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Can the Success of HIV Scale-Up Advance the Global Chronic Non-Communicable Disease Agenda?

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Abstract

Non-communicable diseases (NCDs) are the leading causes of death and disability worldwide but have received suboptimal attention and funding from the global health community. While the first UN General Assembly Special Session (UNGASS) for NCDs in 2011 aimed to stimulate donor funding and political action, only 1.3% of official development assistance for health was allocated to NCDs in 2015, even less than in 2011. In stark contrast, the UNGASS on HIV/AIDS in 2001 sparked billions of dollars in funding for HIV and enabled millions of HIV-infected individuals to access antiretroviral treatment. Using an existing analytic framework, we compare the global responses to the HIV and NCD epidemics and distill lessons from the HIV response that might be utilized to enhance the global NCD response. These include: (1) further educating and empowering communities and patients to increase demand for NCD services and to hold national governments accountable for establishing and achieving NCD targets, and (2) evidence to support the feasibility and effectiveness of large-scale NCD screening and treatment programs in low-resource settings. We conclude with a case study from Swaziland, a country that is making progress in confronting both HIV and NCDs.

Keywords

HIV; non-communicable diseases; global health policy; donor funding; health service scale-up; Swaziland

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Conflict of interest

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Background

In September 2011, the United Nations (UN) convened a UN General Assembly Special Session (UNGASS) on non-communicable diseases (NCDs). The event was the second UN High Level Meeting ever held for a health issue, following the successful UNGASS on HIV/AIDS in 2001. Modeled after its predecessor, the 2011 meeting was intended to catalyze a response to what the World Health Organization (WHO) called an epidemic of “silent killers” that are the leading causes of death and disability worldwide, yet receive little attention from the global health community [1].

Looking back to the prior UNGASS on HIV/AIDS a decade earlier, the NCD meeting aspired to similar goals: rallying multisectoral and cross-national partnerships; stimulating robust donor funding; spurring ambitious targets and commitments on the part of national governments; and catalyzing rapid scale-up of NCD services in resource-limited settings [2]. Advocates highlighted similarities between chronic NCDs and HIV/AIDS, including a stark mismatch between the burden of disease and available funding, and the need for programmatic innovation, continuity care, and health systems strengthening [3–5].

The UNGASS on NCDs was successful at producing a Political Declaration to combat NCDs [6], and many countries affirmed a commitment to ambitious NCD targets and to implementing evidence-based “best buys” [7, 8]. Yet five years later, the global NCD response has languished in what some have called an environment of “malignant neglect” [9]. Despite the fact that NCDs account for 37% of disability-adjusted life years (DALYs) in low-income countries [10], only 1.3% of official development assistance for health was allocated to NCDs in 2015 [11], a proportion that decreased between 2011 and 2015 [12]. Few resource-limited countries have operational national NCD strategies or adequate NCD services, awareness of and treatment-seeking rates for NCDs have not improved [13], and the vast majority of people with cardiovascular disease, diabetes, cancer, and chronic respiratory disease remain undiagnosed and untreated [14, 15]. In contrast, in the years that followed the 2001 UNGASS, global spending on HIV increased by billions of dollars and the number of people initiating antiretroviral treatment (ART) in low and middle income countries soared from 400,000 in 2003 to nearly 17 million in 2015 [16].

Differing global responses to HIV and NCDs

The sluggish response to NCDs despite the global consensus and national commitments articulated at the UNGASS meeting raises the question as to why some health issues galvanize action while others fail to do so. Studies of the comparative effectiveness of global health advocacy efforts suggest that objective characteristics of health issues rarely explain their success or failure in terms of attracting attention, funding, and action [17]. Instead, as Shiffman observes, critical elements include: the clarity and cohesion of ideas used to define, describe, and frame the issue; the strength and nature of the actors lobbying for collective action; and political contexts that enhance leadership support [17]. The framework developed by Shiffman provides useful insights into why some important health issues fail to garner appropriate resources and attention. It has been used to analyze the responses to maternal mortality [18], maternal and child health [19, 20], cervical cancer [21], oral health

[22], mental health [23], and NCDs [24]. In this paper, we use Shiffman's framework to contrast characteristics of HIV and NCDs that may explain the different global responses to the two entities and suggest potential avenues for the path forward (Table 1).

Ideas: Framing the Problems

At the onset of the HIV epidemic, HIV was a new condition never observed before, and it was lethal, and frightening. Affecting children, youth, and adults in their most productive years, its devastating impact was evident to families and communities, and its threat to the economies of most severely-affected countries was apparent to their governments and to the global donor community [2]. The development of effective treatment resulted in what has been called "the Lazarus effect" which transformed HIV into a chronic disease for the few who could access treatment. It also highlighted glaring injustice of inequitable access to treatment by those living in poor countries when contrasted with those in resource-rich settings. The HIV epidemic was framed as both a humanitarian crisis and a threat to economic development and security, messages which resonated with political leaders [25].

