Africa’s Chronic Disease Burden: socio-cultural, economic and health policy implications.

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Many African countries are experiencing epidemics of chronic non-communicable diseases (hereafter chronic diseases). Infectious diseases cause about 69% of deaths on the continent. However, age specific mortality rates from chronic diseases as a whole are actually higher than in virtually all other regions of the world, in both men and women. In some countries, prevalence rates for major conditions like hypertension, diabetes and cancers have risen exponentially over the last twenty years and currently outstrip rates for some infectious diseases such as HIV/AIDS. The WHO (2005) predicts that over the next ten years, Africa will experience the largest increase in death rates from cardiovascular disease, cancer, respiratory disease and diabetes.

Africa’s chronic disease burden has multifaceted roots. Urbanisation, rapidly ageing populations, globalisation, poor lifestyle practices, weak health systems and a lack of political will have been identified as key intersecting factors. In recent years, the role of poverty in the rising burden has become clearer. Africa is experiencing a ‘protracted polarised’ health transition (Frenk et al, 1989) with two key elements. First, populations have lived with a protracted co-existence of infectious and chronic diseases over the last few decades. Second, the double burden of disease is polarized across socio-economic status. While wealthy communities experience higher risk of chronic diseases, poor communities experience higher risk of infectious diseases and a ‘double jeopardy’ of infectious and chronic diseases. The double jeopardy is largely attributable to the rising burden of infectious diseases of poverty, such as tuberculosis and HIV/AIDS and the co-morbid relationships between these infectious diseases and chronic diseases (in particular diabetes, cardiovascular diseases and cancers). There are grave implications for the 38803 million Africans - just over half of the continent’s population – who live below the absolute poverty line of US$1.25 a day.

Because African health policymakers and their development partners prioritize infectious diseases and health issues noted explicitly in the Millennium Development Goals (MDGs), chronic diseases are neglected. Health facilities in most countries lack the appropriate basic and sophisticated equipment, medicines are either expensive or unavailable, health professionals are poorly trained in chronic disease diagnosis and

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management and lack appropriate knowledge and skills. Inefficient biomedical systems and practices are implicated in avoidable complications and deaths. The medical and psychosocial vacuum created by inefficient biomedical services is filled by competitive traditional medicine and faith healing systems that offer unregulated chronic disease care to both urban and rural communities. These health systems deficiencies compound the financial and psychosocial challenges faced by individuals, caregivers and families affected by chronic diseases. Without the development and implementation of policies the rising burden of chronic diseases will cripple health systems, reverse the gains made on the MDGs (especially MDG1, MDG5 and MDG6), and create significant challenges for governance and development.

In this paper, I will make four major arguments and elaborate on aspects of these arguments:

1. Chronic disease risk goes beyond individual lifestyle practices and socio-cultural environments; it is often rooted in and/or exacerbated by structural factors such as food and environmental policies.
2. Chronic diseases affect the economically productive age in many African countries; their impact on avoidable disability and death has enormous implications for national productivity and economic growth;
3. Chronic disease morbidity affects health systems. The WHO (2007) outlines six basic building blocks of health systems: (1) service delivery; (2) information and evidence; (3) medical products and technologies; (4) health workforce; (5) health financing; and (6) leadership and governance. All six blocks are affected by Africa’s rising chronic disease burden.
4. Chronic diseases impact on the MDGs and therefore on broader national development. The ‘protracted polarised’ health transition has implications on efforts to attain the MDGs by 2015, especially MDG1, MDG5 and MDG6. Because the neglect of chronic diseases in many African countries is linked partially to unequal power and knowledge relationships between local policymakers and (international health) development partners, critical attention must be paid to the relationship between the political economy of chronic disease in Africa and attaining MDG8 (develop a global partnership for development).

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6 MDG1 (eradicate extreme poverty and hunger), MDG5 (improve maternal health), MDG6 (combat HIV/AIDS, malaria and other diseases).