Greater priority should be given to stroke prevention in developing countries

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Increased global attention and research needs to be given to stroke prevention and the social and economic effects of the condition in developing countries, according to an academic at the University of East Anglia (UEA).

In a paper published in the current issue of the journal *Development Policy Review*, Prof Peter Lloyd-Sherlock of the School of International Development argues that policy-makers have been slow to recognise the growing scale of the challenge and impacts of stroke in developing countries. He calls for them to prioritise preventative screening and drug treatment and suggests that reducing the incidence of stroke could make a substantial contribution to global poverty reduction.

The focus of health programmes in developing countries is often on infectious diseases, such as HIV/AIDS and TB, whereas stroke and other non-communicable diseases (NCDs) are viewed as something which can wait until the infectious diseases have been 'controlled', despite the heavy burden they place on those affected.

Last month's UN summit on the 2015 Millennium Development Goals included the announcement of major new commitments for initiatives against poverty, hunger and disease. However, stroke and other NCDs are not specifically identified as Millennium Development Goals targets and rarely feature in Poverty Reduction Strategy Papers.

"Stroke is no longer a disease of the rich developed world," said Prof

Lloyd-Sherlock, professor of social policy and international development. "The burden of stroke and other NCDs has risen sharply in developing countries in recent years. Despite the urgency and the apparent affordability of stroke prevention, there is little sign that this agenda is being pursued either globally or, with rare exceptions, nationally. A wholesale upgrading of the debate is needed.

"No initiatives comparable to the Global Fund for AIDS, TB and Malaria have been established for chronic disease, and the Bill and Melinda Gates Foundation does not include chronic disease. The World Bank admits that it does not have a comprehensive chronic disease strategy and that this area has been under-prioritised. Likewise, it is claimed that NGOs have not made a significant contribution to furthering this agenda and the same can be said of bilateral aid agencies such as the UK Department for International Development, where the term 'killer diseases' is usually applied to infectious illnesses, ignoring the heavy burden of mortality from NCDs."

In 'Stroke in Developing Countries: Epidemiology, Impact and Policy Implications', Prof Lloyd-Sherlock reviews existing research on the issue and discusses the social and economic effects of stroke and the scope for interventions to reduce its prevalence and mitigate impacts.

Globally, stroke accounts for around 10% of all deaths. Improved prevention in developed countries has led to a reduction in the risk of dying as a result of stroke, while stroke rates across the developed world fell 42% between 1970 and 2008. Over the same period rates rose 100% for developing countries, which also report substantially higher fatality rates. Most regions will see an increase in deaths caused by stroke and NCDs between 2002 and 2030, with the most notable rise in South Asia. For those who survive, the health consequences include disability, paralysis and cognitive impairment, which can lead to high treatment and care costs, reduced earning capacity, and the risk of impoverishment.

Despite the low cost of preventative drug treatments, a high proportion of the key risk-factors for stroke, such as hypertension, diabetes and raised cholesterol, continue to be untreated in most developing countries and are increasing. While old age is another significant risk factor, because developing countries contain fewer people at the oldest ages, a higher share of stroke occurs among people at younger ages - on average 15 years younger than in developed countries.

In many developing countries the availability of emergency treatment remains extremely limited, especially in rural areas, and the cost prohibitive. However, Prof Lloyd-Sherlock suggests that screening for and treating pre-disposing conditions – for example medication to lower blood pressure or cholesterol levels – could bring immediate benefits. It is claimed that rolling out multi-drug treatments could save 18 million deaths between 2005 and 2015.

Prof Lloyd-Sherlock said: "This form of prevention may offer a relatively cheap and low-tech alternative that has the capacity to generate substantial short-term gains in population health. The process of screening is relatively cheap, only requiring basic equipment and limited staff training, while multi-drug treatment therapies are affordable when compared with drug regimes for TB or HIV/AIDS. Despite this, the scale of these challenges, particularly in low-income settings, should not be down-played."

More information: 'Stroke in Developing Countries: Epidemiology, Impact and Policy Implications' is published in the November issue of Development Policy Review, volume 28, issue 6, pages 693-709.

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