

In this month's *Bulletin*

Dilemma: noncommunicable vs communicable diseases

Noncommunicable diseases — diabetes, heart disease, and cancer, among others — account for only 14% of the total disease burden in sub-Saharan Africa. Communicable diseases make up the bulk of the remaining burden. Should money and effort be spent now in tackling the noncommunicable diseases? In many African countries, as Unwin et al. (pp. 947–953) point out, noncommunicable diseases are on the increase and, as life expectancy rises and Western lifestyle takes hold, are likely to impose a growing burden on a resource-strapped continent. What is needed in the first instance, the authors believe, is research to provide the information on which reliable surveillance systems, better treatment services, and effective preventive programmes could be set up cost-effectively — but within, rather than at the expense of, the still predominant burden of communicable diseases.

Making lifestyle healthier in a rich country

A decade ago, Singapore brought government ministries, health organizations, and other groups together to launch a nationwide programme aimed at getting people to adopt healthier lifestyles. Six years later, as Cutter et al. report (pp. 908–915), a national survey showed that fewer men (but more women) were smoking, more people were taking regular exercise, the prevalence of obesity and diabetes was more or less the same, but high blood cholesterol and hypertension were up. The government's forthcoming new programme will target high-risk groups and bring the food industry into the picture in the hope of achieving a greater overall impact.

Making lifestyle healthier in a poor country

Nissinen et al. (pp. 963–970) describe how the Finns, through an all-out

25-year health promotion effort to reduce risk factors — especially smoking and unhealthy diets — slashed mortality from cardiovascular disease by 68% among men in North Karelia, one of the poorest areas of the country. A key factor was the involvement, not just of people at high risk, but of the whole community. Similar attempts are under way in developing countries, with variable results to date. The authors extract from these experiences a number of lessons that could increase the chances of a successful outcome. Examples: use primary health care services; involve many sectors of the community; collaborate with industry, particularly the food industry; and ensure close collaboration between the local community and national authorities.

Screening for cervical cancer in poor countries

More than 80% of the 230 000 women in the world who die every year from cervical cancer are in developing countries. Many of them might have been saved by an effective screening programme. But in these countries,

well-run programmes are few and far between. Sankaranarayanan et al. (pp. 954–962) review the meagre results reported for these programmes, where they exist, and suggest that the poorest countries should concentrate on improving diagnosis and treatment of cervical cancer before putting their limited resources into screening. Middle-income countries with existing screening programmes should reorganize them in the light of experience elsewhere, whereas those starting from scratch should begin screening in relatively small test areas before going national.

Broken hips in Belgium

Hip fractures are on the increase in several European countries. In Belgium, a hospital survey described by Reginster et al. (pp. 942–946) found a 30% rise in incidence between 1984 and 1996, of which only about 3% could be due to demographic changes, notably ageing of the population. On present trends, the incidence of hip fractures in Belgium could increase sixfold, reaching a total of 28 000 cases over the next half-century. ■



UNICEF/Ellen Toïme

An early start to healthy eating can lower the risk of noncommunicable diseases — the subject of this month's theme articles — later in life. Cancer, cardiovascular disease, and diabetes are three examples.