The approach we are now taking to reverse the tobacco epidemic is a new departure for the global public health community in noncommunicable diseases, an approach we believe can save millions of lives from what is a completely preventable epidemic", said Dr Bettcher.

DER SCHLÜSSEL LIEGT IN DER ERNÄHRUNG

In den letzten 15 Jahren hat sich neben der Mangelernährung in vielen Ländern kalorische Überernährung eines Teils der Bevölkerung etabliert: die Menschen nehmen mehr als genügend Nahrungsenergie zu sich. Wie auch in den Industrieländern führt dies nicht nur zu Übergewicht und Adipositas (Fettleibigkeit), sondern vor allem auch zu Folgeerkrankungen am Herz-Kreislaufsystem und zu Diabetes mellitus Typ II (Zuckerkrankheit durch Insulinresistenz).

Von Michael Krawinkel*

DAS 21. JAHRHUNDERT beginnt mit dem Widerspruch zwischen einer globalen Nahrungsmittelproduktion, die den Bedarf der wachsenden Weltbevölkerung voraussichtlich auch in dreissig Jahren noch decken kann, und zeitweise auftretender Ernährungsunsicherheit sowie regionalen Hungersnöten. Etwa 800 Millionen Menschen haben nicht jeden Tag genug zu essen – manche ein Leben lang.

Unterernährung äussert sich aber nicht nur in Hungersnot. Mangel an einzelnen Nährstoffen, insbesondere Eisen, Vitamin A und Jod, verursacht den sogenannten „hidden hunger“. Dieser äussert sich nicht in Untergewicht, sondern in spezifischen Symptomen von Anämie und Kropf bis zu Erblindung; bei Vitamin A-Mangel auch erhöhter Mortalität durch Infektionen.

Die Ernährungsstörungen stellen die Gesundheitssysteme der Entwicklungsländer vor erhebliche Herausforderungen: die Behandlung der Folgeerkrankungen der Adipositas ist aufwändig, da die meisten Menschen keinen Zugang zu Diagnostik und Therapie haben. Daher kommt der Prävention durch Ernährung – und auch der diätetischen Behandlung – eine weit grössere Bedeutung zu, als in den Industrieländern bisher üblich.

PRÄVALENZ VON HUNGER UND MANGEL-ERNÄHRUNG

Die Daten der Weltgesundheitsorganisation zeigen bis heute eine hohe Rate von Menschen mit Unter- und Mangelernährung an. Über 200 Millionen Menschen weltweit haben einen Body Mass Index von weniger als 17 kg/m². 90 Prozent dieser Menschen leben in 120 Entwicklungsländern. UNICEF zeigte, dass dort 15 Prozent der Kinder mit zu niedrigem Gewicht (<2500 g) geboren werden, in Südasien sind es sogar 25 Prozent, gefolgt von 12 Prozent in Afrika südlich der Sahara.

Eisenmangel betrifft 2,5 Milliarden Menschen weltweit und ist eine der Hauptursachen für die hohe Müttersterblichkeit, da Frauen mit ausgeprägten Anämien die – relativ geringen – Blutverluste unter der Geburt nicht überleben. In Afrika und Asien sind mehr als 50 Prozent der Schwangeren, die eine Schwangerenbetreuung in Anspruch nehmen, davon betroffen.

Vitamin-A-Mangel ist für die Erblindung von 2,8 Millionen Kindern unter 5 Jahren verantwortlich, aber die Xerophthalmie – Die Schädigung der Hornhaut als Folge des Mangels – ist nur eine Seite, denn Vitamin A ist auch für die Immunabwehr von Bedeutung: ein Mangel lässt die Sterblichkeit an Infektionen dramatisch steigen.

*TOBACCO FREE INITIATIVE (TFI), World Health Organization. Thanks to: Alison Clements-Hunt, Communications Officer, Contact: clements-hunta@who.int

NOTE:

1 In addition to the WHO, other partner organizations in the Bloomberg Global Initiative include the Campaign for Tobacco-Free Kids, the Centers for Disease Control and Prevention Foundation, the Johns Hopkins Bloomberg School of Public Health and the World Lung Foundation.



Photo: WHO/Maïri Twaïlib

Der Jodmangel, der bei etwa 700 Millionen Menschen weltweit besteht, äussert sich nicht nur in einer Vergrösserung der Schilddrüse, sondern führt zu einer schweren Einschränkung der geistigen Fähigkeiten und zu vermindertem Wachstum.

Alle Formen der Mangelernährung, besonders aber der Mangel an allen Nährstoffen und Energie – früher als Protein-Energie-Malnutrition bezeichnet – sind zu Beginn des 21. Jahrhunderts auch ein Leitsymptom der fortgeschrittenen HIV-Infektion. Das hängt sowohl mit der Diskrepanz zwischen Energie- und Nährstoffbedarf und der Aufnahme mit der Nahrung zusammen als auch mit den Folgen der Erkrankung und des Todes der aktiven Familienmitglieder in ihren «besten Jahren».

VERÄNDERUNGEN DER ERNÄHRUNG

Beobachtungen in China zeigen eine deutliche Veränderung des Ernährungsverhaltens vieler Menschen in der kurzen Zeit zwischen 1989 und 1997: in allen Einkommensgruppen nahm der Anteil der Menschen, die weniger als 10 Prozent der Nahrungsenergie aus Fett aufnahmen, deutlich ab. Gleichzeitig stieg der Anteil der Menschen, die 30 Prozent und mehr der Nahrungsenergie aus Fett aufnahmen, um den Faktor 2 und erreicht mehr als 50 Prozent in der oberen, mehr als 30 Prozent in der mittleren und immer noch 20 Prozent in der unteren Einkommensgruppe.¹

Die Folgen einer solchen Veränderung sind in vielen Entwicklungsländern dokumentiert, zum Beispiel in Marokko, Ghana, Ägypten und

Tansania, in Chile, Costa Rica und Haiti sowie in China und Indien: die Rate übergewichtiger und adipöser Schulkinder steigt deutlich an. In Tansania haben wir selbst in einer ländlichen Region Raten von über 20 Prozent übergewichtiger Frauen gefunden, Dasselbe Resultat zeigte sich bei Untersuchungen in Sri Lanka.

Bei Untersuchungen in der Ambulanz für Zuckerkrankte (Diabetiker) in einem tansanischen Krankenhaus fanden wir zwei Drittel der Patienten übergewichtig und adipös, was den gleichen Zusammenhang anzeigt wie in Industrieländern.

Der gesteigerte Verzehr von Fett aus Nahrungsmitteln tierischer Herkunft geht mit einer höheren Aufnahme von Cholesterin und gesättigten Fettsäuren einher. Gleichzeitig werden weniger pflanzliche Nahrungsmittel aufgenommen; damit fehlen wichtige Ballaststoffe, die die Ausscheidung von Cholesterin fördern sowie Vitamine und sekundäre Pflanzeninhaltsstoffe, die dem sogenannten oxidativen Stress

vorbeugen. Diesem Stress wird unter anderem Bedeutung für die Entstehung von Arteriosklerose zugeschrieben. Bluthochdruck (arterielle Hypertonie) ist ein weiterer Mediator für Herzinfarkt und Schlaganfall.

Die wirtschaftliche Globalisierung verbessert zumindest für Teile der Bevölkerung in nichtindustrialisierten Ländern den Zugang zu Wissen und Information. Neben dem Zugang zu seriöser Information eröffnet sich damit jedoch auch das Feld der Produktwerbung aller Art sowie einer einseitig positiven Wahrnehmung von Lebensstilen, die als Vorbilder eher gesundheitsabträgliche als gesundheitsfördernde Verhaltensweisen vermitteln. Unter dem – mit vielen Milliarden Dollar und Euro finanzierten – Werbeeinfluss ist das «moderne» Konsumverhalten geprägt worden. Durch den Zusatz von Fett, Zucker und/oder Salz werden pflanzliche Lebensmittel so verarbeitet, dass sie ernährungsphysiologisch eine Reihe von Eigenschaften tierischer Lebensmittel annehmen (etwa Pommes frites, Kartoffelchips, gezuckerte Maisflocken und andere hochverarbeitete Getreideprodukte).

* **MICHAEL KRAWINKEL** ist Professor für Ernährung des Menschen mit Schwerpunkt Ernährung in Entwicklungsländern an der Justus-Liebig-Universität Giessen, Deutschland. Kontakt: Michael.Krawinkel@ernaehrung.uni-giessen.de

ANMERKUNGEN

- 1 Popkin B (2002) The dynamics of the dietary transition in the developing world. In: Caballero B & Popkins B (eds.): The Nutrition Transition – Diet and disease in the developing world. Academic Press, San Diego, S.111-128
- 2 Krawinkel MB, Keding, GB (2006) Bitter Gourd (*Momordica charantia*): A Dietary Approach to Hyperglycemia. *Nutrition Reviews* 64:7: 331-337

FAO (2005) Eradicating world hunger – key to achieving the Millennium Development Goals. The State of Food Insecurity in the World 2005. FAO, Rome.

Gillespie S, Kadiyala S (2005) HIV/AIDS and Food and Nutrition Security: From Evidence to Action. Food Policy Review 7. International Food Policy Research Institute, Washington, D.C.

Hoffmeister M, Lyaruu I, Krawinkel M (2005) Assessment of Nutritional Intake, Body Mass Index and Glycemic Control in Patients with Type-2 Diabetes from Northern Tanzania. *Ann Nutr Metab* 2005; 49: 64-68.

Müller O, Krawinkel M (2005) Malnutrition and health in developing countries. *CMAJ* 173: 279-86.

WHO (2003) Diet, Nutrition and Prevention of Chronic Diseases. WHO Technical Report Series 916. WHO, Geneva.

KEIN ZUGANG ZU DIAGNOSTIK UND THERAPIE

Neben der Vermeidbarkeit der Folgeerkrankungen der Adipositas ist das grösste Dilemma, dem die Entwicklungsländer gegenüber stehen, die Tatsache, dass teure Diagnostik und Therapie nur den wenigsten Menschen dort zugänglich ist. Die meisten – besonders in ländlichen Regionen – können weder die Medikamente noch etwa Insulin bezahlen. Zur Diagnostik und Frühbehandlung von Herzinfarkt gibt es in ganz Afrika weniger Behandlungsplätze als in der Schweiz.

Das hat zur Folge, dass im Jahr 2003 weltweit genauso viele Menschen an den Folgen von Diabetes mellitus starben wie an Aids; und wie bei Aids ereignet sich die grosse Mehrzahl der Todesfälle in Entwicklungsländern, wo kein Zugang zu adäquater Diagnostik und Therapie gewährleistet ist.

Bei Tumorthérapien – auch eine Reihe von Krebserkrankungen wird heute mit Übergewicht und Adipositas in Verbindung gebracht – ist die Situation noch verheerender: Frühdiagnose kann nicht angeboten werden, und die Tumorthérapie mit Medikamenten und Bestrahlung ist für die meisten Patienten unerschwinglich.



Photo: © 2006 Otushabire Tibyangye, Courtesy of Photoshare

Women in Mbarara, Uganda exhibit pineapples and green vegetables at a show to demonstrate nutritional foods that should be eaten by people living with HIV/AIDS, as supplements to the antiretroviral drugs (ARVs) they take. This exhibition in Mbarara was part of the launch of a youth awareness campaign about staying away from the type of love that doesn't last, and can cut futures short.

ANGEPASSTES KRANKHEITSMANAGEMENT

Vor diesem Hintergrund müssen angepasste Konzepte für den Umgang mit den chronischen nicht-übertragbaren Krankheiten entwickelt und gefördert werden. Der Schlüssel für dieses Problem liegt in der Ernährung, und zwar sowohl in der individuellen Ernährung als auch im Bereich der öffentlichen Gesundheitspflege.

Paradoxaerweise bietet die traditionelle afrikanische und asiatische Ernährung vielerorts eine billige und praktikable Alternative zu einer Kost mit importierten und hoch verarbeiteten Lebensmitteln. Sie ist wesentlich auf einer Vielfalt pflanzlicher Lebensmittel aufgebaut und zeichnet sich durch eine geringe Energiedichte sowie durch einen hohen Gehalt an bioaktiven, gesundheitsfördernden Pflanzeninhaltsstoffen aus. Beides sind Eigenschaften, die der Entstehung von Adipositas, Diabetes mellitus Typ II und chronisch-degenerativen Herz- und Gefäßerkrankungen vorbeugen.

Daneben lernen wir über manche indigenen Gemüse- und Kräuterarten, dass sie zur Prävention und Behandlung von Zuckerkrankheit und Herz-Kreislauf-Krankheiten beitragen können. So konnten für die in Asien verbreitete Bittergurke (bitter melon) blutzuckersenkende Wirkungen gezeigt werden²; der potentielle Nutzen für die Diabetesbehandlung ist Gegenstand aktueller Forschung.

Diätetische Ansätze zur Prävention auf individueller und Bevölkerungsebene werden mit Unterstützung der Weltgesundheitsorganisation und in Zusammenhang mit der Förderung körperlicher Aktivität auch in Entwicklungsländern vorangetrieben. Bei der Bekämpfung des Hungers stellt sich heute auch die Aufgabe zu verhindern, dass die Menschen nach Überwindung der Mangelernährung eine kalorische Überernährung entwickeln. Die Bekämpfung des Hungers bleibt aber ebenfalls eine wichtige Aufgabe, denn Mangel vor der Geburt und in der frühen Kindheit haben sich als Risikofaktor für das spätere Auftreten eines «metabolischen Syndroms» herausgestellt: offensichtlich wird der Stoffwechsel in Mangelsituationen so umgestellt, dass auch langfristig alle aufgenommene Nahrungsenergie voll ausgenutzt wird. Ist die Mangelsituation überwunden, führt dies zu Übergewicht und Adipositas.

Ernährung ist ein Schlüssel zur Vermeidung von nicht-infektiösen Gesundheitsstörungen, die sich mit epidemischen Ausmassen auch in den Entwicklungsländern abzeichnen. Dabei darf nicht nur der einzelne Mensch im Blickfeld sein. Die wirkungsvolle Vorbeugung dieser Epidemien ist eine Aufgabe für die Ernährungs-, Gesundheits- und Landwirtschaftspolitik.

An increasing major threat to public health

THE GLOBALIZATION OF ALCOHOL ABUSE

Rapid socio-cultural change and increasing cultural globalization in many parts of the world lead to significant growth in the use of drugs and alcohol and ask for the implementation of effective counter-measures. This article illustrates alcohol abuse as rising major threat to public health and its response by the Blue Cross as one of the few international organizations in the field of alcohol prevention and treatment.

By Irene Abderhalden*

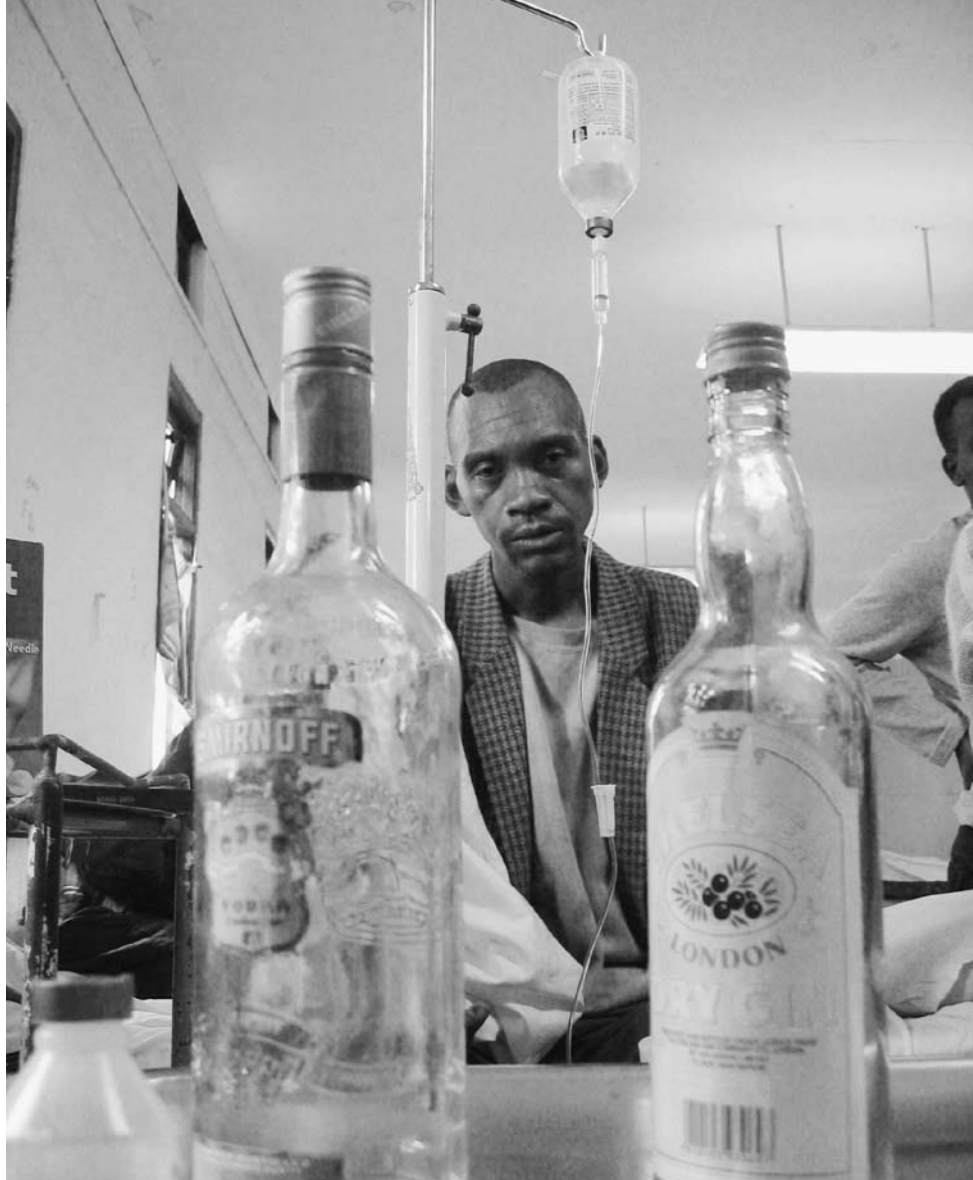
ALCOHOL HAS BEEN

used in many societies of the world for ages. For a long time, however, consumption of alcohol has been strictly regulated by traditions, social norms and natural limitations. More and more however the global alcohol market is expanding, particularly into developing countries. The saturation of markets for alcoholic beverages in the West combined with a higher industry concentration and increased market power has led to the expansion of the international alcohol industry in new markets in Africa, Asia and Latin-America. Meanwhile, in many developing countries, alcohol is often more easily available than clean drinking water. Today the ten biggest multinational brewers sell more than one-third of all industrially produced beer in the world, and their share of the global market is increasing. They make massive marketing efforts aimed particularly at new user groups such as young people, women and ethnic groups who traditionally did not drink. As a consequence, new drinks and drinking habits are being globalized across different continents and sections of the population. For example, young people in developing countries are increasingly drinking and displaying the same harmful pattern of drinking – “binge drinking” – common among young people in developed countries.

One of the challenges is that many developing countries are highly dependent on national revenues from alcohol. In some Indian states for example alcohol makes up as much as 23% of the revenue. (In comparison, 2002, the European Union drew 2.4% revenue from alcohol taxes). Of course, the state dependence on revenue from alcohol tax is not an incentive to impose restrictions on the advertisement and sale of alcohol and strict enforcement of such restrictions. The country seeks to maximize income, but the social costs of alcohol are often overlooked. These costs include the direct expenditures of treating injuries and diseases as well as rehabilitation costs, property loss, law enforcement costs, and losses in productivity due to absenteeism or loss of productive years of life.¹

A VICIOUS CIRCLE OF ADVERSE HEALTH, SOCIAL AND ECONOMIC EFFECTS

Severe health, social and economic effects of alcohol consumption are well documented and witnessed all over the world. Regular alcohol abuse can lead to a multitude of chronic diseases whereas sporadic excessive drinking (binge drinking) is held responsible for acute adverse effects such as accidents, injuries, violence and risk behavior. A link between alcohol and drug abuse with the spread of Aids has been broad-



ly documented, for example in the latest WHO resolution of "Public health problems caused by harmful use of alcohol" of May 2005. Alcohol consumption leads to a higher probability of unprotected sex (and therefore to a higher risk of HIV-infection). Furthermore, a positive diagnosis for HIV can also cause an increase in alcohol consumption which may reduce the success of the treatment of the AIDS infection. Most known chronic diseases attributable to alcohol are diseases of the liver such as fatty liver (adipohepatic), cirrhosis of the liver and alcoholic hepatitis. The risk of acquiring cirrhosis

of the liver rises when an amount of 50g pure alcohol is consumed during the period of 10 to 15 years (which is approximately half a liter of wine or 1.2 liters of beer per day). Chronic alcohol abuse can lead to damage of parts of the nervous system which can cause neurological and mental illnesses. The extent of these damages depends upon the degree and severity of the alcohol consumption, nutrition and individual disposition.

With the daily consumption of more than four glasses of alcohol, the risk for cardiovascular diseases increases significantly. Not on-

ly chronic alcohol abuse but also binge drinking can have a damaging effect on the cardiovascular system. A quarter of all sudden deaths due to heart attacks among young men are a consequence of binge drinking. The risk of a stroke is increased tenfold by this drinking pattern. In some parts of the world where alcohol is brewed uncontrolled and illegally at home (often by those who cannot afford to buy alcohol), ill effects of alcohol consumption can arise from a single bout of drinking.²

Therefore, the World Health Organization has pointed out alcohol abuse as one of the major causes of the global disease burden: 2002, it has been estimated that there are about 2 billion people worldwide who consume alcoholic beverages and among them, 76.3 million with diagnosable alcohol use disorders. In the developing world alcohol ranks as the fourth cause of disability among men; in the industrialized regions it even ranks first. In the European Region alone, 2002 alcohol consumption was responsible for the deaths of 63,000 young people aged from 15 to 29! Such figures document the following statement by T. Babor: "No other product so widely available for consumer use, not even tobacco, accounts for so much disability as alcohol".³

DESTABILIZING THE DAILY HAND TO MOUTH ECONOMY

The increase in alcohol consumption in many developing nations where health and economic systems are weakest is of particularly great concern. Poor people around the globe are vulnerable even to small changes destabilizing their daily hand to mouth economy. For those living under harsh circumstances, alcohol may seem an easy way out. This is also along the lines of the image portrayed by the alcohol producers – a taste of luxury, recreation and the world beyond everyday worries. But the social, economic, health and other problems created by alcohol use are severe additional burdens for poor people.

Men traditionally drink more frequently and more heavily than women. However, the patterns of drinking for men and women are beginning to converge. While men still experience more direct drinking-related harm than women, women as well as children are often the victims of the harmful use of alcohol by men: Domestic violence, broken families, neglected chil-

dren, a husband failing to bring income to the family in addition to the money spent on alcohol – all this put an extremely heavy burden for poor families.

A recent paper in the National Medical Journal of India points out: "Although it is important to recognise that alcohol consumption typically increases with affluence, it should be kept in mind that some of the adverse effects related to drinking are aggravated by poverty. For example malnutrition and infections common among the poor interact with alcohol in the development of liver disease. As a result, alcohol related mortality is often highest among the poor in a society."⁴

THE APPROACH OF THE INTERNATIONAL FEDERATION OF BLUE CROSS

Rapid socio-cultural change and increasing cultural globalization in many parts of the world leading to significant growth in the use of drugs and alcohol ask for the implementation of effective counter-measures. The International Federation of the Blue Cross (IFBC) is one of the few international organizations in the field of prevention, treatment and after-care of alcohol abuse and its related problems.

The IFBC is a politically and denominationally independent umbrella organization consisting of about 40 national member organizations, predominantly in Africa, Europe, Brazil and India. As a global network community the federation supports its member organizations in building up their competence in the field of alcohol- and substance abuse related problems. In collaboration with our partners, we promote the exchange of knowledge and create opportunities for our members to share their experience by developing multi-national projects, transfer of knowhow and project-based partnerships.

Based on christian values, the members of the IFBC are engaged in the prevention and treatment of alcohol and other drug related problems. One of the specific assets is the extensive expertise in the area of self-help work. Furthermore, they commit themselves for comprehensive alcohol-political measures. Particularly our members in the south work under difficult social and political conditions in countries where alcohol dependent people not only look for help in vain, but are also often excluded from communities, stigmatized as being

“useless drunkards” (as it has been the case in Europe in the 19th century, before alcoholism was recognized as an illness). Prevention activities of our member organizations in Africa, India and Brazil integrate services for children and youth at risk through counseling, skills development and creation of employment. Furthermore, awareness for alcohol and drug related issues are created through educational programs in schools, communities and slums. In addition medical and therapeutic help is provided to alcohol dependent people and their families, in close collaboration with churches, self-help groups and other NGO’s.

Based on the strong evidence of the link between alcohol, Aids and poverty we are convinced that if our members succeed in implementing effective alcohol prevention, this will also be a contribution to the prevention of poverty and AIDS. Our goal is not that Blue Cross Organizations start developing AIDS Prevention Programs; however, we aim at integrating the substance abuse issue in existing Aids and poverty programs of other NGO’s. In addition, we put a strong focus on a holistic approach in the projects and services of our member organizations: This requires the consequent inclusion of women and children, a target group that is often strongly directly and indirectly affected by the effects of alcoholism as mentioned above.

***IRENE ABDERHALDEN** is Co-General Secretary of the International Federation of the Blue Cross in Bern, Switzerland. Contact: i.abderhalden@ifbc.info, www.ifbc.info

REFERENCES

- 1 www.add-resources.org
- 2 Overview of the Health Issues to Alcohol Consumption. Brussels: International Life Sciences Institute; 1999.
- 3 Babor T. Alcohol: No Ordinary Commodity – Research and Public Policy. Oxford: Oxford University Press; 2003.
- 4 Subir, Kumar Das; V Balarishnan, D M Vasudevan: Alcohol: Its Health and Social Impact in India. National Medical Journal of India Vol. 19, No. 2, 2006.

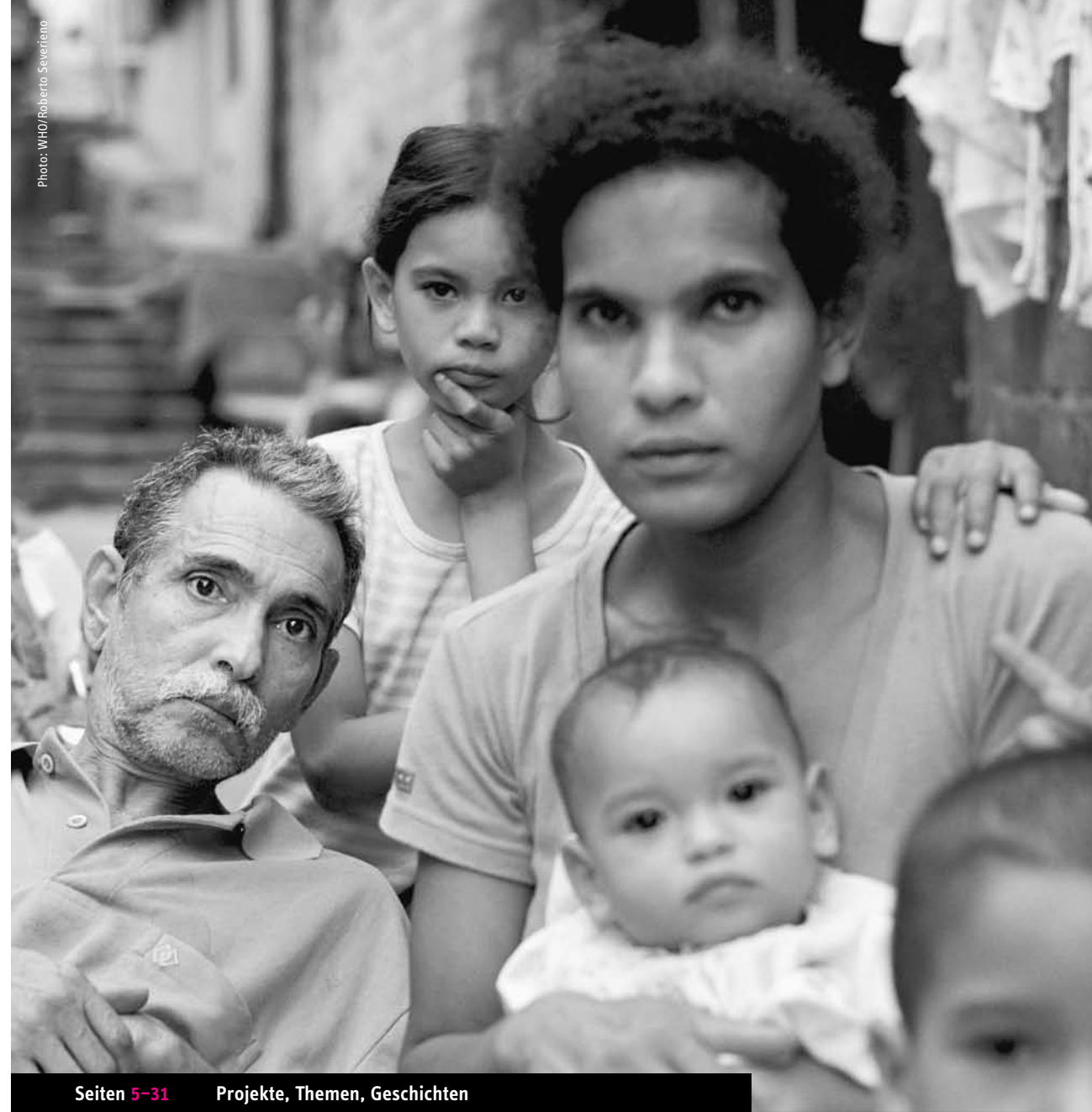
THE SOUTH EMPOWERS THE SOUTH!

Based on the motto “The south empowers the south”, the IFBC develops resource centers on the aspect of substance abuse and related health risks such as poverty and HIV/AIDS. One of the main aims of these centers is to mobilize resources and key people within and outside of the Blue Cross, in order to make it possible to train people on the field so they are qualified to develop sustainable and culture specific projects.

As a project example we like to refer to a community based project lead by the resource centre in Lesotho: In a participative assessment in a local rural community near Maseru, people of the village described unemployment, poverty, boredom and lack of self esteem as causes behind alcohol and drug related problems. Based on this situational analysis, an income generating project has been developed together with the local community and the Blue Cross partners. In this project example, alternative livelihood has been generated through planting and selling trees to the government. The target group of the project addresses young unemployed people at risk as well as those engaged in home brew production of alcohol. (This kind of illegal alcohol production without any legislation or restriction leads to a high availability in rural of alcohol as well as often to severe alcohol dependency of the brewers).

Encouraged by the positive experiences of our first resource centre in Lesotho, the IFBC plans to initiate further centers in Africa, India and Brazil so that increased capacity and networking within the issues of prevention, treatment and advocacy of alcohol and drug related issues will be possible!

Photo: WHO/Roberto Severiano



Seiten 5-31 Projekte, Themen, Geschichten

VEREINZELT GIBT ES SIE DOCH! ANSÄTZE ZUM UMGANG MIT DER EPIDEMIE

LET'S JOIN THE HYPERTENSION CLUB!

Self-help groups and self-management of chronic diseases have been proposed as a model for the future to address the burgeoning prevalence of chronic diseases occurring also in developing countries.¹ Aspects of the self-help group and self-management models, such as empowerment of the patients and increasing their control over their own health, are highly aligned with the Community Action for Health model of the Kyrgyz Swiss Swedish Health Project.

By Elizabeth Lundeen and Tobias Schüth*

THE KYRGYZ *Swiss Swedish Health Project (KYSS-HP)*, which is funded by the Swiss Agency for Development and Cooperation and Sida and implemented by the Swiss Red Cross since 1999, works with villagers in six regions of Kyrgyzstan to identify the diseases and health determinants that are the highest priorities among people. The KYSS-HP then partners with Village Health Committees that are established in each village to implement health actions to address these diseases. This model of empowering communities in Kyrgyzstan to work to improve health in the village has been named *Community Action for Health (CAH)* and is an integral part of the country's health reforms.²

HYPERTENSION: THE EPIDEMIOLOGICAL SITUATION

Hypertension and related diseases have been identified as a significant health concern in Kyrgyzstan, both through epidemiological evidence and by Kyrgyz people themselves through participatory assessments of village health priorities. Kyrgyzstan is a mountainous, former Soviet country that has been facing many of the same changes in the health of its population as other Commonwealth of Inde-

pendent States countries in this transition. The burden of hypertension in Kyrgyzstan during the Soviet era was not nearly as significant as it is today. A report published by the Kyrgyz Research Institute of Cardiology in 1985 stated that of males ages 30-59, 18.7% had hypertension.³ Since the fall of the Soviet Union, however, as has been the case in many former-Soviet countries, the prevalence of hypertension in Kyrgyzstan has drastically increased, and hypertension and related diseases are now well established problems.

Research published in 2005 demonstrated a very high prevalence of hypertension in two Kyrgyz villages – the prevalence of hypertension after age-standardization to the WHO standard population was 39% (46% among men and 33% among women).⁴ The authors of this research suggested that the high prevalence of hypertension could lead to a coming epidemic of cardiovascular disease in Kyrgyzstan, and speculated that causes of this high prevalence may include physical inactivity, overweight, liberal use of salt, and alcoholism.⁵ Kyrgyzstan's number of Disability Adjusted Life Years (DALYs) lost due to heart disease is the twelfth highest of all countries in the world.⁶ Kyrgyzstan's DALYs lost due to



Taking blood pressure for hypertension action research

Photos: SRK

stroke is the second highest of all countries in the world.⁷ Thus, hypertension and its related diseases are taking a serious toll on the Kyrgyz population by shortening life spans and years of productive, healthy lives.