In contrast, NCDs are not perceived as novel threats, and are often incorrectly considered diseases of the elderly or of the wealthy despite evidence to the contrary [26]. Although there is growing evidence of the cost-effectiveness of NCD prevention, screening, and management [27], NCDs are often perceived as costly to address, less important than infectious diseases, and as a problem for future generations rather than for immediate action [28]. These misconceptions may be due to the chronicity of NCDs, the diversity of prevention, care and treatment interventions, and the fact that many disparate conditions are grouped under one label [29]. The sheer numbers of people living with NCDs may also result in therapeutic nihilism about the feasibility of treatment. Lastly, the diversity of NCDs and of individuals affected has contributed to fragmented civil society activism. Many characteristics of these conditions result in difficulty in communicating about them effectively, and consequently, misperceptions about them (Table 1).

Actor Power: Networks and Advocates

In many resource-rich countries, men who have sex with men (MSM) were disproportionately affected in the early years of the HIV epidemic. The MSM community, politicized by its struggles for civil rights, was positioned to rise to combat the stigma and AIDS denialism rampant at the time, and to fight for access to prevention, care, and treatment [30, 31]. A strong grassroots movement arose out of necessity to provide care and support for people living with HIV/AIDS (PLWH), combat HIV myths and stigma, and to advocate for funding of HIV programs and research. By the early 2000's, solidarity amongst communities affected by HIV empowered advocates to fight for an augmented HIV response around the world, particularly in resource-constrained settings. Over the ensuing decade, the success of large-scale HIV programs in low-resource settings provided crucial evidence of the feasibility and impact of scaling up HIV treatment, further increasing pressure on policy makers and donors to maintain and build on this momentum [32].

In contrast, the diverse communities affected by NCDs have been less successful at creating a cohesive voice and to speak as one, and consequently have had limited impact on

expanding access to NCD services, despite evidence showing that the engagement of civil society in advocacy, accountability, and NCD service provision can catalyze national action [33]. Multisectoral partnerships including the NCD Alliance, the Global Alliance for Chronic Diseases, and the WHO Global Coordination Mechanism on NCDs (GCM/NCD) have formed to support civil society groups and to improve coordination between multisectoral stakeholders. However, these groups co-exist with disease-specific initiatives, such as the International Diabetes Foundation, the International Union Against Tuberculosis and Lung Diseases, the World Heart Federation, and the Union for International Cancer Control, creating a complex advocacy environment. The necessity of separate, parallel efforts for different diseases impedes the WHO GCM/NCD from providing the level of central leadership and organizing power for all NCDs, as offered by the Joint UN Programme on HIV/AIDS (UNAIDS) for HIV initiatives (Table 1).

Political Contexts and Policy Environments

While the 2001 UNGASS on HIV took place at a time of increasing global health funding and a growing number and diversity of global health donors, the 2011 UNGASS on NCDs occurred in the midst of a global economic crisis, which limited opportunities for new funding. NCDs were also disadvantaged by their omission from the 2000 Millennium Development Goals (MDGs) [34, 35]. The HIV response was enabled by the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, and by unique political partnerships in the United States that created the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 2004. To date, no analogous funding initiatives exist for NCDs. The inclusion of NCDs in the Sustainable Development Goals (SDGs) is noted as a policy victory, but has yet to be matched with an increase in funding commitments [36].

Leveraging the Lessons of HIV

The emergency response to HIV was not without its limitations, but the scale-up of HIV services is credited with preventing 30 million new HIV infections, saving 7.8 million lives, averting 9 million orphans and transforming global health more broadly [37]. The Shiffman framework suggests that while some variables that contribute to successful global networks may be unmodifiable (e.g., global political context), attention to NCD message framing and actor networks are critically important.

In terms of actor networks, lessons from the HIV response suggest that multisectoral advocacy and outreach to inform communities can increase demand for NCD services and spur action on the part of health providers as well as political leaders. Alignment of NCD activism with global goals – whether in relation to the SDGs or the current movement for Universal Health Coverage – may increase pressure on national governments to reach targets. Another important resource may be PLWH, now living longer on ART and confronting the same NCD risks as other members of their families and communities without HIV infection [38, 39].

In terms of ideas and message framing, one missing element for global mobilization may be the lack of evidence of the feasibility, acceptability, impact and cost-effectiveness of large-scale NCD screening and treatment programs. The NCD community has a remarkable

opportunity to garner the programmatic lessons learned from the successful HIV response on how to design, deliver, scale-up and evaluate continuity care services in resource-limited settings; these same chronic care platforms could also be leveraged to provide NCD services to PLWH and/or to the general population [5, 40–43]. The successful integration of NCD services for people living with HIV getting care in HIV programs can provide both proof of concept for large-scale NCD screening, diagnosis, and management services and a portfolio of programmatic strategies and tools that can be adopted for the general population [44].

Swaziland – A Case Study

The Kingdom of Swaziland faces the world's most severe HIV epidemic, with an estimated HIV prevalence of 31% among adults [45]. Over the past decade, the government has scaled up HIV treatment with funding support from PEPFAR and the Global Fund. The Swaziland Ministry of Health (MOH) and the Swaziland National AIDS Program (SNAP) have rapidly expanded and decentralized HIV treatment services and approximately 70% of the country's estimated 222,102 PLWH have initiated ART [46]. As a result, annual mortality from HIV has decreased by 35% in under a decade [47].

As in other countries, NCDs had not captured the attention of Swaziland's public health experts, largely due to the severity of other health threats such as HIV and tuberculosis. However, a recent population survey found a high prevalence of NCDs and their risk factors among adults aged 15–69 years [48]. One in five of those surveyed were obese, an additional 23.4% were overweight, and 24.5% had elevated blood pressure [48]. Overall, 8.7% of the population had either existing cardiovascular disease or >30% ten-year risk of a cardiovascular event. Surveillance data suggest that NCDs already account for 24% of annual deaths nationally [49]. Many of these deaths could be prevented with early diagnosis and appropriate management.

Recognizing the potential to leverage the HIV platform to enhance NCD services, the MOH is taking two key steps: (1) integrating screening, treatment, and referral for diabetes, hypertension, and cervical cancer into HIV programs, and (2) adapting the chronic care models originally developed for HIV for use in NCD management for the general population. In 2014, MOH launched a national NCD strategic plan and convened an NCD Technical Working Group to guide these activities moving forward.

HIV-NCD integration

The NCD strategic plan in Swaziland prioritized integration of HIV and NCD services, in order to diagnose and treat NCDs amongst persons living with HIV. HIV provider training is being expanded to include training on integrated clinical management of HIV and NCDs, and clinical practice guidelines have been developed for NCDs such as diabetes, hypertension, dyslipidemia, cerebrovascular accidents and chronic obstructive pulmonary disease. High-volume HIV clinics were also equipped to conduct cervical cancer screening and management using visual inspection with acetic acid, cryotherapy, and palliative care, as needed. NCD-related indicators have been incorporated into the country's electronic HIV medical records systems, which are currently being rolled out. Once implemented at scale,

this will enhance long-term follow-up for chronic NCD care, as well as routine program monitoring and evaluation of integrated HIV and NCD services.

Swaziland's National NCD Program

The MOH has also adapted previously HIV-specific systems and tools for non-HIV settings. Several resources developed for the HIV/NCD integration initiative have been adopted for use in the general population, including a locally adapted screening tool for depression, monitoring and evaluation systems and tools, the NCD clinical practice guidelines, and clinical mentorship strategies. HIV-infected women were initially prioritized for cervical cancer screening and treatment services, but this has evolved with the services now available to all women, irrespective of HIV sero-status.

The national NCD program is also replicating the public health approach that has been the cornerstone of HIV scale-up. The expansion of HIV treatment was enabled by decentralization of HIV care and treatment services to lower-level facilities, task shifting to enable nurses to manage HIV-infected patients, and the training of community health workers and peer educators to serve hard-to-reach populations [50]. Building upon this success, the same approach is now being used to facilitate the scale-up of services for NCDs. At the policy level, the Tobacco Products Control Act passed in 2013 has provided a legal framework to regulate illicit tobacco sales and prevent access to minors, in accordance with the country's commitment to the WHO Framework Convention on Tobacco Control [51].

Lastly, consistent with the grassroots engagement that epitomized the HIV response, civil society organizations are playing an increased role in the NCD response in Swaziland. For example, Diabetes Swaziland, a non-profit organization, has trained 120 community caregivers to provide home-based diabetes care, and has trained 100 diabetes peer educators. Swaziland Cancer Survivors and Caregivers (CANASWA) conducts community education programs to promote healthy lifestyles, empower the community to recognize early signs and symptoms and seek care for NCDs, and increase awareness and demand for NCD screening and care. The Swaziland Breast and Cervical Cancer Network (SBCCN) is a non-governmental organization that supports health worker training and the procurement of equipment necessary to screen and treat cervical cancer.

