From (re-)framing NCDs to shaping public health policies on NCDs and communicable diseases

Catherine Cavalin, Alain Lescoat

the AIDS movement, YP-CDN, inspired by a need to apply a social justice and human rights frame to NCDs, has worked closely with traditional access to medicines activists and technical experts to add nine essential medicines for NCDs to the WHO Essential Medicines List.[2] YP-CDN currently advocates, through its grassroots chapters in east Africa, for this global policy to be reflected at national levels.

NCDFREE and the YP-CDN are preparing the next generation to lead on preventing and treating NCDs. Through NCDFREE's bootcamps, hundreds of young people from varying personal and professional backgrounds in Australia, America, Canada, Denmark, Egypt, Germany, and the UK have gained awareness and advocacy skills to ignite systemic and sustainable change. NCDFREE is actively working toward a wider reach in all regions. YP-CDN's NextGen Leaders programme, a partnership with RTI International, has trained more than 100 young people in east Africa since September, 2016, to advocate for local and national change on tangible country-specific NCD priorities set by young people, and to hold their governments accountable to their NCD commitments. While YP-CDN's chapter in Kenya is championing the cause of rheumatic heart disease, the chapter in Uganda is working with a civil society network on improving access to radiotherapy.

"Be human. Be specific. Be vivid."[1] By communicating with our audiences in a comprehensible manner through visual and engaging means—infographics, short films, social media, campaigns, and events—we can take our message to new and existing audiences, and most importantly, share the stories and voices of people living with NCDs. In 2013, NCDFREE's #theface campaign collected personal NCD stories from around the world via social media. In 2016, the #feastofideas campaign again harnessed the power of social media to crowdsource 10 000 food system solutions from 56 countries. These campaigns demonstrate the power of low cost, wide-reaching, intersectoral, and innovative activities in informing and empowering the NCD movement.

The NCD tide is turning and we all have a part to play in driving positive change. Our organisations do not have all the answers, but we believe that engaging with young people and people living with NCDs through new and engaging media, as well as developing hard and soft skills to influence policy and hold governments accountable, are crucial steps.

All authors are either employees or volunteers for NCDFREE or YP-CDN. IK is also an employee of RTI International (India).

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A senior adviser to the Global Fund taught Richard Horton (July 22, p 346)[1] some lessons that were drawn from the struggle against three communicable diseases—tuberculosis, malaria, and AIDS—that keep scourging global health. To raise funds to combat non-communicable diseases (NCDs), one should "translate [one's] evidence into clear and simple political (not technical) messages", "articulate why [one] need[s] money—what exactly will [one] spend it on and what will be the results of that investment", "break down [one's] broad global demands into tangible country-specific needs", and "connect [one's] case to the big political picture—give it meaning".

What proposals can we formulate to meet these requests? First, the Global Burden of Disease (GBD) has repeatedly highlighted the growing importance of NCDs.[2] There is no further need to demonstrate the relevance of a public health approach. Moreover, as the debate initiated by Luke Allen and Andrea Feigl[3,4] in *The Lancet Global Health* illustrates, socioenvironmental factors identified at the onset or aggravation of NCDs must be taken seriously to also fight communicable diseases more efficiently.[5] Second, as these socioenvironmental causes, cofactors, and triggers of both NCDs and communicable diseases lie in living and working material conditions, money is needed to implement transdisciplinary research that would combine an in-depth clinical approach to the frequent diverse presentations of the diseases at stake, an epidemiological inquiry into the socioenvironmental sources of exposure to hazards, and social data collected through general population surveys, in association with thorough qualitative interviews, on people's life trajectories, social habits, and daily practices. The results expected from such collaborations will not only provide a detailed description of environmental risk factors,[6] but also a better knowledge of social determinants of health that are still unknown.[7] Third, according to a cost-benefit approach, the resource breakdown should prioritise the situations that remain the most unreadable through the general pattern of the epidemiologic transition.[8] In this respect, countries like South Africa would be on the front line, to understand the terrible combination of high prevalences of communicable diseases and growing prevalences of NCDs, and to provide preventive tools against socioenvironmental hazards in a context of large health inequalities. Finally, is it necessary to draw a "big political picture"?[1] As Richard Horton reminds us, a lot has been done to

frame[9] NCDs as a so-called public issue.[10] To shift from framing to shaping public policies is the only way to make the public health targets of the Sustainable Development Goals effective and efficient, beyond slogans.

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You're not speaking my language: reframing NCDs for politicians and policy makers

Richard Horton correctly identified inadequate framing as an important reason for why the world's leading causes of death and disability—non-communicable diseases (NCDs)—are not being seriously addressed by global leaders (July 22, p 346).[1]

The non-communicable misnomer wrong-foots the uninitiated and implicitly promotes individualistic above societal solutions.[2] The most effective interventions are population-level multisectoral policies that are unpopular with libertarians and much more challenging to introduce than individualistic, health-only initiatives.[3]

There is some modelled evidence for the costs of action and inaction on NCDs,[4] but it is written with little thought for the intended audience—more technical document than policy brief. Again, there has been a move towards curating personal stories (eg, NCDs & me) but these efforts haven't broken into the public consciousness yet. The average voter has no idea what an NCD is, nor do patients living with NCDs, nor the vast majority of health professionals. Why would politicians?

Changing the name might help.[2] So would presenting evidence in policy makers' own language with attention to returns on investment, trade-offs, and opportunity costs. Politicians need engaging narratives and ways of linking NCDs with priorities such as global warming, economic growth, and migration. President Trump's recent budget proposal used a security framing that could work well for NCDs,[5] especially since European leaders are being pushed to meet NATO spending commitments. A final, fruitful prism is pandemic preparedness, which is important to both President Trump and WHO Director-General Dr Tedros. The NCD community could do more to leverage global outbreak vernacular to mobilise additional resources for this neglected slow-motion disaster.[6]

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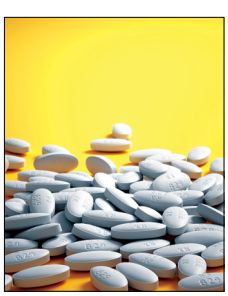
Concerns related to the nocebo effect

We read with interest the finding of Ajay Gupta and colleagues (June 24, p 2473)[1] of an absence of attributable risk of muscle-related adverse events to statin therapy in the blinded randomised controlled phase by contrast with an excess risk in the non-randomised, open-label extension phase in the same population. These results were attributed to the nocebo effect. We note that the overall proportion of participants reporting muscle-related adverse events was lower in the non-blinded, non-randomised phase than in the masked randomised phase. This might be explained by selective uptake or cessation of statins by participants in the follow-up phase, since 3364 (68%) of 4972 participants who had been randomly assigned to statin therapy made the choice to continue the drug in the open phase, whereas only 3045 (62%) of 4927 participants who had been randomly assigned to placebo opted to take atorvostatin. It would



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For more on **NCDs & me** see http://apps.who.int/ncds-and-me/