STRESS AS LEADING CAUSE

To better understand the potential reasons behind the drastic increase in the prevalence of hypertension in Kyrgyzstan and the high morbidity and mortality associated with cardiovascular diseases, the Kyrgyz Swiss Swedish Health Project conducted several studies on salt excretion (as a measure of salt intake), cholesterol levels, and the prevalence of overweight and alcoholism. The studies enabled the Project to exclude the traditional risk factors, such as high cholesterol, high salt intake, alcoholism and overweight, as decisive factors causing the high cardiovascular disease morbidity and mortality: Blood lipids were found to be normal in a sample from Naryn oblast; salt intake in three oblasts ranged from 7-9 g/day, as measured by 24-hour urinary sodium excretion; the prevalence of heavy alcohol consumption is low at about 1%; overweight prevalence is still low, although an emerging risk factor.

By excluding these traditional risk factors, the studies suggest that stress and depression, caused by massive socioeconomic upheavals following the breakup of the Soviet Union, are the most likely factors behind the dramatic increase in hypertension prevalence and cardiovascular disease mortality in the last fifteen years.

A PRIORITY FOR THE PEOPLE

In addition to the epidemiological evidence, Kyrgyz people themselves have identified hypertension and related diseases as a significant health concern.

KYSS-HP worked with Village Health Committees in Naryn, Talas, and Issyk-kul Oblasts to conduct an *Action Research* on the prevalence of hypertension and related risk factors. Action Research is an important part of the Community Action for Health model, as it empowers Village Health Committees to better understand the health situation in their village by gathering data on diseases, behaviors, and health determinants. Additionally, Action Research serves as a very effective mechanism to raise awareness in the village of the prevalence and burden of diseases. The Action Research on hypertension was a critical step in raising

awareness, which would serve as a foundation to mobilize support for the subsequent implementation of the hypertension health action.

The Action Research was conducted in all villages in Naryn, Talas and Issyk-kul Oblasts during the summers of 2005 and 2006. Village Health Committees were trained to take blood pressure measurements using automatic wrist blood pressure monitors. They went to all houses in the villages and measured the blood pressure of all persons in each household who were 18 years of age or older, which resulted in a sample size of over 140'000 people.

There were many interesting findings from the Action Research, which provided direction for the development of a strategy and health action for hypertension. It was found that Naryn, Talas and Issyk-kul Oblasts all have a very high overall prevalence of hypertension – 43.3% in Talas, 40.6% in Naryn, and 46.5% in Issyk-kul (hypertension was defined as ≥ 140 systolic pressure, or ≥ 90 diastolic pressure, or taking medicine for blood pressure). The prevalence of hypertension for the three oblasts combined was 43.7%. Differences in prevalence figures across oblasts are most likely due to differences in lifestyle or economic factors. The research also found that men are more likely to suffer from hypertension than women, as 47.1% of men and 41.1% of women had hypertension. The difference in hypertension prevalence between genders was statistically significant.

AWARENESS AS A KEY FACTOR

Other concerning findings from the research pertain to awareness of the condition, treatment, and control of hypertension. The percentage of Kyrgyz people with hypertension who are aware of their condition (20.2%) is alarmingly low. Additionally, the percentage of people with hypertension who are taking treatment (17.9%) is very low. However, the percentage taking treatment is much higher among those who know they have hypertension (62.5%), suggesting that lack of awareness is a key factor in lack of treatment among people with hypertension. Achieving successful control of blood pressure, among those taking treatment, is also a problem, as only 29.9% of people taking treatment had controlled blood pressure. Following the Action Research, the KYSS-HP concluded the following:

- The high prevalence of hypertension in the three studied oblasts confirms the urgent need for a community-based intervention in Kyrgyz villages that empowers people to treat and control their condition.
- The low percentage of people with hypertension who are aware of their condition underscores the importance of raising awareness of hypertension and the seriousness of this condition among villagers.
- The low percentage of those with hypertension who are taking treatment and have their blood pressure controlled demonstrates the importance of increasing access to hypertension drugs in villages, educating hypertensive people about the importance of ongoing use of these drugs, and working with health care providers on appropriate prescribing practices.
- The high prevalence of smoking found through the Action Research (~40% among men) validates the need to work with communities to promote lifestyle changes to enable better cardiovascular health.

ESTABLISHING OF HYPERTENSION CLUBS

As a next step in developing the health action on hypertension, KYSS-HP staff reviewed the literature on community-based interventions for management of chronic diseases. Two themes that emerged from the literature were self-management of chronic diseases and self-help or mutual support groups, and interesting evidence on these topics was found from both developed and developing countries. Both the Alma Ata Declaration on Primary Health Care and Ottawa Charter for Health Promotion began to encourage people's involvement in their health care, and since then, many countries have experimented with self-management programs and self-help groups as a means of enhancing the participation of the patient. In Croatia and Slovenia, *Hypertension Clubs* have proven to be an effective tool in increasing people's compliance with long-term treatment regimens and improving quality of life for people with a chronic condition.⁸

KYSS-HP also found through the literature review information on the *Chronic Disease Self Management Program*, a program developed at Stanford University which was designed to give people with chronic diseases a central role in managing their own condition. The Program



Members of the local health commission measure the hypertension of villagers.

differs from other methods in that it does not just focus on patient education, but teaches patients concrete self-management skills (problem-solving skills) which when exercised, enhance the self-efficacy of patients.⁹

Focus groups in several Kyrgyz villages revealed that people were very interested in Hypertension Clubs which would provide support, information, and an opportunity to have their blood pressure frequently checked. Therefore, to address the high prevalence of hypertension through a community-based intervention, the KYSS-HP developed a pilot health action being implemented in Jumgal rayon of Naryn oblast, which establishes Hypertension Clubs in the villages. The health action just started in July of 2007, and has so far involved ten clubs with 5-10 members each. Members of the Village Health Committee are trained so that they may be peer leaders for the club meetings. The peer leaders receive an automatic upper arm

blood pressure monitor, which allows them to take blood pressure measurements at each meeting. Club members are given a "health passport" to track their own progress toward controlling their blood pressure.

Comprehensive informational materials have been developed and are used as "lesson plans" for the club leaders to guide each club meeting. The meetings address: understanding hypertension and its causes, lifestyle and diet changes, stress and its role in hypertension and cardiovascular disease, and proper use of medications through prescription by a local primary health care provider, who is informed about the Hypertension Clubs.

After the completion of the sessions with prepared lessons, it is up to the members of the Hypertension Club whether they will continue to meet together to check blood pressure and provide support to each other in their efforts to control their hypertension. The auto-

matic blood pressure monitors will stay with the peer leaders to allow club members easy access to blood pressure monitoring. As this is a pilot intervention, the KYSS-HP will monitor with great interest the progression of the Hypertension Clubs to see which groups decide to continue meeting, how often they meet and for how long following the completion of the prepared educational materials.

CHALLENGES

Through the health reforms, the Kyrgyz government has designated hypertension and cardiovascular disease as major health priorities. Work is currently being done on the de-

velopment of cardiovascular treatment protocols and guidelines which utilize cost-effective medicines, and the health reforms have enabled many of those medicines to be subsidized through the Mandatory Health Insurance Fund. Also, treatment for hypertension and cardiovascular disease is currently available in all primary health care facilities, and organizations in Kyrgyzstan are working on continuous quality improvement for cardiovascular care, particularly at the primary health care level.

However, a significant obstacle in addressing hypertension in Kyrgyzstan is that the most appropriate medicines to treat hypertension are not always available at the village level, and the cost of these medicines can sometimes prohibit their use among all those who need them (especially given the fact that subsidies for medicines through the health insurance fund are not functioning everywhere in the country). Jungal rayon of Naryn oblast was chosen as the location for the *Community Action for Health* pilot intervention to establish Hypertension Clubs because pharmacies exist in all villages in this rayon. Pharmacies at the village level are essential for easy access to antihypertensive medication. If the pilot health action proves to be successful and justifies the extension of this strategy to other Community Action for Health areas, a challenge in scaling-up this intervention will be the lack of pharmacies in many Kyrgyz villages. However, although many villages presently lack pharmacies, it is foreseen that through the health reforms, pharmacies will be established in most Kyrgyz villages over the coming years.

***ELIZABETH LUNDEEN** received her Master's in Public Health from Yale University. She has been working full-time for the Swiss Red Cross in Kyrgyzstan since May 2006, and was also working as a consultant for the SRC for two years prior to that, researching social capital in villages. Elizabeth's expertise is in conducting research to inform strategies and program planning and assess the impact of interventions. Contact: elizabeth-lundeen@elcat.kg

DR. TOBIAS SCHÜTH is Medical Doctor and Public Health Specialist. He worked in India and Bangladesh prior to being project leader of the KYSS project since 2001. He has vast experience in the areas of community empowerment and self help. Contact: tobias@elkat.kg, www.cah.kg

REFERENCES

- 1 Khanindra, K. Health Promotion Through Self-Care and Community Participation: Elements of a Proposed Programme in the Developing Countries. *BMC Public Health*. 2004). 4:11.
- 2 Schüth, T. Approach and First Results of a Pilot Project in Naryn Oblast: Community Action for Health in Kyrgyzstan. *Medicus Mundi Bulletin*. (2005). No.95.
- 3 Mirrakhimov, M. Prevalence and Clinical Peculiarities of Essential Hypertension in a Population Living at High Altitude. *Cor Vasa*. (1985) 27 (1) pg. 25.
- 4 Young, JH. The Coming Epidemic. Hypertension in Rural Kyrgyzstan, Central Asia. *Journal of Human Hypertension*. (2005) 19, pg. 146.
- 5 Young, JH. The Coming Epidemic. Hypertension in Rural Kyrgyzstan, Central Asia. *Journal of Human Hypertension*. (2005) 19, 146-148.
- 6 Centers for Disease Control. Atlas of Heart Disease and Stroke. World Data Table.
- 7 Centers for Disease Control. Atlas of Heart Disease and Stroke. World Data Table.
- 8 Kulcar, Z. Self-Help, Mutual Aid and Chronic Patients' Clubs in Croatia, Yugoslavia: Discussion Paper. *Journal of the Royal Society of Medicine*. (1991), Vol 84, pg. 288.
- 9 Bodenheimer, T. Patient Self-Management of Chronic Disease in Primary Care *Journal of the American Medical Association*. (2002), Vol. 288 No. 19, pg. 2469.

DIABETES MAY AFFECT THE WHOLE FAMILY ...

Chronic diseases, such as diabetes, inordinately affect the population and health care systems of the poorer countries in the European region. A pilot approach, developed by the Swiss NGO Fondation Partnerships in Health (FPH) with the public sector, patient and professional associations demonstrates that increased prevention and improved patient care can be integrated successfully into the primary health care system, benefiting patients, families, and health providers.

By Bettina Schwethelm, Francisca Merino, Suzana Hadzialjevic, Damir Lalicic, and Aida Muslic*

DUE TO CHANGING diets and sedentary life styles, diabetes rates are growing epidemically worldwide. Without major changes, WHO expects diabetes deaths to increase by more than 50%. Because most patients with chronic diseases in low and middle income countries are actually under 70 years¹, diabetes presents a significant psychosocial and economic burden for the individuals, their families, the health care system and country. Diabetes increases the overall risk of dying: the risk of dying from heart disease, stroke, and kidney failure, as well as the rate of visual impairment and blindness, foot amputations, and limb nerve damage.

Premature deaths and long-term disability are to a large degree preventable, however, medical treatment alone is insufficient. Diabetes requires significant and persistent life style changes and continuous monitoring and control of blood sugar levels. The behavioural changes and the patient's reaction to them, as well as some of side effects of the disease may affect the whole family. In severe cases (blindness, foot amputations, dialysis, heart condition), adults who would otherwise still be economically active can require significant home care. To address the patient and the family's

multiple needs, a comprehensive psycho-social and medical support system is needed by the patient and his/her family.

HEALTH CARE IN ONE OF THE POOREST COUNTRIES

Bosnia and Herzegovina (B&H), one of the poorest European countries, has a complex health care system, with 13 ministries of health and 13 health insurance funds, and 264 health care institutions. Patients in need of treatment often have to travel long distances for services that are covered by their geographic entity health insurance fund, even though the services may be available at closer proximity and cost, provided by another entity. This results in significant additional costs to the patient and health care system.

In 2000, Bosnia and Herzegovina reported estimated 111'000 diabetes patients. This number is expected to increase to 180'000 patients by 2030². Because of the high costs of the disease and resulting complications, improved capability of the health care system to prevent and manage diabetes as much as possible at the primary health care level, is an important contribution to the ongoing health reform efforts of the government.

Fondation Partnerships in Health (FPH), a Swiss NGO, has supported health reform efforts of Bosnia and Herzegovina since 1998. Several projects in partnerships with the Geneva University Hospitals and funded by the Swiss Agency for Development and Cooperation have built local capacity to retrain doctors and nurses in family medicine, rehabilitated ambulatory clinics, and procured essential equipment in key regions across the country. In addition, from 2005 to 2007, FPH provided basic HIV training to 1313 primary care doctors and nurses, using infectious diseases specialists and primary care trainers. This has also contributed to strengthening the working relationship between specialists and the primary care level.

In 2005, patients diagnosed at the primary/ambulatory level of care with diabetes in the Canton of Sarajevo were immediately referred to specialist care. Sarajevo had one diabetes specialty clinic, serving a population of nearly half a million people and more than 10'000 patients with diabetes. Before the introduction of the new multi-disciplinary approach in 2006, specialists would share limited information with the patient, in order not to create anxiety. Patients would be requested to return to

the specialist, if necessary daily, to check glucose levels, and be referred immediately to the hospital when specialists were overloaded with cases or on the weekend. Psychosocial counselling was not available to the patient, and primary health care providers were lacking the basic information about diabetes to provide routine care, follow-up, and counselling. Today, this situation has changed substantially in the Canton of Sarajevo thanks to an innovative pilot project.

MULTI-DISCIPLINARY TREATMENT AND CARE

In 2006, Fondation Partnerships in Health and its partners (the Canton Sarajevo, the Cantonal Ministry of Health and its primary and secondary health care system, the professional chambers of doctors and nurses, and the Diabetic Patient Association, with financing from the Canadian Agency for International Development, the Medtronic Foundation, and the Vontobel Stiftung) developed a new approach to diabetes that encompasses primordial, primary and secondary prevention, including improved treatment and care for more than 2000 diabetic patients. Under the guidance of a locally established working group consisting of FPH staff, an eminent Sarajevo diabetologist, Professor Dr. Heljic, and representatives of the other local partners, multi-disciplinary diabetes teams were established at the primary care level. These teams consist of family medicine doctors and nurses, social workers and psychologists and are directly linked to the specialists and their nursing staff at the secondary level.

To build the capacity of the cantonal health care system, a training-of-trainer course was developed, based on internationally validated technical curricula, team building approaches, and adult pedagogical methodologies. Twelve trainer teams (consisting of a diabetologist, nurse, family medicine doctor and nurse, psychologist and social worker) completed this course and then trained 151 family medicine teams (doctor and nurse), six social workers, and five psychologists in the Sarajevo health centres and ambulatory clinics. In addition, the 12 trainer teams were trained to provide supervision and support to the trained staff at the primary care level to assist them to implement the new government-approved protocols and apply their new skills, particularly related to patient education. International patient education ma-



XXX

* **BETTINA SCHWETHELM**, PhD, MPH, is the Executive Director of Fondation Partnerships in Health, a Swiss NGO working in chronic and infectious diseases advocacy, prevention and care in the Western Balkans and Central Asia. Francisca Merino, MD, a family physician from Chile, is the Medical Advisor of Partnerships in Health. Dr. Suzana Hadzialjevic is a family physician and the Medical Director of Partnerships in Health, B&H. She co-manages the diabetes project with Damir Lalicic. Damir Lalicic serves as Nursing Expert and Project Manager of Partnerships in Health, B&H and is Co-manager of the diabetes project. Aida Muslic develops and manages the programs of Partnerships in Health in Bosnien and Herzegovina. Contact: bsch@partnershipsinhealth.ch.

REFERENCES

- 1 Preventing Chronic Diseases: A vital investment WHO, 2005
- 2 WHO, Diabetes in the European Region: www.who.int/diabetes/facts/worldfigures/en/index4.html

terials were adapted for local use, and the team developed an information booklet for children, with input from young patients with diabetes.

IMPROVING PREVENTION

One of the local project partners is the Diabetic Patient Association which has worked closely with Fondation Partnerships in Health and the Ministry of Health staff on the organization of activities for the World Diabetes Day on November 14, the development of information, education and communication (IEC) materials, public education, and the promotion of the new services with their members. For the World Diabetes Day in 2006, all 12 participating clinics offered screening for diabetes, and 442 individuals were tested. Of these, 132 had glucose levels exceeding 7 mmol/l, the cut-off level for diabetes. These individuals were referred directly to the new medical and psychosocial support services that are assisting them now in bringing their disease under control and prevent serious and costly side effects.

Because of the great success of this one-day event, a special one-month campaign to reach high-risk individuals for screening was organized for December 2006 to January 2007. Pharmaceutical companies (Novo Nordisk, Oktal Pharma, Roche Diagnostics, and Bauerfiend) assisted with some of the testing materials, reagents, and equipment, further increasing the public-private cooperation around diabetes prevention and care.

EXPANDING ACCESS TO INDIVIDUALIZED COUNSELLING

Until this project had started, all patients were served by the main Diabetes Clinic at the University Hospital campus. The local working group members agreed that counselling and specialty care is needed to be more accessible to many of the patients in the Canton. A Diabetes Counselling Centre was established at one of the largest ambulatory care facilities, Ilidza, outside of the city centre of Sarajevo.



The new counselling site opened in May 2007 and is staffed by a family medicine doctor and nurse who received additional training in counselling, adult and child education, and diabetes technical skills. The Centre was equipped with educational materials, glucometers, testing strips and books donated by Roche and Otkal Pharma. Using a patient appointment system, individualized attention is given to assisting patients and their families with insulin injection techniques and use of the blood glucose meter, individualized diabetes meal planning, and other special needs. The centre is also organizing patient support group sessions.

Approximately 110 patients per month benefit now from these special services that help individuals to take an active role in controlling their disease and preventing some of the serious consequences. Because of critical needs in other geographic locations, the Canton of Sarajevo has requested FPH's assistance in helping to set up two more counselling centres.

Radio, television, and newspapers have covered many of the key events of the project, including the celebration of the World Diabetes Day, the training workshops for the multi-disciplinary teams, the opening of the Ilidza Diabetes Counselling Centre, and the one-month screening campaign. Each of these events has provided a special opportunity to talk about diabetes and educate the public about its caus-

es, possibilities for prevention, as well as the symptoms that should alert individuals to get tested.

THE FUTURE

Fondation Partnerships in Health and its local partners are implementing methodologies to track patient satisfaction with this new approach and monitor the skills of the participating providers. In addition, they are working on scaling up this approach with current and new donors to more underserved and remote rural areas, given the success of the pilot project and continuing needs of patients and the health care system.

Story from an involved doctor

“HEY, THIS ONE IS ON INSULIN.”

The patient, 65 years, walked into my office confused, scared... accompanied by his worried wife. With sunken eyes, red face and dry lips looked like a person lost in desert for many days. He was confused and told me that he was very healthy until yesterday, but suddenly felt very thirsty, hungry and often needed to go to the toilet.

He was diagnosed with severe diabetes, with a blood sugar level of 29.5, and urine showing the presence of ketones. He did not understand how it could happen at his age, as he had eaten well, felt fine and was not obese. It was obvious that he was trying to hide his despair with the diagnosis of this newly discovered disease. Very proudly he mentioned that his wife is a great cook and the he loves pies, baklavas, meet...

When I told him that he would need insulin injections, he jumped out of his chair and asked me to give any other medication, promising that he will listen to all advice and obey any other solution. I had the feeling he would be a difficult patient.

I told him about the new project to prevent diabetes and related complications and referred him to our family medicine team that had just been trained to deal with diabetic patients. I also convinced him to take insulin for few days and maybe later on he would be able to continue with tablets, but I was almost sure that he would need to stay on insulin injections.

Within a few days time his blood sugar level became more normal and his appearance improved, but at every visit he asked me when he will be able to drop the insulin injections. I contacted the psychologist of our team and his family doctor and explained that the patient needs to stay on insulin for another 3 weeks. After consultation with my colleagues I thought that with appropriate psychological support and nutrition advice, he should be able to get used to being insulin dependent.

Meanwhile, the trained nurse from the counselling section educated the patient about proper insulin intake, and his wife was counselled about the type of food to prepare, and the family medicine team provide other routine care.

At the 3-week check up, there was significant improvement. When I asked the patient how he is dealing with insulin therapy, he became very embarrassed, and admitted that he does not use the therapy at all. After all the efforts I had made, I was surprised and a bit angry. To make me happy, the patient suggested measuring his blood sugar level. I was shocked when the nurse told me that his level was only 7.8mmol, just two hours after the meal.

He smiled and told me about his talks with psychologist and family medicine doctor who tried to help him overcome his fear of insulin therapy. He promised them that he would take care of what he eats and get sufficient exercise, just so he would not to inject himself and have people talk „hey, this one is on insulin“. His strong will and support from my trained colleagues helped him to achieve some control over his disease.

By Dr. Azra Avdagić, Dom Zdravlja Sarajevo

KARIESPROPHYLAXE IN AFRIKA: NOCH KEINE ERFOLGSGESCHICHTE

Aufgrund eigener Untersuchungen wissen wir, dass etwa die Hälfte der Schulkinder südlich der Sahara ein Gebiss mit Kariesaktivität zeigt. Die Zahnzerstörungen sind mit zunehmendem Alter meist derart, dass nur noch Zahnentfernungen als therapeutische Massnahme in Frage kommen. Das Wissen der Bevölkerung um die Ursachen der Karies und um die Möglichkeiten, diese mit korrekter Mundhygiene und dem Einsatz von Fluoriden zu verhindern, ist nach wie vor minimal. Für mich als Projektleiter der Zahnklinik von Ifakara im tansanischen Süden wird es Zeit, eine Bilanz der nun schon fast 15-jährigen Prophylaxetätigkeit vor Ort zu ziehen.

Von Michael Willi

OBWOHL aufgrund des Spardruckes von Kantonen und Gemeinden in den letzten Jahren auch im Bereich der Schulzahnpflege ein markanter Leistungsabbau stattgefunden hat, gehört die Schweiz noch immer zu den wenigen Ländern der Welt, in denen jedes Schulkind vom ersten bis zum letzten Schultag zahnmedizinisch betreut wird. Zahnbürstinstruktionen und Kariesaufklärung in der Grundschule, klassenweises Einbürsten hochkonzentrierter Fluoride sowie jährliche Kontrollen durch den Zahnarzt haben in den letzten Jahrzehnten zu einem massiven Rückgang der Karies bei Schulkindern geführt. Die Wirksamkeit dieser Massnahmen zur Prophylaxe der Karies ist vielfach wissenschaftlich erforscht und dokumentiert worden. Für Schweizer Schulkinder ist es heute selbstverständlich, mit einem karies- und oft auch füllungsreifen Gebiss die Schule zu verlassen. Das Bewusstsein für Zahngesundheit und Mundhygiene hat zur Folge, dass ein grosser Teil der ehemaligen Schüler auch im Erwachsenenalter regelmässige zahnärztliche Betreuung wünscht.

Angesichts dieses Erfolges der Prophylaxe hat Secours Dentaire International (SDI) seit seiner Gründung vor über zwanzig Jahren bei der Einrichtung von Kliniken in Afrika höchsten Wert auf die Einbeziehung der Schulzahnpflege gelegt. Die Erkenntnisse, was die Prophylaxe zu leisten vermag, sind international bekannt, und auch in Ländern der dritten Welt gibt es Prophylaxeprogramme – zumindest auf dem Papier. In Tansania zum Beispiel hat die Regierung mit Hilfe dänischer Zahnärzte ein Handbuch entwickelt, in dem Prophylaxeaktionen beschrieben werden. Diese sollten von Lehrpersonen im Rahmen des Lehrplanes unterrichtet werden. Unsere Erfahrungen haben aber gezeigt, dass eine Vermittlung dieser Inhalte praktisch nicht stattfindet, zumal die Lehrpersonen selber kaum über das notwendige Wissen verfügen. Hier wird das Personal der SDI-Zahnkliniken aktiv, in dem wöchentlich die Schulen besucht, Schulkinder untersucht und Prophylaxeaktionen erteilt werden.



Schulkinder bei der Zahnuntersuchung in der Klinik von Ifakara

SCHULZAHNPFLEGE NACH SCHWEIZER VORBILD

Die von Secours Dentaire International geförderten Prophylaxeprogramme, die klassenweise in den Grundschulen durchgeführt werden, sind ähnlich wie in der Schweiz aufgebaut. Sie bestehen aus einer Prophylaxeaktion, einer Demonstration des Gebrauchs von Zahnbürsten und schliesslich einer klinischen Gebissuntersuchung. Dabei erhalten die Kinder, die einer Therapie bedürfen, eine schriftliche Information zuhause den Eltern, in der diese aufgefordert werden, das Kind in der Klinik behandeln zu lassen. 1997 wurden in allen SDI-Projekten zusammen in 452 Lektionen über 90'000 Kin-

der unterrichtet. Trotz hohem Bevölkerungswachstum konnte diese Zahl bis heute nicht gesteigert werden, was netto einer Reduktion unserer Prophylaxeaktivitäten gleichkommt. Die Ursachen dafür sind vielfältig und oftmals führen politische Gründe (Zimbabwe, Kongo) zu einer Reduktion oder gar einem Unterbruch unserer Aktivitäten.

Die Basis der SDI-Aktivitäten in afrikanischen Ländern ist immer eine gut funktionierende stationäre Zahnklinik, die mindestens einmal jährlich vom SDI-Projektleiter, der während des gesamten Jahres Ansprechpartner in Europa für das afrikanische Klinikteam ist, besucht wird. Nur so ist die Kontinuität von technischer, materieller und ideeller Unterstützung gesichert, was uns gleichzeitig eine hohe und gleich bleibende Qualität der zahnärztlichen Leistungen garantiert.

In Ifakara, etwa 600 km landeinwärts von Dar es Salaam, der grössten Stadt Tansanias, befindet sich das St. Francis District Hospital. Hier betreibt Secours Dentaire International seit 1992 eine Zahnklinik. Die moderne

* DR. MED. DENT MICHAEL WILLI ist Zahnarzt mit eigener Praxis in Emmenbrücke bei Luzern. Seit 1992 engagiert er sich als Projektleiter für Tansania bei Secours Dentaire International, einer Hilfsorganisation von Schweizer Zahnärzten. Kontakt: michael.willi@secours-dentaire.ch

Einrichtung, die Versorgung mit auch in Europa üblichen Verbrauchsmaterialien und der durch SDI-Experten ermöglichte Ausbildungsstand des Klinikpersonals machen das "dental unit" zu einer der besten zahnärztlichen Einrichtungen im ganzen Land.

Beeindruckend sind die gestiegenen Patientenzahlen seit der Kliniköffnung Ende 1992: Nach einem anfänglichen Run auf die Klinik kam es in den 90er Jahren zu einer Konsolidierung der Patientenzahlen auf ca. 4'000 pro Jahr. Ab dem Jahr 2000 ging es dann kontinuierlich aufwärts, und noch dieses Jahr wird die Klinik die Grenze von 9'000 Patienten überschreiten. Konkret bedeutet dies eine Verdoppelung der Patientenzahlen innerhalb von 7 Jahren. Damit verbunden sind natürlich auch eine massive Zunahme des Materialverbrauches und eine stärkere Belastung der Infrastruktur, was die Kosten für die Partnerorganisation Secours Dentaire International in die Höhe trieb.

EINE ZWIESPÄLTIGE BILANZ

Der Erfolg der Klinik in Ifakara ist zu einem grossen Teil der Zunahme der Bevölkerung zuzuschreiben, denn auch die Schulklassen werden immer grösser und zahlreicher. Der Einsatz der Prophylaxeteams in den Schulen hat allerdings mit dieser Entwicklung nicht standgehalten und ist im Gegenteil eher zurückgegangen. Die Gründe dafür sind vielfältig, aber im friedlichen Tansania nicht politischer Natur:

Mangelnde Kapazitäten: Durch das erhöhte Patientenaufkommen wurden die ursprünglich freien Kapazitäten der personell überdotierten Klinik weitgehend abgebaut. Eine Aufstockung des Personals kam für das Spital aus finanziellen Gründen nicht in Frage.

Mangelndes Verständnis: Sowohl von der Spitalleitung als auch vom Klinikteam wird die Karies-Prophylaxe nicht als prioritär betrachtet, sondern eher als Dienstleistung für die Geldgeber aus der Schweiz. Das Verständnis, dass nur ein flächendeckender Einsatz in den Schulen auf allen Stufen und über Jahre hinweg, eine Änderung der Ernährungs- und Hygienegeohnheiten bringen kann, fehlt weitgehend. Dazu kommt die Tatsache, dass das Prophylaxepersonal für diese Extraleistungen ausserhalb der Klinik entsprechend entlohnt werden will. Dies ist zwar verständlich, erschwert aber die ganze Angelegenheit erheblich.

Mangelnde Einflussmöglichkeiten: Da die Unabhängigkeit der Kliniken auch eines der Ziele von Secours Dentaire International war, müssen wir auch unseren schwindenden Einfluss auf die Führung der Kliniken in Kauf nehmen. Nachdem einige der zehn SDI-Zahnkliniken eine gewisse finanzielle und materielle Unabhängigkeit erreicht haben, ist Secours Dentaire International dort nicht mehr im operationellen Bereich tätig. Unsere Funktion beschränkt sich weitgehend auf die Beratung und die Lieferung von in Afrika nicht erhältlichem Verbrauchsmaterial. Deshalb wurde in Kliniken wie Ifakara die Formel «Material gegen Prophylaxe» zum Grundsatz der künftigen Kooperation mit den afrikanischen Partnern: Als einziges Druckmittel, um die Prophylaxe durchzusetzen, ist uns die Sistierung der Materiallieferungen geblieben. Diese Massnahme ist jedoch wegen der langen Lieferzeiten mit Containern (zeitweise mehr als ein Jahr) praktisch nicht steuerbar. Wir sind also mehr oder weniger auf den Goodwill der afrikanischen Partner angewiesen.

Die Durchsetzung der Prophylaxe, vor über zwanzig Jahren als wichtigstes Ziel unserer Aktivitäten in Afrika formuliert, wurde bis heute nicht einmal annähernd erreicht. Der Vergleich mit der Schweiz, wo grosse Erfolge erzielt werden konnten, zeigt, dass hier schon zu Beginn der Aktivitäten eine breite Basis das Problem der Karies erkannte und bereit war, Gegenmassnahmen einzuleiten. Es ging den Vertretern von Eltern, Behörden, Lehrern und Zahnärzten darum, die Volksgesundheit zu verbessern. Nur diese Allianz war in der Lage, grundsätzliche Veränderungen zum Positiven herbeizuführen. In Afrika bleiben wir von Secours Dentaire International weitgehend einsame Rufer in der Wüste.

Ist jetzt Resignation oder gar die Aufgabe unserer Projekte angesagt? Keinesfalls, denn wir dürfen stolz darauf sein, dass durch die seit Jahren funktionierenden SDI-Kliniken vielen tausend Patienten auf professionelle Art geholfen werden konnte. Der flächendeckende Einsatz der Prophylaxe muss weiterhin unser Ziel bleiben, wenn der Erfolg auch auf sich warten lässt. Es handelt sich hier um eine Langzeitinvestition, bei der Ausdauer und Hartnäckigkeit gefragt sind. Die Erfahrungen aus der Schweiz bestärken uns in der Überzeugung, dass die Zielrichtung stimmt, wenngleich der Weg in Afrika anders und wesentlich schwieriger ist.

KREBSBEKÄMPFUNG – IN KUBA EINE SELBSTVER- STÄNDLICHKEIT

Ist Krebs denn überhaupt relevant für Entwicklungsprojekte? Krebs heute weltweit mehr Todesopfer als Malaria, Tuberkulose und Aids zusammen. Im Jahr 2000 wurden rund 10 Millionen Krebsdiagnosen gestellt – bis ins Jahr 2030 dürften es, das Bevölkerungswachstum eingerechnet, bereits 30 Millionen sein. Kuba, schon seit Jahrzehnten aktiv im Kampf gegen den Krebs, hat entsprechend eines Beschlusses der WHO vom Mai 2005 die Krebsbekämpfung zu einer seiner Prioritäten erklärt.

Von Marianne Widmer Eppel*

KREBSMEDIZIN gehört nicht zum Kernbereich der internationalen Zusammenarbeit mit den Ländern des Südens. Entwicklungsprojekte fokussieren auf die ärmsten Bevölkerungsgruppen und helfen, Basisstrukturen für die Gesundheitsversorgung und Gesundheitserziehung aufzubauen, den Zugang zu Medikamenten zu verbessern oder die Bevölkerung bei ihren legitimen Forderungen nach angemessener Gesundheitsversorgung gegenüber dem Staat oder den lokalen Behörden zu stärken. Partnerorganisationen sind häufig lokale NGOs und Selbsthilfegruppen; kirchliche Organisationen kooperieren mitunter mit Spitälern, die sie oft schon seit vielen Jahrzehnten betreiben. Der Kampf gegen Aids hat die internationale Zusammenarbeit gelehrt, Gesundheitsaspekte im Sinne von Aufklärung und Umgang mit den gesellschaftlichen, demographischen und psychosozialen Auswirkungen der Epidemie auf das Projektumfeld in der Kooperation generell zu berücksichtigen.

Krebs hingegen kann kaum auf lokaler Ebene an der Basis bekämpft werden und ist auch kein Transversalthema. Wirksame Projekte im Bereich Krebs müssen eingebettet sein in eine

nationale Gesundheitspolitik, sie müssen über funktionierende, national vernetzte Gesundheitsstrukturen an die Basis getragen werden. Sie verlangen nach kontinuierlicher Versorgung mit Medikamenten und einer funktionierenden Infrastruktur, zum Beispiel bei der Strahlentherapie. Effizienz, Verbreitung und Zugänglichkeit der vorhandenen Gesundheitsstrukturen sind entscheidend. Der Kampf gegen Krebs ist ein langfristiges, unspektakuläres Unterfangen.

Es sind die armutsbedingten Krebsarten wie Gebärmutterhals-, Speiseröhre- und Leberkrebs, an denen immer mehr Menschen im Süden erkranken. Aber auch Brust-, Lungen-, Dickdarm- und Prostatakrebs, also Tumorerkrankungen, die dem sogenannten westlichen Lebensstil zugeschrieben werden, nehmen kontinuierlich zu. Zu den Ursachen gehören das Risikoverhalten und die Lebensumstände der Menschen: Alkohol- und Tabakkonsum, unausgewogene Ernährung und abgasverschmutzte Luft in den Metropolen, in denen immer mehr Menschen leben. In den Entwicklungsländern mangelt es heute drastisch an Präventions- und Früherkennungsmassnahmen an



Patient/innen während der ambulanten Chemotherapie an der Nationalen Krebsklinik INOR in Havanna



XXX

der Basis und auf der mittleren Versorgungsebene. Die Entwicklungsländer verfügen zusammen nur etwa über ein Drittel der weltweit vorhandenen strahlentherapeutischen Geräte – zudem sind diese in den einzelnen Ländern selber sehr ungleich verteilt; ärmere Bevölkerungsschichten haben kaum Zugang.

KUBA – SEIT JAHRZEHNEN AM BALL

Die häufigste Todesursache von Kubaner/innen sind Herz-Kreislaufversagen, an zweiter Stelle steht Krebs. Bei einer Gesamtbevölkerung von 11,2 Millionen wurden in den letzten Jahren durchschnittlich 27.000 neue Krebsfälle pro Jahr registriert. Sowohl die Krebserkrankungen als auch die Todesfälle aufgrund bösartiger Tumore nahmen seit 2001 um vier Prozent zu. Die häufigsten Tumorarten sind Brustkrebs, Gebärmutterhalskrebs und Dickdarmkrebs bei Frauen – auch Lungenkrebs wird bei Frauen immer häufiger; bei Männern sind es Lungenkrebs, Prostatakrebs und Dickdarmkrebs. Betroffen sind vor allem Menschen über 60 Jahren, die Zunahme von Krebs hat also auch mit der gestiegenen Lebenserwartung in Kuba zu tun. In Kuba wurde bereits 1961 das erste nationale Krebsprogramm entwickelt, zu einer Zeit also, als Infektionskrankheiten die vorrangigen

Gesundheitsprobleme der Entwicklungsländer darstellten. Das Programm war ausgerichtet auf den als Armutskrankheit bezeichneten Gebärmutterhalskrebs. Parallel zum Aufbau der bis heute bestehenden Gesundheitsstrukturen wurde das Krebsprogramm kontinuierlich ausgebaut und neue medizinische und technologische Möglichkeiten integriert. So wurde bereits 1976 ein nationales Krebsregister angelegt und landesweit Daten von Krebsfällen zusammengetragen, systematisiert und den Fachleuten zur Verfügung gestellt. In den 1990er-Jahren investierte das kubanische Gesundheitsministerium vermehrt in Forschung und Produktion von Krebsmedikamenten (Zytostatika). Dennoch konnten nicht in allen Bereichen Erfolge erzielt werden: Die Erneuerung oder Modernisierung der strahlentherapeutischen Geräte war über Jahre hinweg nicht möglich. Auch bei der Digitalisierung der Krebsdaten, die in den Industriestaaten neue Möglichkeiten zur Prävention und Früherkennung von Tumorerkrankungen zu erschliessen begannen, verlor Kuba mangels der entsprechenden Informationstechnologie den Anschluss.

Kuba hat die Krebsmedizin zu einer seiner Prioritäten erklärt und setzt damit einen entsprechenden Beschluss der Weltgesundheitsor-

ganisation WHO vom Jahr 2005 direkt um. Das Nationale Programm zur Krebsbekämpfung (Programa Nacional para el Control de Cáncer PNCC) hat sich zum Ziel gesetzt, bis ins Jahr 2015 die Krebserkrankungen sowie deren Mortalität drastisch zu reduzieren. Dazu sind vielfältige Anstrengungen notwendig.

Die Krebsbekämpfung in Kuba, die bereits heute ein breites Spektrum umfasst – Forschung und Produktion von Medikamenten, Beobachtung von Entwicklungen und Tendenzen, Präventions- und Aufklärungsarbeit sowie Diagnose und Behandlung, einschliesslich einer Palliativmedizin zur Begleitung von Krebserkrankten ohne Heilungschancen – soll in allen Bereichen gestärkt und ausgebaut werden. Durch regelmässige Kontrollen, genauere Kenntnisse von Symptomen und dem Einsatz moderner Diagnosegeräte soll eine Verbesserung von Diagnose und Früherkennung bewirkt werden. Die Behandlungsmöglichkeiten sollen durch ein breiteres und verbessertes Spektrum an Medikamenten, einer fortschrittlicheren Tumorchirurgie und einer moderneren Infrastruktur zum Beispiel in der Strahlentherapie verbessert werden. Mittelfristige Entspannung in den Engpässen der Spitalversorgung erhofft man durch günstige Lieferverträge mit chine-

sischen Firmen, aber auch durch die medizinische Zusammenarbeit mit Venezuela zu erzielen. Die vermehrte Investition in Präventionskampagnen sollen Risikoverhalten bewusst machen, aber auch der Zusammenhang zwischen sozialen und umweltbedingten Faktoren und das damit verbundene Krebsrisiko sollen verdeutlicht werden. Das Nationale Programm zur Krebsbekämpfung umfasst alle Bereiche und engagiert deren Akteure für die Formulierung einer wirksamen Krebspolitik.

MÄNGEL UND ENGPÄSSE ÜBERWINDEN

Länder wie Kuba machen uns bewusst, dass der Staat in der Gesundheitsversorgung eine führende Rolle übernehmen muss. Effizienz, Verbreitung und Zugänglichkeit der vorhandenen Gesundheitsstrukturen sind entscheidend für die Durchsetzung einer wirksamen Krebsmedizin zu Gunsten der gesamten Bevölkerung. Kuba ist auf gutem Wege, seine Ziele zu erreichen. Trotzdem gilt es noch viele punktuelle Mängel und Engpässe, zu überwinden. Dazu leistet mediCuba-Suisse seit Jahren einen wesentlichen Beitrag.

mediCuba-Suisse finanziert moderne Informationstechnologie und Weiterbildung für das nationale Krebsregister: In allen Provin-



«DIE REGIERUNGEN MÜSSEN IN DER GESUNDHEITSVERSORGUNG EINE FÜHRENDE ROLLE ÜBERNEHMEN.»

Verfügen Länder des Südens über Mittel und Strategien für eine angemessene Krebsmedizin?

Wir haben festgestellt, dass das Vorhandensein und die Qualität von Gesundheitsstrukturen wichtiger sind als die finanziellen Mittel eines Landes. Entscheidend ist also nicht das Bruttozialprodukt, sondern der politische Wille. Die Regierungen müssen in der Gesundheitsversorgung eine führende Rolle übernehmen. Doch auch Staaten allein richten angesichts der globalen gesundheitspolitischen Herausforderungen immer weniger aus. Pandemien wie Aids, und Phänomene wie SARS oder die Vogelgrippe haben die Industriestaaten aufgeschreckt. In einer international renommierten Wissenschaftszeitschrift stand unlängst zu lesen, dass die zukünftige, globale Gesundheitsversorgung wichtigstes Thema jeder nationalen Aussenpolitik sein sollte. Pandemien, Migration, Umwelteinflüsse, Armut und Ernährung

sind Stichworte in der Agenda einer Gesundheits-Aussenpolitik, die alle Länder betreffen. Was Krebs angeht, dürfen wir nicht vergessen: Krebs fordert heute weltweit mehr Todesopfer als Malaria, Tuberkulose und Aids zusammen. Die Regierungen müssen also bei Krebs einen Schwerpunkt setzen, und es braucht globale Kampagnen. Die Welt-Gesundheitsorganisation hat darum im Mai 2005 zum ersten Mal in ihrer Geschichte Krebs zu einer ihrer Prioritäten erklärt.

Ist Krebs ein Gesundheitsproblem für Entwicklungsländern?

Noch vor 25 Jahren gab es in den Industriestaaten etwa gleich viele Krebsopfer wie in den Entwicklungsländern zusammen, nämlich etwa 2,1 Millionen; im Jahr 2020 werden drei Viertel der Krebstoten in Entwicklungsländern anfallen. Heute bereits werden in den Entwicklungsländern rund 70% aller weltweit diagnostizierten Krebsfälle registriert, doch diese Länder verfügen nur über ein Drittel der strahlentherapeutischen Anlagen. Es gibt Länder in Afrika und vereinzelt auch in Asien, die nicht eine einzige Radiologiemaschine besitzen.

Haben Krebspatient/innen in Entwicklungsländern reale Aussichten auf medikamentöse Behandlung?

Punkto Medikamente stehen wir eigentlich nicht so schlecht da. Schon heute verfügen wir über eine beachtliche Palette von Medikamenten, und in Zukunft wird es immer mehr wirksame Medikamente gegen bösartige Tumore geben. Wie bei Aids ist aber auch bei Krebs der Zugang zu Medikamenten wesentlich von der Kaufkraft der Patient/innen bzw. von der Gesundheitsversorgung in den Ländern der Patient/innen abhängig. Ein multinationaler Pharmakonzern hat unlängst einen Impfstoff gegen das Papillom – ein Virus, das in rund hundert verschiedenen Arten auftritt, sexuell übertragen wird und für praktisch alle Krebsarten des Gebärmutterhalses verantwortlich ist – auf den Markt gebracht. Die Wirksamkeit des Impfstoffs ist zwar auf fünf Jahre beschränkt ist und kann nur etwa drei Viertel der bösartigen Wucherungen verhindern – aber immerhin. Di-

ese Impfung kostet in der Schweiz 600 Franken. Die Pharmaindustrie hält den Preis für die Impfung in den Industriestaaten hoch, um ihn in Entwicklungsländern bis zu zehnmal günstiger verkaufen zu können. Doch auch 60 Franken oder 50 US-Dollar sind in einer Volkswirtschaft, die pro Kopf und Jahr 15 Dollar ausgibt, ein unverhältnismässiger Preis. Für die Mehrzahl der Krebskranken weltweit wird diese Impfung unerreichbar bleiben, wenn es nicht fundamentale Veränderungen in den internationalen Handels- und Wirtschaftsbeziehungen gibt.

Was unternimmt die International Union against Cancer?

Wir haben im Jahr 2006 die erste globale Kampagne lanciert, ausgerichtet auf Krebs bei Kindern. Obschon nur etwa zwei Prozent der bösartigen Tumore bei Kindern auftritt, können wir in der pädiatrischen Onkologie das Heilungspotenzial bei rechtzeitig erkannten Tumorbildungen leicht aufzeigen und damit dem Gefühl der Hilflosigkeit entgegenwirken. Gegenwärtig arbeiten wir an 36 Projekten in 16 Ländern, mit dem Ziel, die Bedingungen für Prävention, Kontrolle und Behandlung zu verbessern. Für die Pilotphase haben wir fünf Entwicklungsländer ausgewählt: Vietnam, Sri Lanka, Jemen, Tansania und Nicaragua. Die nächste Kampagne richtet sich an Jugendliche, auch sie setzt bei der Früherkennung und Prävention an. Die Aufklärungsarbeit stützt sich auf vier einfache Botschaften: Nicht Rauchen, genügend Körperbewegung, lange Sonneneinstrahlung vermeiden und Infektionen bekämpfen, am besten mit Impfungen.

PROF. DR. MED. FRANCO CAVALLI, Onkologe, Präsident der International Union against Cancer IUC, Chefarzt der Klinik San Giovanni in Bellinzona, und Vizepräsident von mediCuba-Suisse, im Gespräch mit Marianne Widmer Eppel (August 2007).

zen werden für die Sammlung und Systematisierung der Daten neue Computer installiert, welche die Einführung des international zertifizierten Computerprogramms zur Erfassung und Verarbeitung von Krebsdaten ermöglichen. Für die Wartung und einheitliche Nutzung des Programms werden landesweit Weiterbildungen durchgeführt.

Ende 2007 startet ein neues Projekt zu Gunsten der onkologischen Beobachtung. Mit Hilfe angemessener Computertechnologie werden virtuelle Räume geschaffen, welche die landesweite Vernetzung von Institutionen ermöglichen, die in der Krebsmedizin tätig sind. Das Netz geht jedoch weit über das eigentliche Gesundheitswesen hinaus, indem es beispielsweise auch die Frauenföderation FMI, Jugendverbände oder Grossbetriebe einbezieht. Die onkologische Beobachtung soll zu einem richtungsweisenden Instrument für die nationale Krebspolitik in Sachen Prävention, Früherkennung und Therapie ausgebaut werden.

Ein weiterer Projektschwerpunkt von mediCuba-Suisse liegt in der Weiterbildung und Vernetzung von ärztlichen, pflegenden und psychologischen Fachleuten sowie Sozialarbeiter/innen, die in der palliativmedizinischen Betreuung tätig sind. Palliativmedizin hilft Menschen mit unheilbaren Krankheiten und deren Angehörigen in der letzten Lebensphase. Sie lindert Schmerzen und Symptome und hilft, die Autonomie der Patient/innen solange wie möglich zu erhalten. Der Ansatz verbindet moderne Krebsmedizin mit pflegerischer und psychosozialer Betreuung. Dazu nötig sind geeignete Spitaleinrichtungen für die ambulante Behandlung, aber auch die professionelle Begleitung von Patient/innen und Familien zu Hause.

Den Ausbau der Produktion von Zytostatika (Krebsmedikamenten) unterstützt mediCuba-Suisse gemeinsam mit dem Netzwerk mediCuba-Europa. Nach einer Übergangsphase sollen in Havanna bis ins Jahr 2010 acht zusätzliche Zytostatika hergestellt werden können.

* **MARIANNE WIDMER EPEL** ist Programmkoordinatorin von mediCuba-Suisse. Kontakt: info@medicuba.ch

COMBINED EFFORTS ARE MUCH NEEDED

Cancer is low on the health agendas of low- and middle-income countries (LMCs) even as other chronic diseases have begun to gain attention. Eleven million cases of cancer now occur annually worldwide, six million of them in LMCs. Five million deaths from cancer – one million more than deaths from AIDS – occur each year in LMCs. As the competing risk of infectious disease declines, cancer and other chronic diseases will move to the forefront as contributors to poor health, more so if LMCs adopt the unhealthy behaviors of high-income countries. Steps taken now – particularly in prevention – will be rewarded by curbing the growth in cancer rates.

By Hellen Gelband and Frank A. Sloan*

LOW- AND middle-income countries include nations vastly different in resources, rates of economic growth, political and social conditions, and the state of health care services and infrastructure. In low-income countries, defined by the World Bank as having a per capita gross national income less than 825 US\$ in 2004, cancer control is minimal at best. In upper middle-income countries, with a gross national income per capita of 3,256-10,065 US\$ in 2004, most of the population may have access to at least some cancer services.

The priorities and programs of LMCs are deeply influenced by the “global health community” – public- and private-sector agencies and organizations that provide advice, assistance, services, and financial support for health. LMCs and the global community at large should be increasing resources proportionately for cancer and other chronic diseases, yet this has not happened to any noticeable degree.

The mix of cancers in different areas of the world varies by environment, geography, and standard of living. The rise in cigarette smok-

ing has made lung cancer the most common cancer in men and overall in LMCs and high-income countries. Breast cancer is similarly the most common cancer in women everywhere. In LMCs, cancers of the stomach and liver are next most common in men, and cancers of the cervix and stomach in women. Most cancers of the stomach, liver, and cervix are caused by infectious agents: the bacterium *Helicobacter pylori*, hepatitis B and C viruses, and human papillomaviruses, respectively. In LMCs, 26 percent of all cancers are attributable directly to infectious agents; in high-income countries, the figure is about 8 percent.

Cancer stage at the time of detection in LMCs is, on average, substantially further advanced than in wealthy countries. Patients in LMCs also tend to have co-morbidities that make recovery from cancer less likely than it is for patients in high-income countries.

CANCER CONTROL AND CANCER PLANNING

Cancer control includes all activities and interventions intended to reduce the burden of can-

cer, either by reducing incidence or mortality, or by alleviating suffering. Prevention, early detection, diagnosis, treatment, psychosocial support, and palliative care are the components of cancer control. Surveillance and monitoring are also needed to understand the cancer burden, plan, and track progress. All aspects of cancer control require financial and human resources, including training and education to build the required human resource base, and information for the public to understand what they can do and the services available.

Not all of cancer control is conducted within the health care system. Many effective tobacco control interventions are legal and regulatory in nature. Making morphine available for pain control involves narcotics control authorities as well as the health care system. Other interventions are allied to parts of the health care system that are unrelated to cancer: vaccination against hepatitis B virus to prevent liver cancer is conducted by childhood immunization programs.

Deciding on national cancer control priorities is best done through national cancer control planning. A 2005 World Health Assembly resolution calls on all 192 WHO Member States to develop national cancer plans and programs. Although cancer plans must eventually be embraced by government to be fully effective, they may be developed outside of government, for example, by NGOs. Regardless of the process, cancer planning must involve the full spectrum of stakeholders and interest groups. A process has been well described by WHO with additional guidance from the International Union Against Cancer and other sources. The plan need not cover every aspect of cancer control. It might focus initially, for example on tobacco control and palliative care.

PREVENTION POSSIBILITIES

Tobacco control. Globally, tobacco causes more premature deaths from cancer – and even greater numbers from other causes – than any other single agent. Experience in high-income countries and a few LMCs has shown that tobacco use and its impact can be reduced substantially through various policy measures. These include raising prices by increasing taxes, banning smoking in public places, banning advertising and promotion of tobacco products, requiring large and dramatic warnings,

and counteradvertising to publicize the adverse effects of tobacco and the benefits of quitting. The top priority for cancer control is to convince the world’s 1.1 billion smokers (80 percent of whom live in LMCs) to quit: Cessation by today’s smokers will lead to substantial health gains over the next five decades. Preventing children from starting smoking will have full benefits after 2050.

Hepatitis B vaccination. Hepatitis B Virus causes (often with a co-factor) most cases of liver cancer, taking 500’000 lives each year globally. A safe and effective HBV vaccine has been used in most high-income countries and many LMCs since the 1990s, yet vaccination coverage is poor in many countries with the highest rates of liver cancer. In 2001, fewer than 10 percent of babies in Southeast Asia and Africa – among the worst affected areas – were vaccinated against Hepatitis B Virus.

Hepatitis B Virus vaccines costs less than 2 US\$ per person through UNICEF, which can be subsidized by the Global Alliance for Vaccines and Immunization. The future payoffs for Hepatitis B Virus vaccination and other scheduled immunizations are enormous; vaccination should remain as high on the cancer control agenda as it is on the child health agenda.

Vaccination cannot help the 360 million people worldwide who are currently infected with Hepatitis B Virus. However, limiting exposure to the most ubiquitous co-factor – aflatoxin – can substantially lower the risk of liver cancer. Contamination of stored grain by aflatoxin – a chemical produced by certain fungi under humid storage conditions – can be reduced by using low technology techniques such as drying crops in the sun, discarding moldy kernels, and storing crops in natural fiber sacks on wooden pallets.

Cervical cancer screening and human papillomavirus vaccines. Nearly 300’000 women die from cervical cancer each year, 85 percent of them in LMCs. The cause is persistent infection with one of several strains of the human papillomavirus. Improved living standards, effective treatment for cervical cancer, and screening using the Papanicolaou (Pap) smear are responsible for the steep decline in incidence and mortality from cervical cancer in high-income countries. Two strategies could transform cervical cancer control in LMCs: 1. vaccines to prevent human papillomavirus in-

fection, and 2. screening methods that are more compatible with LMC resources and infrastructure than are Pap smear programs.

Vaccines against the most common carcinogenic strains of human papillomavirus have recently been marketed. Although the initial market is in affluent countries, the greatest impact of these vaccines will be in LMCs. The vaccines could prevent of hundreds of thousands of deaths every year, starting several decades after establishment of a vaccination program. Governments and the international health community should take concrete steps now to develop human papillomavirus immunization policies and the means to pay for what is currently an expensive vaccine. However for pre-vaccination generations of women, the vaccines cannot help.

DIAGNOSIS, TREATMENT, AND PSYCHOSOCIAL SUPPORT

Most people in low-income countries have no access to curative cancer treatment. In middle-income countries, services are variable but limited. Where few or no services exist, the emphasis should be on establishing a core of expertise and limited cancer management that can be expanded as resources permit. Where some services are available but resources are stretched or inadequate, the emphases should be: 1. ensuring that the most appropriate and cost-effective measures are provided in well-equipped medical institutions, and futile treatments are avoided; and 2. ensuring that services can expand with available resources.

People with cancer and those around them benefit from psychosocial support – from healthcare professionals and lay people – to deal with the physical, psychological, and social impacts of the disease, regardless of other aspects of treatment. Psychosocial support can commence at diagnosis and continue through treatment and recovery or death.

Resource-level-appropriate treatment for curable cancers. The concept of “resource-level appropriateness” recognizes that more than one intervention may be effective for curable cancers. The most appropriate choice for an LMC may not be the current choice in New York or Paris. For example, breast-conserving surgery for early-stage breast cancer requires treatment with radiotherapy. If radiotherapy is not available, more extensive surgery may also

be life saving, while maintaining a good quality of life. The range of choices is not always available, however. A major exception is a recent, highly innovative effort, the Breast Health Global Initiative, which is an international collaboration initiated by an American breast surgeon, with a wide range of partners from high-income countries and LMCs. Breast Health Global Initiative has produced a comprehensive set of resource-specific, stage-specific evidence-based guide-lines, which will be updated biannually, for all aspects of breast cancer management.

The Breast Health Global Initiative model could be applied to other common cancers for which highly effective treatments are available, for example cancers of the cervix, head and neck, and colon and rectum. Common cancers of children and young adults – leukemias and lymphomas, retinoblastoma, and testicular cancer – are also highly curable, and would benefit from this type of focus.

Cancer “Centers of Excellence.” Providing guidelines for cancer diagnosis and treatment is of no benefit without medical professionals who can apply them. Countries should consider supporting at least one well-functioning cancer center where patients can go for diagnosis, treatment, palliation, and psychosocial services. The center should also conduct locally relevant research. Even with limited capacity, such centers can act as focal points for national cancer control and as points of contact for the international community. The center may be as small as a unit in a hospital, offering selected treatments. In countries where cancer centers already exist, enhancing the functions of one or more centers may be most appropriate.

Financing for cancer centers LMCs can come from a variety of public and private sources, including taxes on tobacco products. International support is available, including the Programme of Action for Cancer Therapy (PACT), a relatively new initiative of the International Atomic Energy Agency. The Programme of Action for Cancer Therapy is expanding to all aspects of cancer management from a 25-year history of support for radiotherapy. The program is attracting collaborators from U.N. Member States and others and is likely to be a major source of new and upgraded cancer centers for at least the next decade.

Institutional twinning involves long-term pairings of established cancer centers, mainly in high-income countries, with new or existing centers in LMCs. Successful twinning programs involve regular exchanges of information and often personnel, attention to funding (although not necessarily money flowing from the high-income partner), training, and technical issues. The oncology community is well organized in affluent countries and has the capacity to help to organize twinning programs.

A special opportunity and responsibility is the treatment of children and young people with highly curable cancers. The total numbers are small compared with cancers in adults – approximately 160’000 children and young adults get cancer every year, worldwide. Currently, 80 percent of U.S. children under age 15 with cancer are cured, but 80 percent of the world’s children who develop cancer live in countries where most have no access to treatment.

Palliative care. Late diagnosis of most cancers in LMCs and a lack of treatment options makes palliative care even more important. The cornerstone of palliative care is pain control with oral morphine or other strong opioid analgesics. These medications are largely unavailable in LMCs. In addition to medication, pallia-

tive care involves a range of services to relieve and manage symptoms and provide psychosocial support to patients and families in their communities. The two major obstacles to palliative care in LMCs are: 1. the irrational fear of opioids that continues to exist among policy makers, regulators, law enforcement, health professionals; and 2. lack of programs to deliver palliative care at the community level. Both have been overcome in some LMCs, however, demonstrating that it is possible.

SURVEILLANCE AND MONITORING

Few LMCs have accurate data about their cancer burden or major risk factors for cancer. Estimates of cancer incidence and mortality by cancer type, age, and gender have been produced for every country by the International Agency for Research on Cancer. These estimates are useful for setting initial priorities, but not for tracking progress or defining priorities. Major improvements in vital and health statistics are long-term goals, but over the short term, modest improvements can be made. It is relatively inexpensive to gather information on the major risk factors for cancer and other non-communicable diseases in periodic cross-sectional surveys. WHO has developed standardized survey instruments in *STEPS*, a Stepwise Approach to Chronic Disease Risk Factor Surveillance.

Gathering national mortality data is a much more ambitious undertaking. In low-income countries, many people die without medical care or a death certificate, so medical records cannot support such a system. Systems using “verbal autopsies” can be developed in place of medical certification, as has been demonstrated in India’s *Million Death Study*.

Longitudinal studies of chronic disease risk factors and causes of death involving in total several million people have been initiated as collaborations between researchers in LMCs and high-income countries, with early results from China, India, and Mexico. After initial interviews and measurements, households are revisited periodically to record vital status, and participants are resurveyed every few years.

Finally, cancer registries that record cancer cases and outcomes – in specific hospitals, or more usefully, in defined geographic areas – are important for understanding local cancer patterns. Registries require sustained commit-

***HELLEN GELBAND** directed the Institute of Medicine study on Cancer Control in Low- and Middle-Income Countries. She is currently a scholar-in-residence at Institute of Medicine and a project director at Resources for the Future in Washington, D.C. Contact: HGelband@nas.edu. Frank A. Sloan chaired the Institute of Medicine committee on Cancer Control in Low- and Middle-Income Countries. He is Professor of Health Policy and Management and Professor of Economics at Duke University, and directs the Duke Center for Health Policy, Law and Management Contact: fsloan@duke.edu.

This paper is taken from the report “Cancer Control Opportunities in Low- and Middle-Income Countries” of the U.S. Institute of Medicine (IOM) of the National Academies. The report can be ordered through the National Academies Press (www.nap.edu). It can be downloaded free of charge in Low- and Middle-Income Countries. References: see online edition of the Bulletin, www.medicusmundi.ch.

ments and trained personnel, which are most feasible in urban areas where diagnosis and treatment are available.

THE ROLE OF THE GLOBAL COMMUNITY

Cancer control will not advance in LMCs without support from the global health community. Multilateral and bilateral aid agencies, foundations and other philanthropies, professional organizations and the academic community, all have roles to play in developing the global cancer control agenda, working with countries to prioritize and plan next steps, and providing resources to carry out plans. With a few exceptions, cancer control has had little support compared with efforts for infectious and nutritional diseases.

So far, cancer-specific organizations have promoted cancer control in LMCs. WHO's small cancer program has continued to provide guidance and other parts of WHO headquarters have taken up specific cancers or types of exposures. The International Agency for Research on Cancer has led in defining the causes of cancer and in surveillance, largely to the benefit of high-income countries, but increasingly for LMCs. The voluntary International Union Against Cancer, largely devoted to cancer control and advocacy in resource-rich countries, has become more active in LMCs in recent years. The broader global health community has, by and large, not followed.

Burgeoning global health programs at universities around the world are also untapped resources for cancer control. Efforts to inform faculty and administrators are needed to make them aware of projects in cancer control, in addition to the traditional emphases on infectious and nutritional diseases. Cancer centers in the United States and other wealthy countries also may not be aware of opportunities for twinning and other collaborations in LMCs.

Has progress been made?

CONTROL OF CARDIOVASCULAR DISEASE IN AFRICA

Cardiovascular disease (CVD) is no longer merely an emerging problem in Africa, but has become firmly established and its magnitude is approaching that of an epidemic. While the risk factors and the pattern of diseases causing cardiovascular disease may differ from those in Europe and North America, the impact is greater in Africa and is compounded by the persisting and difficult-to-eradicate communicable diseases. Additionally, the fight against CVD competes with education, housing, transportation, defence and ignorance.

By Salomon Kadiri*

THE PICTURE of cardiovascular disease in Africa today is what it was in Europe and North America in the sixties and, at least for the immediate future, with no clear indication that a large-scale change is around the corner. This paints a sad picture and unless there is mass concerted effort now, time may run out. It is against this that the small progress in this area and the prospects for change are discussed, for indeed the prospects are there.

The causes of cardiovascular disease have been thoroughly discussed in the literature, and the differences between the causes in sub-Saharan Africa and the developed countries owe largely to differences in lifestyle. In sub-Saharan Africa stroke and heart failure are major health problems, and ischaemic heart disease is far less common. Recent events have not helped as the situation evolved. The downturn in the economy of most sub-Saharan African countries and the subsequent interventions of the World Bank, International Monetary Fund and other funding agencies has led to health services being rationalised and approached from a more cost cutting or money minded intent. International aid to African countries is often dispersed in national bud-

gets and programmes with the result that the impact on the individual is ultimately reduced. This is reflected in the practice, or even policy, of many African countries whereby only about 5% of the budget is spent on health. In the same line it should not be forgotten that cardiovascular disease is not on the agenda of the Millennium Development Goals.

DIFFICULT CONDITIONS

Control of cardiovascular disease has been dogged by problems at various other levels. Inadequate practice, in the way of blood pressure measurement, cardiovascular risk assessment, treatment of hypertension and poor blood pressure control rates, still exist. Research drives progress but, unfortunately, sub-Saharan African countries, with only a few exceptions, perform poorly in this area. More meaningful research requiring international collaboration is almost always carried out in conjunction with workers in the advanced countries with the constant fear of the imposition of ideas on the African collaborators. Another limitation is the poor access to the little research output from Africa. Unable or disinclined to publish in more widely circulating journals, many re-

searchers publish their works in journals circulating largely within countries or even regions of countries and this only heightens the isolation felt by these workers.

Then there is the problem with the workforce. Africa harbours a sixth of the world population, 1'640'000 (2.8%) of the world total health workforce of 59'220'000 but accounts for health expenditures less than 1% of the world total. The 2006 World Health Report further states that most countries in Africa face a critical shortage of health service providers and also highlights the low pay and purchasing power of these workers and the unavailability of needed drugs. It goes on to state that smaller proportions of patients in Africa perceive that they had been treated with respect when visiting health facilities. Poor conditions of work, low morale and motivation, poor supervision and migration militate against effective health services. As ever, there is the likelihood of counter measures from certain economic sectors, such as the tobacco and beverage industries, which will fight to push their sales and not necessarily the health of their employees.

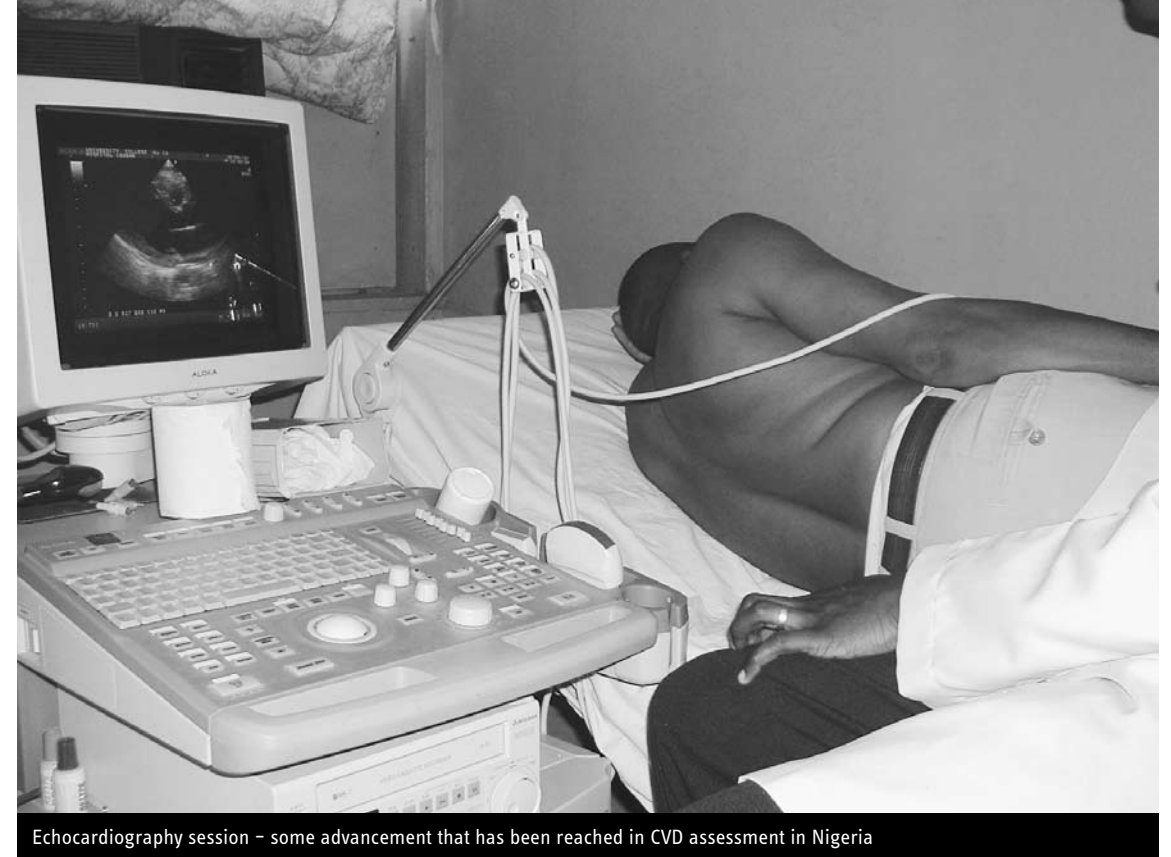
RAYS OF HOPE

Increasing awareness and knowledge: Many professional associations and other bodies have emerged in many countries of Africa all with the aim of increasing awareness, knowledge and treatment of cardiovascular disease. These include national and international professional associations and non-governmental organisations which provide guidelines for management of CVD, organise conferences and workshops. Sometimes they also offer screening services. Several of such organisations operate among others in Nigeria, South Africa, Kenya and Egypt. Continental bodies engaged in this area include The International Forum for Hypertension Control and Prevention In Africa (IFHA), Pan-African Society of Cardiology, African Association of Nephrology and the Africa Heart Network. The IFHA, the Nigerian Hypertension Society, and the Southern African Hypertension Society, just to mention a few, have developed guidelines for the management of hypertension, and there is evidence that these have been well received. Most of such initiatives started only two decades ago and are strengthened to this day. The World Heart Foundation, alone or in partner-

ship with other bodies, assists in the training of health care professionals in cardiovascular disease prevention and implementation of CVD guidelines.

