Scaling up action on NCDs

The Defeat-NCD Partnership

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Zeana has type 1 diabetes and hypertension. She lives with her family in Dar es Salaam, Tanzania.
Mohamed has type 2 diabetes and lives in Sri Lanka.

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Non-communicable diseases (NCDs) are the leading cause of death and disability globally.

71% of global deaths in 2016 were due to NCDs
41 million of the overall 57 million deaths

3/4 occur in low- and middle-income countries (LMICs)
32 million deaths

* Least developed countries (United Nations, 2017), low-income countries and lower-middle income countries (World Bank, 2018).
NCDs result in millions of premature deaths each year

15 million died prematurely from an NCD between the ages of 30 and 69 years in 2016

4/5 premature deaths occur in LMICs

Adults in LMICs face the highest risks of dying before reaching the age of 70 from one of the four main NCDs — almost double the rate for adults in high-income countries.

Four major NCDs are responsible the majority of NCD-related deaths

80% of global NCD-related deaths are due to four major NCDs

Death and disability from NCDs in LMICs are increasing...

...faster than the rate of decline from communicable diseases

Deaths from communicable diseases and NCDs in LMICs, 2000–2016

NCDs are closely associated with poverty and vice versa

Poverty exposes individuals to the risk factors that cause NCDs and increases the risks of experiencing disability and premature death.


U LAY MYINT
U Lay Myint has type 2 diabetes, hypertension and diabetes-related eye complications. He is a rickshaw driver and lives in Myanmar.

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The cycle of NCDs and poverty

Developing a NCD in a low-resource country increases the risk of falling into poverty

100 million people are pushed below the poverty line annually due to the high-cost of health services

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NCDs are often interconnected with other NCDs and communicable diseases

Often, two or more NCDs manifest in the same individual

NCDs threaten progress towards the 2030 Agenda for Sustainable Development

According to WHO, due to lack of progress in combating NCDs it is likely that SDG target 3.4 (by 2030 reduce by one-third pre-mature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing) will not be met.

Significant barriers exist to accessing essential medicines and technologies for NCDs in LMICs

Weak supply chains

Inadequate health systems

Overburdened regulatory structures

Conflicting national essential medicine lists

Insufficient financing

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The Defeat-NCD Partnership
A bold response to SDG 3.4 – reducing premature mortality from NCDs

OUR VISION

A world where there is universal health coverage for all people with NCDs.

The Defeat-NCD Partnership
A bold response to SDG 3.4 – reducing premature mortality from NCDs

OUR MISSION

Enable and assist low-resource countries to scale-up sustained action against NCDs...

...so that they can progress on *Sustainable Development Goal (SDG) 3*...

...to achieve target 3.4 to reduce, by one-third, premature mortality from NCDs by 2030.
Focused on low-resource* countries

90 countries**

* Least developed countries (United Nations, 2017), low-income countries and lower-middle income countries (World Bank, 2018).
** The number of countries can change as official UN and World bank lists are updated.

Four action-orientated tracks to directly address barriers to NCD diagnosis and treatment in low-resource countries

1. **NCD NATIONAL NCD CAPACITY BUILDING**
   - Make sure governments have **institutional capacities, structures, systems, and financing** in place to tackle NCDs.

2. **NCD COMMUNITY SCALE-UP OF NCD SERVICES**
   - Bring more of the necessary **NCD prevention and management services** to the **communities** and **people** who need them most.

3. **NCD ESSENTIAL NCD SUPPLIES & DISTRIBUTION**
   - Enable the **consistent provision** of affordable **essential medicines, diagnostics, and equipment** for NCDs.

4. **NCD SUSTAINABLE NCD FINANCING**
   - Establish a **long-term sustainable financing model** for NCD programming in low-resource countries.
Our overall objective is to ensure that partner countries have institutional capacities, structures, systems, and financing in place to tackle NCDs in a sustainable manner.

- Support governments and national ministries of health to assess gaps in their institutional capabilities and health systems
- Epidemiological, economic and service delivery studies
- Training and technical advice
- Procurement and distribution capacity planning
- Developing domestic public–private partnerships
- Support to organise domestic and international financing
- Prioritisation of national expertise, institutions and civil society
- Participatory process
Our overall objective is to bring more of the necessary NCD prevention and management services directly to the communities and people who need them most.

