In September 2011, the United Nations General Assembly is holding a High-Level Meeting on the prevention and control of noncommunicable diseases (NCDs). In the following essay, Felicia Marie Knaul, director of the Harvard Global Equity Initiative (HGEI), and Harvard School of Public Health Dean Julio Frenk offer a new perspective on how to reframe this urgent and evolving public health issue. This framework is being applied by the Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries—a group of global leaders from the cancer care and public health communities originally convened through HSPH, HGEI, Harvard Medical School, and the Dana-Farber Cancer Institute. A report on the Task Force’s first two years of work will be released this fall.

In the realms of social and economic development, low- and middle-income countries differ in many ways. Yet in the realm of health, they share an emerging challenge: the compound burden of increasingly prevalent chronic and noncommunicable diseases, combined with a backlog of disease and illness associated with “underdevelopment” and typically related to preventable infections.

As the backlog recedes in the face of progress in public health and medicine, the relative burden of chronic and noncommunicable disease increases. Although the epidemiological landscape varies among countries, it is universally true that it will be increasingly defined by aging populations and by what have previously been called “noncommunicable diseases,” or NCDs—but which we believe should be called New Challenge Diseases, with the same acronym.
A LINGUISTIC STRAITJACKET

Today, the decades-long distinctions between "chronic" and "acute," and "communicable" and "noncommunicable," are increasingly irrelevant and inaccurate. Many diseases labeled as noncommunicable and treated as chronic in fact originate from a preventable infection—for example, cervical cancer. At the same time, several diseases of infectious origin are chronic—most notably, HIV/AIDS.

The false dichotomies—which strongly shaped public health in the past—today place a heavy burden on research and on policy. The nomenclature itself has become a straitjacket that prevents the most effective translation of research into evidence, advocacy, and policymaking. Health systems can become trapped in a static model that doesn’t adapt to epidemiological change, medical breakthroughs, or opportunities for innovation in delivery and financing of care.

"Noncommunicable" is the obvious example of this rigid and restrictive terminology. To begin with, defining anything as a "non" implies a subservience to some other entity that is dominant. It also implies that the group can be characterized by what it is not (in this case, "communicable"). And "non" pits one group against another—communicable versus noncommunicable—fueling a situation where advocates compete rather than work together to better apply scarce resources.

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FROM “NONCOMMUNICABLE” TO “NEW CHALLENGES”

The acronym “NCD” is well known and much used in academic and policy circles. As a result of extensive research and lobbying, the neglected health challenge is about to receive the attention it deserves through the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs, scheduled for September 2011. This is only the second UN meeting of heads of state and government dedicated to health—the first was on HIV/AIDS a decade ago—and it sets the stage for a global call to action.

Perhaps we can have the best of both worlds by maintaining the acronym NCD while adapting it to encompass the realities of the health dilemmas currently faced by low- and middle-income countries: New Challenge Diseases.

Adopting the concept of New Challenge Diseases enables us to better respond to the misunderstandings that currently detract from more effective action. There is a widespread belief, for example, that expanding access to health care for NCDs is an unrealistic goal for developing countries. Debunking this notion would permit us to examine what can be done rather than what cannot.

We can develop comprehensive strategies to address NCDs in low- and middle-income countries. We can offer cost-effective treatment alongside prevention. We can strengthen health systems so that they respond to the complex array of diseases afflicting all countries, rich and poor.

DEBUNKING MYTHS

Meeting the NCD challenge requires overcoming four myths:

Myth #1: NCDs are not a major problem in developing countries. Two decades of research about the epidemiologic transition in developing countries have documented the rising importance of noncommunicable diseases. The UN Summit on NCDs and the meetings and documents that have led up to it reflect the impact of evidence.

Myth #2: Even if NCDs are important, there is little that developing nations can do to address them. Actually, we already have cost-effective interventions for the majority of NCDs in developing regions, and we should deploy them alongside preventive strategies in a full cycle of care.

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**Myth #3:** Even if there are effective interventions, developing countries cannot afford them. As many of the successful initiatives demonstrate, we can mobilize both global and national resources in a fiscally responsible way that vastly expands access to comprehensive services for NCDs.

**Myth #4:** Responding to the challenge of NCDs would siphon attention from more urgent priorities, mainly the health-related Millennium Development Goals. This myth is especially pernicious because it polarizes the global health community in a zero-sum, competitive mentality. Instead, we should look for synergies among disease-specific programs and strengthen health systems so they can address the multiple, diverse, and complex needs of people who are the real patients, not just the specific ailments that plague them.

- First, a new generation of health promotion and disease prevention strategies;
- Second, universal social protection guaranteeing access to high-quality care without fear of financial catastrophe;
- Third, innovations in the delivery of health services that draw on the technological and managerial revolutions of our times.

Countering the New Challenge Diseases will demand shared learning among countries, based on rigorously evaluating national innovations. Equally important will be mobilizing global solidarity in our interdependent world.

The upcoming UN Meeting poses a unique opportunity to secure the place of New Challenge Diseases in the global health agenda. The outcomes of this meeting must include road maps for implementation that will present new responsibilities and opportunities that the global health community should actively take up as we seek to bridge unhealthy divides and strengthen our ability to confront new challenges. We must invest in education and capacity building, as well as in research that will supply the necessary evidence to guide both national and global health policymaking through the ambitious process of moving from resolutions to action.

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**New Challenge Diseases**

These four myths are familiar to the public health community because they were applied to AIDS only a decade ago: The same four misconceptions were put forward as justifications for inaction. Fortunately, they were not heeded, in large part due to the force of the UN meeting convened in 2001. Expanded access to prevention and care for HIV/AIDS counts as one of the greatest achievements in the history of global health.

**COMPREHENSIVE RESPONSE**

The same success can now apply to New Challenge Diseases—including responding to the new face of AIDS as a chronic illness. We must craft appropriate and effective evidence-based policies and engage all relevant actors in multi-stakeholder frameworks for action.

NCDs drive a health scenario that can be characterized by two words: change and complexity. This complexity can be addressed through a comprehensive response built on three pillars: