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PREFACE

Meeting the Challenge of NCD: We Cannot Wait

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A decade ago, the world prepared to confront one of the greatest public health and moral challenges in human history. The pages of medical journals were filled with debates about whether it was possible to act on anything close to the scale that was needed to tackle the scourge of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome. Many years and many lives were wasted as researchers and policymakers with the best of intentions invented a conflict between prevention and care and pointed to countless reasons, including high fixed costs, as well as human resources and infrastructural deficits, why the time was not yet ripe for the massive provision of lifesaving treatment to poor people in need worldwide.

Thanks to the unflinching resolve of a global coalition of courageous activists, physicians, researchers, and policymakers in fighting back against the double standard that deemed some lives worth saving and others expendable, the world did finally unite in an unprecedented demonstration of international solidarity. In Rwanda, though, we still have much work to do; we now have universal access to antiretroviral therapy and have driven the rate of mother-to-child transmission of HIV below 2%. Real-world experience in the fight against HIV/acquired immunodeficiency syndrome has provided a firm rebuke to facile notions of what is possible in resource-constrained countries, and many wealthy nations now look to countries like Bangladesh, India, and Rwanda for lessons on high-value delivery of care for infectious disease.

Today, I believe that the world stands at a similar crossroads in the movement to confront the rapidly growing burden of noncommunicable diseases such as heart disease, cancer, diabetes, and respiratory disease. We now face the challenge of equipping health systems with the means to ade-

quately prevent, treat, and monitor this group of complex chronic conditions, which together account for more than 60% of all deaths. The complexity of this task is enormous and its urgency fierce, but there is no question of whether we possess the tools to meet it head on. Political lassitude and uninspired vision—not some kind of inherent shortcomings on the part of developing country policymakers, clinicians, or patients—are the greatest threats to our success.

I believe that health is a human right. In Rwanda, this understanding is enshrined in our constitution, and we do not miss opportunities to improve the health and well-being of our population. Building on the success of our evidence-based and equity-driven efforts to control infectious diseases, we are now in the process of designing and implementing strategic national plans for the prevention, care, and treatment of noncommunicable diseases. Current World Health Organization estimates show that noncommunicable diseases account for approximately 25% of Rwanda's burden of disease.

Rwanda understands that health is fundamentally biosocial, and that efforts to reduce morbidity and mortality due to chronic diseases require a holistic and person-centered approach. As we have learned repeatedly from infectious diseases, the causes of poor health outcomes are closely linked with poverty through a vicious cycle. Rwanda, therefore, begins with the goal of prioritizing the needs of the poorest and most vulnerable citizens.

Rwanda's comprehensive national plan for cervical cancer illustrates our approach well and helps to clarify key delivery principles for our work to combat noncommunicable diseases. Cervical cancer is a disease of poverty worldwide, with 76% of new cases and 88% of deaths now occurring in developing countries. As one of the few vaccine-prevent-

able noncommunicable diseases, cervical cancer also represents a unique opportunity for Rwanda to build on a strong and decentralized care delivery system for infectious diseases in pivoting to integrate cancer care and control.

Through a public-private partnership with Merck, we launched the first human papillomavirus vaccination program among low-income countries and achieved over 95% coverage among eligible girls in the program's first year. A partnership with Qiagen has catalyzed the expansion of universal cervical cancer screening for women between the ages of 35 and 45 years. Our collaborations with donor governments, nongovernmental organizations, and teaching hospitals in high-income countries are helping us to build the necessary infrastructure and train the specialists needed for effective treatment across the country.

As always in Rwanda, disease-specific programs are implemented in such a way as to be integrated and to strengthen the entire health sector by priming our system to address other conditions. Our early efforts for cervical cancer will soon be accompanied by much broader programs for early detection and treatment of other cancers, as well as a population-based cancer registry. In February 2012, the Rwanda Task Force on Expanded Access to Cancer Care and Control will launch strategic national plans for both pediatric and adult cancers. Similar efforts are underway to comprehensively address heart disease, diabetes, respiratory disease, injuries, and mental health. At the same time, as we scale up care and treatment, we are also looking upstream to bring evidence-based policy to bear on proximal determinants of noncommunicable diseases such as tobacco control, guidelines for sugar intake, and the use of seatbelts.

A commitment to addressing the burden of noncommunicable diseases means a long-horizon commitment that spans the realms of clinical medicine, public health policy, behavior change communication, and implementation science. None of

us, from the community health worker serving in the most rural village to the Ministers of Health, Finance, and Decentralization in the capital city, are exempt from the responsibility to work together in meeting the challenge of noncommunicable diseases.

As was the case with HIV, action against noncommunicable diseases at the local and national levels must be joined by efforts to build capacity and share best practices across borders and continents. This is precisely the aim of this special issue of *Global Heart*, and I am honored to have the opportunity to introduce this seminal collection of approaches that aim to support countries in their efforts to improve noncommunicable disease prevention and control. Building a body of rigorous research on high-value approaches is an essential element of mobilizing the political will and resources needed. By conclusively demonstrating principles for effective implementation, we can help to overcome the shortsightedness and search for quick fixes that often characterize times of financial instability. We cannot afford not to act now—the cost of inaction is unacceptable.

The next generation of global solidarity must be more strategic, more efficient, and more country-driven. The dialogue begun many years ago, globally recognized at the United Nations High-Level Meeting on Non-Communicable Diseases, and carried on in these pages is a wonderful start, but we have much work to do in creating a future in which the greatest risk factor for dying of a noncommunicable disease is not where one is born. My vision for Rwanda is for our country to become a place where cardiology and cancer patients are referred from around the region and where our doctors can harness all the tools of science—not just those currently considered appropriate for Africa—in treating our people in the most dignified way possible. Such a future is within our grasp, and history will judge us by our efforts to meet the challenge.