- Scaling up community education and screening for risk factors AND early disease management
- Rolling out greater use of digital tools, we aim to expand affordable access to treatment
- Equipping primary healthcare facilities
- Training healthcare workers to identify those at risk and treat those with an NCD
- Humanitarian Emergency Response Facility to support people in disaster and conflict situations
**NCD ESSENTIAL SUPPLIES & DISTRIBUTION**

**Our overall objective** enable the consistent provision of affordable essential NCD medicines, diagnostics, and equipment in low-resource countries.

- Market sizing and price tracking studies conducted in resource poor countries
- Structured to create a competitive environment and bring transparency to the process
- Leveraging market dynamics, such as pooled purchasing power
- Online procurement facility
- Improved quality control
- Standardisation
- More effective supply chains
- Financial returns from The Defeat-NCD Marketplace Network will be reinvested
Our overall objective is to establish a long-term sustainable financing model for NCD programming in low-resource countries.

Establish a NCD Financing Facility to support countries in the prevention and management of NCDs from their own national and social welfare budgets, includes:

- Microfinancing and insurance schemes
- Innovative commercial investing via public-private partnerships
- Social and philanthropic funding
- Development assistance from multilateral and bilateral partners
Efforts from the Partnership will help towards achieving other SDGs and their respective targets

SDG 3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

SDG 3.8 Achieve universal health coverage

SDG 3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries

SDG 3.D Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

SDG 5 Achieve gender equality and empower all women and girls

SDG 10 Reduce inequality within and among countries

SDG 17.3 Mobilize additional financial resources for developing countries from multiple sources
Diabetes in low-resource countries

ZEANA MASOUD SAID
Zeana has type 1 diabetes and hypertension. She lives with her family in Dar es Salaam, Tanzania
Diabetes is a growing concern worldwide

The current and projected global prevalence of diabetes

- **48% increase** in diabetes
- **425 million** adults have diabetes¹
- **693 million** adults will have diabetes¹

Every third person with diabetes is living in a low-resource country, many are unaware of their condition.

145 million adults in low-resource countries have diabetes\(^1\)

60% of whom are undiagnosed\(^1\)

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Left untreated, diabetes is associated with debilitating complications and premature death.

50% of people diagnosed with type 2 diabetes have at least one diabetes-related complication at the time of diagnosis.

Diabetes-related complications:
- Stroke
- Blindness
- Cardiovascular diseases
- Kidney diseases
- Amputation

People with diabetes in low-resource countries are at high risk of health-related complications

In low-income countries,

more than three-quarters (76%) of people with diabetes are undiagnosed and at risk of developing serious diabetes-related complications.

Basic medical cost for the treatment of diabetes is beyond the means of many people living in low-resource countries.

In Benin, **212 US dollars** is the minimum public sector cost for treatment of uncomplicated diabetes (diabetes without any comorbidities).

This is equal to almost **27%** of the GNI (gross national income)* per capita for Benin.

The **GNI per capita** is the dollar value of a country's final **income** in a year, divided by its population.

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Hypertension in low-resource countries

ZEANA MASOUD SAID
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More than 1 billion adults have hypertension worldwide, double as many as in 1975

The increase is driven by population growth and ageing.

529 million
women (20.1%) are hypertensive

597 million
men (24.1%) are hypertensive

The prevalence of hypertension is rising in low-resource countries

**Hypertension** has transitioned from a risk factor largely affecting high income countries to one that is now most prevalent in low-income countries in south Asia and sub-Saharan Africa.

Risk factors for hypertension include:

- Advancing age
- Obesity
- Ethnicity
- High-sodium diet
- Excessive alcohol assumption
- Physical activity

Elevated blood pressure (hypertension) is the leading metabolic risk factor and is common among people with diabetes.

**Hypertension**, also known as high or raised blood pressure is a condition in which the blood vessels have persistently raised pressure.

Four out of 10 people diagnosed with type 2 diabetes are already hypertensive at diagnosis.

Hypertension contributes to the burden of heart disease and stroke

In 2016, an estimated 17.9 million people died from cardiovascular diseases (CVDs), representing 31% of all global deaths.

Hypertension is responsible for at least 50% of deaths due to heart disease and strokes.

80% of CVD burden exists in low- and middle-income countries.

Blood pressure-lowering drug classes need to be available and affordable to improve hypertension control

When available, 31% of households in low-income countries are unable to afford* two blood pressure-lowering medicines.

Compared with fewer than 1% of households in high-income countries who are unable to afford* two types blood pressure-lowering medicines.

* Medicines were considered affordable if their combined cost was less than 20% of the households' capacity to pay.

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