Despite these promising initiatives, there are important barriers to the further scale-up of NCD services in the country. While these initiatives move towards national-level NCD service provision, they remain disease-specific, and further efforts will be required to achieve coordinated comprehensive care for NCDs. The most critical issue is the lack of funding for NCD-specific programs as leveraging the HIV platform can only go so far. Demonstrating the feasibility, affordability, and impact of large-scale NCD screening and treatment programs will be an important step towards advocating for additional funding. In addition, pursuing the implementation science agenda should be considered a priority for MOH and civil society organizations as this will help inform the design and implementation of such programs.

Conclusion

Insufficient attention has been given to the growing NCD epidemic. In order to augment the NCD response, it may be prudent to understand the framing and networking strategies employed by those engaged in the HIV response. Leveraging lessons from the scale-up of HIV treatment as well as the chronic care platforms developed for the management of HIV may also serve to catapult the NCD response. Identifying synergies between HIV and NCD programs, and aligning both with the movement towards universal health coverage, may also be effective to enable securing of the necessary resources and political will, and ultimately overcoming the current prevailing inertia of policy makers and donors.

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Highlights

- NCDs are leading causes of global deaths but receive negligible global health funding, unlike HIV
- A political priority framework setting helps explain different global responses to NCDs and HIV
- Successful scale-up of chronic HIV care can serve as a model to inform national-level NCD programs
- NCD prevention and management requires input and demand from affected communities and patients
- A Swaziland case study demonstrates early success in adapting HIV systems and tools for NCD care

Table 1

Comparison of selected determinants of political priority setting from the early global responses to the HIV/AIDS and NCD epidemics adapted from the Shiffman framework (2009)

HIV/AIDS	NCDs
1) Ideas: the way the health challenge is understood and communicated	
• HIV is one disease and was a new and highly visible health threat	• NCDs are a collection of diseases, not perceived as novel threats
• ART was widely understood to be highly effective – its impact was described as “Lazarus-like”, returning people from the brink of death. Disparities in access to ART were starkly visible.	• NCD treatment varies from condition to condition; treatment effectiveness is also variable; therapeutic nihilism about the feasibility of treatment for some NCDs was prevalent
• HIV was framed as a threat to development and security, as it visibly affected young, working-age people and destabilized economies	• Incorrectly considered “diseases of the elderly” and “diseases of the wealthy,” the NCD threat is poorly recognized
• HIV is commonly framed as a humanitarian crisis by civil society	• NCDs are often perceived as a secondary issue to infectious diseases, “a crisis for future generations.”
2) Actor power: the strength of the individuals and organizations concerned with the issue	
• Grassroots community activism led by those affected by HIV arose to dispel stigma and AIDS denialism	• Generally low awareness and demand from patients, and low civil society involvement, especially in low-resource settings where healthcare is organized around HIV
• In 1996, Joint United Nations Programme on HIV/AIDS (UNAIDS) formed as a dedicated UN branch to tackle the HIV/AIDS epidemic, offering crucial central leadership and organizing power	• Multisectoral partnerships (e.g., NCD Alliance and GACD in 2009) have organized to unite policy makers, donors, researchers and civil society organizations; WHO GCM/NCD was established in 2014 to coordinate global efforts and improve accountability to NCD targets
3) Political context: the environments in which actors connected with the issue operate	
• In 1980s, dominantly conservative US politics emphasized personal responsibility and abstinence, effectively blaming HIV-infected persons and stagnating HIV efforts	• NCDs currently perceived as largely “diseases of preventable individual behaviors,” placing responsibility on populations affected
• HIV UNGASS occurred in the context of global economic growth and increased funding scale and diversity	• NCD UNGASS occurred during global economic crisis, with reduced funding availability
• Long-term financial commitments were demonstrated by the Global Fund, PEPFAR and other international initiatives	• To date, no large-scale dedicated funding commitment for NCDs akin to PEPFAR for AIDS
• HIV, and other infectious diseases (e.g., malaria and tuberculosis) were explicitly included in 2000 MDG targets	• NCD targets were omitted from MDGs but included in SDGs in 2015

Abbreviations: AIDS - acquired immune deficiency syndrome; ART - antiretroviral therapy; GACD - Global Alliance for Chronic Diseases; GCM/NCD - Global Coordination Mechanism on NCDs; Global Fund – Global Fund to fight AIDS, Tuberculosis and Malaria; HIV - human immunodeficiency virus; MDG – Millennium Development Goals; NCD - non-communicable disease; PEPFAR – President’s Emergency Plan for AIDS Relief; SDG – Sustainable Development Goals; UN – United Nations; WHO – World Health Organization