Fostering research: Some attention is paid to non-communicable diseases research in Africa even in the face of the communicable diseases burden, and hope comes from many directions. National surveys have been carried out in some countries including South Africa and Nigeria and a few countries have produced guidelines for the treatment of hypertension. There has also been some impact of knowledge that has been put into practice – as for example: One report from Ife in Nigeria showed an improvement in anti-hypertensive prescription patterns, with regard to cardiovascular protection for more than ten years; it also identified the most cost-effective regimen. Furthermore, it was reported from Tanzania that the treatment that was recommended as the most ideal one, i.e., the faithful application of preventive cardiology practice, was not the most cost-effective step. On the surface it might appear that this presents a conflict but, in reality, it only calls for locally relevant and applicable research. Thus, research needs to be pushed in order to find less costly solutions. In yet another report of a study of women in Accra, Ghana, it was shown that women, especially those under 50, were willing to adopt weight reduction as a measure to reduce cardiovascular risk. Although these reports do not represent overwhelming evidence, they nevertheless offer hope.

Redistributing resources: The major portion of money spent on cardiovascular disease is expended on expensive treatment. It has been suggested that even if no additional resources are available, redistribution of existing resources with additions to preventive services will yield greater cost-effectiveness. Some CVD prevention measures can be implemented within the existing structure at primary, secondary and tertiary care centres. Decision makers can be more readily involved if they believe they are especially at risk of CVD. A proposal has been made for a template of CVD control based on strengthening the commitment of policy makers, focussing on prevalent modifiable risk factors, decentralization, surveillance and research. Among others, this approach recommends, focussing on primordial and prima-



Echocardiography session – some advancement that has been reached in CVD assessment in Nigeria

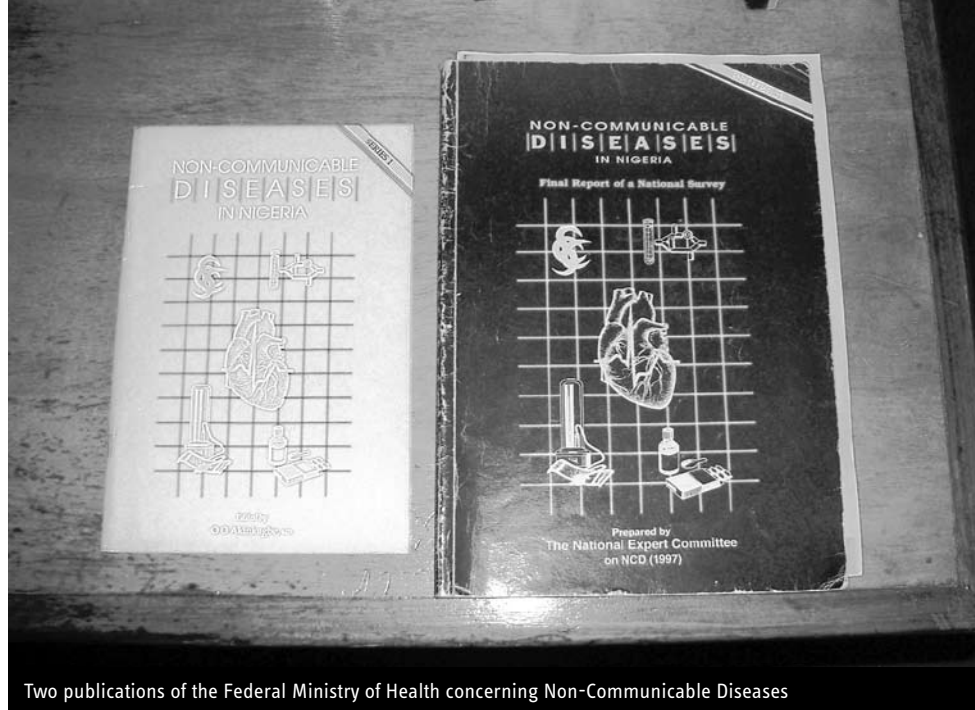
ry prevention and concurrently targeting high-risk groups and setting a higher blood pressure threshold for drug therapy of hypertension. The point has to be made that local strategies are needed to address the locally prevalent medical, social or economic conditions.

Facilitating partnerships: Initiatives such as African Journals Online and others have sought to address the issue of the isolation suffered by many African journals and authors by providing indexing services, yet, much remains to be done. Internet access is becoming widely available to most secondary and tertiary care centres, and we can expect a transformation in information dissemination in the near future, especially with the coming of the New Partnership for Africa's Development. One of its goals is the facilitation of partnerships among African collaborators and also with those in industrialised countries. There is a place for high-tech medical education and practice. For example, Tele-Cardiology, already in use in some parts of South Africa, could become more widely used and could establish vital access to both patients and cardiologists that are great dis-

tances apart. Encouraging results have already been recorded and doctors have made remote decisions far from the patients, just by studying certain electronically transmitted patient characteristics.

Educating the public: Large strides have been taken in educating the public about CVD although the media has not been utilized to the fullest. Not as many people today would ascribe sudden death to supernatural phenomena as would have 30 or 20 years ago. It is not uncommon, these days, for people to readily prefer stroke or heart attack as the cause of sudden death – rightly or wrongly, depending on the circumstances. Not all have embraced modern medicine, however. Many still turn to their traditions, spirituality or religious houses for relief, although economic considerations may be partly responsible.

Finding the root determinants: An approach not yet fully explored in the fight against CVD is to examine the root determinants of CVD. Root determinants are those factors that determine the immediate risk factors and seek to explain, for example, why people smoke or



Two publications of the Federal Ministry of Health concerning Non-Communicable Diseases

drink and thus become liable to developing a cardiovascular disease. It is possible that this approach may take us back to what might have been the problem all along, namely the inequities in the system.

A TWO-CLASS SYSTEM STILL EXISTS

By and large, the drugs needed for treatment of hypertension are available and physicians rightly prescribe them, individualizing the prescriptions in the appropriate situation. Older therapies persist alongside newer regimens, and there is the increasing use of generic drugs. Many secondary care facilities provide basic x-ray and electrocardiography services, and most tertiary care facilities provide echocardiography and computer tomography scanning services. A few now offer magnetic resonance imaging. Certain centres all through the continent offer medical and some surgical treat-

ment of cardiac diseases. However, the success of a treatment programme depends largely on the affordability of the drugs and procedures, and when there is no state or insurance covered treatment, as is often the case, payment has to be made from one's own pocket. The cost of certain drug prescriptions could easily consume a substantial proportion of the income of many low-paid workers, and this is a weakness of the system. Self-help is commendable, has played and will continue to play pivotal roles in health care, but it cannot be accepted as a replacement for government services – lest the inequities in the system be further accentuated.

It is perhaps too early to pass clear judgement on the performance of the various initiatives and, in this regard, we will have to wait and see what future surveys reveal. As with many other situations in sub-Saharan Africa, it appears that two classes of beneficiaries have emerged. There are the privileged, who receive information and education, can act on them and receive care when needed, and the less privileged who are not as lucky and bear the brunt of the problem. Unfortunately, the latter category forms the majority. Therefore, progress at the community level lags behind that at the individual level.

*SALOMON KADIRI is Professor of the Department of Medicine at the University College Hospital Ibadan, Nigeria. Contact: skadiri@comui.edu.ng. References: see online edition of the Bulletin, www.medicusmundi.ch.

A TRIPARTITE PUBLIC-PRIVATE PARTNERSHIP

In Pakistan, a tripartite public-private partnership was developed among the Ministry of Health, the nongovernmental organization Heartfile and the World Health Organization. NGOs typically assume a contractual role. This was the first time an NGO participated in a national health program. The partnership developed a national integrated plan for health promotion and the prevention and control of noncommunicable diseases.

By Sania Nishtar*

MOST DEVELOPING

countries do not comprehensively address chronic diseases as part of their health agendas due to lack of resources, limited capacity within the health system and the threat that the institution of vertical programs pose in terms of weakening health systems and competing with other health issues. However an integrated partnership-based approach could obviate some of these issues. Chronic non-communicable diseases are estimated to cause 35 million deaths worldwide annually; of these 80% occur in the developing countries. In Pakistan – with a population of 150 million – chronic diseases are among the top ten causes of mortality and morbidity and account for approximately 25% of the total deaths. One in three adults suffers from high blood pressure; the prevalence of diabetes is reported at 10%, 54% men use tobacco in one form or the other whereas Karachi reports one of the highest incidences of breast cancer for any Asian population.

However, as in most other developing countries, non-communicable diseases had not featured prominently on the country's health agenda until 2003 which is when the efforts of the NGO Heartfile led to the creation of a tripartite public-private partnership constituted by Ministry of Health, Government of Pakistan, Heartfile and the World Health Organ-

ization Pakistan office. This led to the development of a public health plan of action – the *National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan (NAP-NCD)* – currently in its first phase of implementation. The impact of the Plan, in terms of changes in population outcomes can only be assessed over a period of time. However, in this article we share experiences about the process, the perceived merits and limitations; discuss issues with its implementation, highlight the value that such partnership arrangements can bring in facilitating the missions and mandates of participating agencies and suggest options for generalizability.

A POPULATION-BASED APPROACH

Developed in a three stage process, the National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan looked at non-communicable diseases in an expanded definition. Therefore in addition to conventional non-communicable diseases or diseases that are linked by common risk factors – cardiovascular disease, diabetes, cancer and chronic lung conditions – mental illnesses and injuries were also added to this framework. The first stage of the Plan's development involved planning within the individu-

al streams of diseases; the second included priority setting whereas the third stage involved developing an integrated approach. This was assisted by the Integrated Framework for Action – a tool which aims to identify areas for common action across the broad range of communicable diseases on the one hand and helps to set country targets at a process, output and outcome level on the other in addition to allowing an assessment of progress to be made in this direction.

The Action Plan prioritizes a population-based approach to non-communicable diseases encompassing mass education, behavioural change communication, legislation, regulation, since these have the greatest potential to reduce non-communicable diseases risk and uphold the principles of equity given that the high risk approach may be inaccessible to the majority of the country's under-privileged population; 30% of Pakistan's population is below the poverty line of 1 US\$ a day.

The first phase of implementation of the Action Plan focused on surveillance and behavioral change communication. The former included the setting up of an integrated population based surveillance system for NCD risk factors with models on population surveillance on injuries, mental health and stroke and program evaluation. The latter focused on two approaches – an integrated behavioral change communication strategy through an electronic media intervention targeting 90% of the country's population on the one hand and incorporation of NCDs in the workplan of Lady Health Workers on the other. Lady Health Workers are Pakistan's field force of more than 70'000 grass roots level health care givers, who had, up then been involved with delivering reproductive health and communicable disease services, door to door in poor and under-privileged rural areas at the grass roots level covering 70% of Pakistan population. Heartfile had previously pilot tested this approach in one district by training 700 Lady Health Workers and introducing cardiovascular disease prevention as part of their work-plan.

The second phase of implementation is envisaged to reorient health services to a more preventative orientation with a focus on training and capacity-building of health professionals, up-scaling of basic infrastructure and ensuring availability and access to certain drugs

at all levels of healthcare. Since healthcare delivery in Pakistan is characterized by a variety of roles played by different categories of healthcare providers, all will be drawn into the loop.

MERITS

Within the public health system. By grouping non-communicable diseases and integrating actions, there is a shift from a vertical approach to diseases. By horizontally integrating actions with existing initiatives, it contributes to strengthening of the public health system whereas the integration of contemporary concepts such as the integrated models on surveillance and behavioral change communication will yield empirical evidence for emerging chronic disease programs in other low resource settings. The inbuilt evaluation mechanism of this model allows program assessment at a process and outcome level and an assessment of the level of contribution partners have made in achieving these objectives.

Engaging non-governmental organizations. In this model the NGO works in a nationally agreed framework. Non-governmental organizations and the civil society can contribute to achieving national goals; however this potential remains largely untapped. This model provides a mechanism for engaging non-governmental organization in the national decision making process and ensures their participation both in the formulation of health policy and implementation of national plans. The model will generate empirical evidence of relevance to the sustainability of non-governmental organizations in the developing countries, many of which are under funding constraints because of shifting donor focus on program aid as part of the Sector Wide Approach rather than project aid in which the civil society benefits directly. In this model, World Health Organization is gaining experience with a model where World Health Organization resources – which are otherwise, allocated for the public sector – support the private sector in a country model. The experience is also likely to yield evidence for other developing countries where tightly knit community structures and channels such as those created by primary health care and social welfare activities with out reach at the grass roots level can be conducive for advancing the chronic disease prevention agenda.

LIMITATIONS

Lack of procedural clarity. The initial stages of the program endured implementation challenges because of lack of procedural clarity in relation to public-private partnerships in the health sector within the country. Governments generally engage NGOs in a contractual mode. However as opposed to this approach, here was a case of a public-private engagement where the private sector partner lent impetus to the creation of the partnership, took active part in the decision making process and technically guided the design and implementation of the project. Such partnerships are known to create a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners; however, these also illustrate complex issues, as such arrangements bring together players with different interests and objectives, working within different governance structures. The implementation of this project therefore underscored the need to establish principles and norms of such arrangements and policy, legislative and operational frameworks in order to obviate allied ethical and procedural issues. It is envisaged that a firmer understanding of issues and clear articulation of policies will act as a bridge between the current mistrust between the public and the private sectors.

Bureaucracy as a bottleneck. Program implementation also gave insight into issues – widely perceived as implementation bottlenecks – which are generic to project implementation in a developing country bureaucracy. Key amongst these was onerous financial and administrative procedures and decision making delays. Lack of managerial authority, no accountability of the decision making process and lack of administrative efficiency in the public sector were observed to be important contributory factors to delays at the decision making and administrative levels – complicated by lack of performance-based incen-

tives. These considerations highlight the need for strengthening institutional governance and accountability mechanisms.

Public sector: lack of capacity and motivation. In addition, it was observed that there was also a lack of capacity and/or motivation to deliver on stipulated targets within the public sector. Capacity issues at a human resource level were also complicated by low numbers for certain categories, migration of skilled workers, misdistribution of workforce, staff absenteeism, dual job holding, lack of motivation to perform and the proverbial brain drain – manifestations of the lack of economic opportunities and incentives often complicated by other factors. This warrants changes in the present arrangement of public and civil service operations, building performance-based incentives and creating a milieu to enhance performance.

Decentralisation issues: The implementation of this program also brought to the forefront, problems at the level of the federal-provincial interface particularly with reference to counterpart institutional arrangements, sharing of resources, issues with the ownership of federally led programs at the provincial level, the issue of provincial-district souring of relationships and the undue control that provinces exercise over fund-flows and personnel. These considerations warrant strategic and structural changes not only at the level of the public private interface but also broader governance and implementations arrangements in relation to public health programming in order to improve health outcomes.

AN EMPIRICAL BASIS FOR AN INTEGRATED APPROACH

Notwithstanding the before mentioned limitations, the National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan serves as an empirical basis for an integrated approach to non-communicable diseases on one hand, and an experimental basis of health sector reform in the area of public-private collaboration on the other; most developing countries have limited approach with each. It also yields useful lessons for Ministries of Health, non-governmental organization and multilateral agencies for setting up non-communicable disease programs in the developing countries.

*Dr. Sania Nishtar; SI, FRCP, PhD, Founder and President of Heartfile, Islamabad, Pakistan. Contact: sania@heartfile.org, www.heartfile.org. References: see online edition of the Bulletin, www.medicus-mundi.ch

ASSOCIATION DE MALFAITEURS

Dans les pays en développement, la tuberculose est la complication infectieuse et la cause de décès la plus fréquente de l'infection VIH et le VIH est l'infection la plus souvent associée à la tuberculose. La mise à disposition des trithérapies antirétrovirales sous forme de médicaments génériques d'un prix abordable a pour conséquence une révision complète des programmes de prise en charge des deux maladies, et la nécessité de coordonner le diagnostic et les soins et de former les équipes soignantes dans la gestion des deux affections.

Par J-P. Zellweger*

AU SENS STRICT, ni la tuberculose ni le SIDA ne sont des maladies chroniques. La tuberculose correctement traitée est guérissable. Non traitée (ou non traitable, dans le cas des résistances médicamenteuses), elle est mortelle à brève échéance dans la plupart des cas, comme le SIDA. Il s'agit par contre de la plus redoutable «Association de malfaiteurs» que l'on puisse imaginer dans le domaine de la santé publique. Comme les mycobactéries tuberculeuses et le virus VIH attaquent les mêmes systèmes de défense de l'organisme, les cellules CD4, les porteurs du virus VIH sont particulièrement sensibles à l'infection tuberculeuse, contre laquelle ils ne possèdent plus de défenses naturelles et les tuberculeux porteurs du virus VIH ont des chances de guérison plus faibles et rechutent plus souvent que les autres.

LA CO-INFECTION TB ET VIH

L'OMS évalue à 40 millions le nombre de personnes infectées par le VIH dans le monde, dont 25 millions en Afrique. La tuberculose pour sa part se déclare chez environ 8 millions de personnes par année et représente la complication infectieuse la plus fréquente chez les

malades infectés par le VIH¹. La proportion de malades co-infectés est faible dans les pays occidentaux, où l'infection tuberculeuse est rare dans la population d'adultes jeunes, mais elle est beaucoup plus élevée dans les régions où la tuberculose et le VIH touchent la même classe d'âge.

Globalement, 11% des malades tuberculeux sont co-infectés par le VIH, mais la proportion s'élève à 38% en Afrique et peut atteindre 75% dans certains pays comme le Malawi et le Zimbabwe. A l'inverse, une forte proportion des porteurs du VIH développeront une tuberculose (entre 30 et 75% selon le risque annuel d'infection dans la population locale). Il existe ainsi une relation entre la prévalence du VIH dans la population générale et la proportion de cas positifs parmi les tuberculeux de la même région². L'interaction entre le VIH et la tuberculose, longtemps négligée, est considérée actuellement comme le facteur déterminant pour l'évolution future de la tuberculose dans le monde. Dans les régions du monde où la prévalence du VIH dans la population générale est inférieure à 4%, l'incidence de la tuberculose est stable ou en baisse. Dans les régions où la



Mères de famille traitées dans un Dispensaire Antituberculeux, République du Bénin.



Est-ce «seulement» la tuberculose ou aussi le SIDA?

prévalence dépasse 4%, l'incidence de la tuberculose augmente, et cela même dans les pays qui disposent d'un programme efficace de lutte antituberculeuse (stratégie DOTS de l'OMS)³.

Dans les populations où les tuberculeux sont fréquemment co-infectés par le VIH, on assiste à une augmentation progressive de la proportion de femmes parmi les malades, donc à une augmentation du risque de transmission de la tuberculose (et du VIH) de la mère à l'enfant. Chez les enfants séropositifs, la tuberculose représente également une cause fréquente d'infection respiratoire aiguë. Dans l'ensemble, les séropositifs ont cependant plus souvent des formes de tuberculose extra-pulmonaire, non contagieuse, donc leur influence sur la transmission de la maladie dans la population générale semble plus faible que celui des tuberculeux séronégatifs⁴. La co-infection complique également le traitement de la tuberculose, en raison de la fréquence élevée des intolérances médicamenteuses observées chez les patients séropositifs et des interactions médicamenteuses entre les antituberculeux (en particulier la rifampicine) et certains antirétroviraux⁵.

LES PROGRÈS RÉCENTS

Le grand changement intervenu au cours des dix dernières années est le développement de thérapies antirétrovirales efficaces (TAR ou HAART) et leur mise à disposition sous forme de médicaments génériques d'un coût abordable dans les pays en développement. Les traitements antirétroviraux ont ainsi transformé une maladie mortelle à brève échéance dans la majorité des cas en une affection chronique traitable, même si elle n'est pas guérissable⁶. En outre, grâce aux efforts de nombreuses institutions internationales, des gouvernements et de l'industrie pharmaceutique, le prix des traitements a baissé de 20 000 US\$ par personne et par an en 1996 à 132 US\$ en 2005⁷. Il est ainsi possible d'offrir aux malades et aux personnes infectées un traitement qui va prolonger leur vie. L'approche de l'infection, axée exclusivement sur la prévention, repose maintenant sur deux piliers complémentaires. La prolongation de la vie et la diminution des infections opportunistes ont cependant eu pour effet, même en Occident, d'augmenter l'importance de la tuberculose comme manifestation inaugurale du SIDA. En outre, l'efficacité des traitements an-

tirétroviraux a eu parfois pour effet pervers de diminuer les efforts de prévention, donc d'augmenter le nombre de cas d'infection dans certains groupes de population⁸.

Les indications aux traitements et les conditions de la prise en charge ont été définies en tenant compte des possibilités limitées des pays les plus touchés par la maladie⁹ et de la co-infection tuberculeuse. Sur le terrain, les équipes responsables doivent par contre apprendre à gérer sur le long terme des traitements complexes et souvent mal tolérés, et conduire simultanément le traitement de deux maladies infectieuses.

LUTTE COORDONNÉE CONTRE LA TB ET L'INFECTION VIH

Dans les pays où les deux infections sont courantes, il existe en général des programmes de lutte contre chacune des maladies, qui ont longtemps travaillé isolément. La reconnaissance de l'interaction étroite entre les deux maladies conduit progressivement à une collaboration entre les programmes, voire à leur intégration. Les programmes de lutte contre le SIDA sont incités à dépister rapidement la tuberculose chez les sujets séropositifs présentant des symptômes suspects, voire à rechercher chez eux une infection tuberculeuse latente, si les moyens techniques et financiers le permettent. A l'inverse, les programmes de lutte antituberculeuse sont incités à vérifier le statut VIH de tous les malades tuberculeux, afin d'offrir à ceux des malades co-infectés qui sont éligibles un traitement antirétroviral simultané ou séquentiel. Un tel changement d'attitude implique une coordination des moyens techniques et une formation adaptée du personnel des deux types de formations sanitaires.

Chez les patients porteurs du VIH qui reçoivent une thérapie antirétrovirale, la nature et la fréquence des infections opportunistes, y compris de la tuberculose, a diminué, sans que le risque disparaisse totalement.

L'administration d'un traitement antirétroviral aux malades co-infectés a pour effet de réduire le nombre de décès en cours de traitement de la tuberculose, mais pose un grand nombre de problèmes pratiques liés aux effets indésirables des deux traitements, aux interactions médicamenteuses, à l'impossibilité fréquente d'assurer un suivi biologique des patients en l'absence de réseau de laboratoires et aux

problèmes logistiques liés à l'interaction entre deux programmes différents et souvent indépendants, soit le Programme Tuberculose et le Programme SIDA¹⁰. En règle générale, le traitement antituberculeux est prioritaire (en raison du risque de propagation de la maladie et de la réponse rapide au traitement antituberculeux) et les antirétroviraux sont introduits après quelques semaines ou quelques mois de traitement antituberculeux, sauf urgence (si le nombre des CD4 est inférieur à 100 ou si le malade se trouve au stade IV du SIDA).

Sur le plan pratique, l'OMS et l'Union Internationale contre la Tuberculose s'accordent pour préconiser une collaboration étroite entre les Programmes Tuberculose et les Programmes SIDA, une utilisation large de méthodes de dépistage simple, et surtout une formation des professionnels de la santé des deux domaines, de manière à faciliter le diagnostic de la tuberculose chez les malades porteurs du VIH et à reconnaître rapidement les porteurs de VIH chez les malades tuberculeux, pour leur offrir un traitement préventif de co-trimoxazole ou un traitement antirétroviral^{5,11}. Le dépistage de l'infection VIH chez une mère impose l'examen de l'enfant, à qui un traitement préventif ou antirétroviral sera également proposé si nécessaire. Cela implique une collaboration étroite entre les deux programmes sanitaires, voire la création d'un programme commun, et une répartition précise des tâches dans le terrain.

LE PROGRAMME INTÉGRÉ DE LUTTE CONTRE LA CO-INFECTION AU BÉNIN

A titre d'exemple, un programme de soins intégrés des malades co-infectés («Integrated HIV Care») vient d'être lancé dans trois pays, la République Démocratique du Congo, le Myanmar et le Bénin, sous la direction scientifique de l'Union Internationale contre la Tuberculose et avec l'appui de la Communauté Européenne, de la Coopération Suisse et de la Ligue Pulmonaire Suisse. Au Bénin, ce programme prévoit:

- une collaboration étroite entre le Programme Tuberculose et le Programme SIDA,
- une formation des travailleurs de la santé de chaque programme dans la reconnaissance et la prise en charge de l'autre maladie,
- un équipement des laboratoires de terrain pour le dépistage de l'infection VIH et la numération des CD4 au moyen de tests simples,

- le test VIH systématique de tous les malades tuberculeux, sauf refus («opt out»),
- la formation du personnel en conseil pré- et post-test,
- la mise à disposition de médicaments antirétroviraux dans les centres de traitement de la tuberculose et
- une surveillance des cohortes de malades mis sous traitement.

Depuis 2006, le programme commun dirigé par une coordinatrice spécialement formée a entrepris la préparation et la distribution dans toutes les formations sanitaires d'un manuel de prise en charge des malades co-infectés, la formation par petits groupes des professionnels de la santé actifs dans le terrain, l'équipement des laboratoires périphériques en matériel de test rapide du VIH et des laboratoires régionaux et appareils de comptage des CD4, organisé la distribution des médicaments préventifs (co-trimoxazole) et des antirétroviraux aux ma-

lades tuberculeux co-infectés. La surveillance s'effectue selon un modèle inspiré du programme de surveillance de cohortes de tuberculeux, qui a déjà fait ses preuves au Malawi^{12,13}.

CONCLUSIONS

En l'absence du VIH, l'OMS estime que le nombre de cas de tuberculose diminuerait dans le monde au lieu d'augmenter de 1.5% par an, comme c'est le cas actuellement³. Il n'y a donc aucun doute que l'avenir de la lutte antituberculeuse, au moins dans les pays les plus touchés, passe par la maîtrise de l'épidémie de VIH. Une des conditions à remplir est l'existence de programmes locaux efficaces et la disponibilité des travailleurs de santé, souvent en nombre nettement insuffisant pour faire face aux problèmes. L'appel lancé à l'occasion de la Conférence de Toronto en août 2006 par l'AIDS Care Watch attire l'attention du monde politique et scientifique sur cette évidence et fixe les priorités dans ce domaine¹⁴.

* DR JEAN-PIERRE ZELLWEGER, pneumologue FMH, Centre de compétence tuberculose de la Ligue pulmonaire suisse, est chargé de cours à la Policlinique Médicale Universitaire, Lausanne, Contact: zellwegerjp@swissonline.ch

RÉFÉRENCES

- 1 Murray JF. Pulmonary complications of HIV-1 infection among adults living in Sub-Saharan Africa. *Int J Tuberc Lung Dis* 2005; 9(8): 826-835.
- 2 Corbett EL, Marston B, Churchyard GJ et al. Tuberculosis in sub-Saharan Africa: opportunities, challenges, and change in the era of antiretroviral treatment. *Lancet* 2006; 367(9514): 926-937.
- 3 Nunn P, Williams B, Floyd K et al. Tuberculosis control in the era of HIV. *Nat Rev Immunol* 2005; 5(10): 819-826.
- 4 Reid A, Scano F, Getahun H et al. Towards universal access to HIV prevention, treatment, care, and support: the role of tuberculosis/HIV collaboration. *Lancet Infect Dis* 2006; 6(8): 483-495.
- 5 Fujiwara PI, Clevenbergh P, Dlodlo RA. Management of adults living with HIV/AIDS in low-income, high-burden settings, with special reference to persons with tuberculosis. *Int J Tuberc Lung Dis* 2005; 9(9): 946-958.
- 6 Simon V, Ho DD, Abdool KQ. HIV/AIDS epidemiology, pathogenesis, prevention, and treatment. *Lancet* 2006; 368(9534): 489-504.

- 7 Schwartlander B, Grubb I, Perriens J. The 10-year struggle to provide antiretroviral treatment to people with HIV in the developing world. *Lancet* 2006; 368(9534): 541-546.
- 8 Office fédéral de la santé publique. Déclaration VIH en Suisse. *Bull OFSP* 2006;(31): 624.
- 9 Gilks CF, Crowley S, Ekpini R et al. The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings. *Lancet* 2006; 368(9534): 505-510.
- 10 Kwara A, Flanigan TP, Carter EJ. Highly active antiretroviral therapy (HAART) in adults with tuberculosis: current status. *Int J Tuberc Lung Dis* 2005; 9(3): 248-257.
- 11 Harries A, Maher D, Graham S. TB/HIV: a clinical manual. 2 ed. Geneva: WHO/HTM/TB/2004.329, 2004
- 12 Harries AD. HIV/AIDS: the epidemic, its impact and turning the tide. *Int J Tuberc Lung Dis* 2005; 9(5): 471-474
- 13 Libamba E, Makombe S, Harries AD et al. Scaling up antiretroviral therapy in Africa: learning from tuberculosis control programmes - the case of Malawi. *Int J Tuberc Lung Dis* 2005; 9(10): 1062-1071.
- 14 AIDS Care Watch. HIV and Tuberculosis: turning the tide against TB and HIV Co-infection. *AIDSCarewatch*, 2006.

MAGAZIN

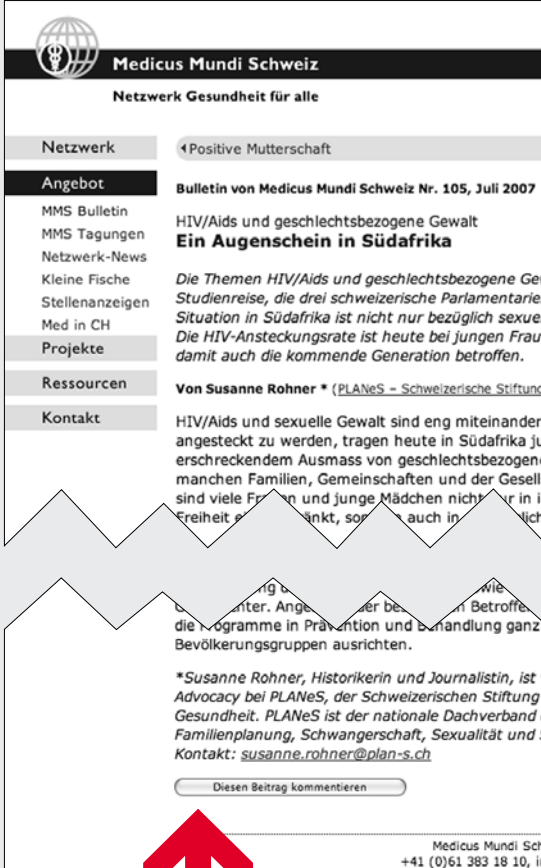
«DIESEN BEITRAG KOMMENTIEREN»

Haben Sie sich über einen Beitrag im aktuellen Bulletin besonders gefreut oder geärgert? Hätten Sie «dazu eigentlich auch noch etwas zu sagen?»

Auf unserer Website finden Sie «auf einen Blick» respektive mit zwei, drei «Klicks» den Zugang zu den Mitgliedern und Partnern des Netzwerks Gesundheit für alle – und zu allen Beiträgen, die aus ihrem Kreis in den letzten Jahren ins Netzwerk eingeflossen sind. Das Archiv umfasst auch die Bulletinausgaben der letzten zehn Jahre.

Ein «Archiv» muss aber nicht vor sich hin stauben: Sie haben die Möglichkeit, sämtliche Schwerpunktbeiträge des aktuellen und der vergangenen Bulletins online zu kommentieren und mit Ihren Hinweisen zu ergänzen.

«Diesen Beitrag kommentieren» kann durch aus Räume und neue Perspektiven in der Auseinandersetzung mit wichtigen Themen unserer Arbeit eröffnen. Der Schlüssel liegt in Ihrer Hand!



The screenshot shows the website for Medicus Mundi Schweiz, a network for health for all. The page features a navigation menu on the left with categories like 'Angebot', 'Projekte', and 'Ressourcen'. The main content area displays an article titled 'Ein Augenschein in Südafrika' about HIV/AIDS and gender-based violence. Below the article, there is a button labeled 'Diesen Beitrag kommentieren' (Comment on this article), which is highlighted by a large red arrow pointing upwards.

Medicus Mundi Schweiz
Netzwerk Gesundheit für alle

Netzwerk > Positive Mutterschaft

Angebot

MMS Bulletin
MMS Tagungen
Netzwerk-News
Kleine Fische
Stellenanzeigen
Med in CH
Projekte

Ressourcen

Kontakt

Bulletin von Medicus Mundi Schweiz Nr. 105, Juli 2007

HIV/Aids und geschlechtsbezogene Gewalt
Ein Augenschein in Südafrika

Die Themen HIV/Aids und geschlechtsbezogene Gewalt Studienreise, die drei schweizerische Parlamentarier Situation in Südafrika ist nicht nur bezüglich sexueller Die HIV-Ansteckungsrate ist heute bei jungen Frauen damit auch die kommende Generation betroffen.

Von Susanne Rohner * (PLANeS – Schweizerische Stiftung)

HIV/Aids und sexuelle Gewalt sind eng miteinander angesteckt zu werden, tragen heute in Südafrika ein erschreckendem Ausmass von geschlechtsbezogener manchen Familien, Gemeinschaften und der Gesellschaft sind viele Frauen und junge Mädchen nicht nur in ihrer Freiheit eingeschränkt, sondern auch in ihrer

ig be... Wie
riter. Ange... der bes... in Betroffene
die Programme in Prävention und Behandlung ganz
Bevölkerungsgruppen ausrichten.

*Susanne Rohner, Historikerin und Journalistin, ist v
Advocacy bei PLANeS, der Schweizerischen Stiftung f
Gesundheit. PLANeS ist der nationale Dachverband d
Familienplanung, Schwangerschaft, Sexualität und S
Kontakt: susanne.rohner@plan-s.ch

Diesen Beitrag kommentieren

Medicus Mundi Schweiz
+41 (0)61 383 18 10, in