medical treatment, his blood pressure spiraled and he slowly lost his eyesight and movement of his left leg, forcing him to quit his job. Now, aged 45, Martin is upset that he can no longer support his family, ultimately leading to his child's removal from school.

As I reflected on this situation, I realized how Martin is an example of an individual who did everything right in his own capacity, but was a victim of structural violence. In Pathologies of Power, Paul Farmer describes structural violence as "processes and forces that conspire—whether through routine, ritual … or hard surfaces of life to constrain [human] agency."[17

Martin presented to a health center and engaged with the formal medical system when he developed symptoms and sought further treatment. Yet, the current system's infrastructure was unable to help him. His sedentary lifestyle as a truck driver most likely led to his erratic diet. His additional suffering was brought on by a combination of insufficient public health provisions (i.e. NCD awareness) that further exacerbated his hypertension. Although I found myself struck by this immense feeling of injustice, it led me to reflect on whose responsibility it should be to help address this pressing issue.

The problem of NCDs in LMICs such as Uganda is nuanced, multifaceted, and challenging. First, there is a low overall spending on government funded healthcare in Uganda, which in 2015 stood at 1.3%.[18 This is far from the recommendations put forward by the WHO Commission on Macro Economics, who suggest that low-income countries should allocate at least 5% of their GDP on health.[19 In addition, between the fiscal year 2013-2014, "government funds contributed 17.7%, private funds 41.1%, and development partner funds 41.2% to the current health expenditure.[20

The effect is two-fold: patients often have to shoulder the financial burden for health services and, a significant amount of Uganda's healthcare agenda is set by external funders who may not understand the country's changing health dynamics.

Second, there is low public awareness. In late June, I met with a physician at the Mulago National Referral Hospital in Kampala, Uganda. He shared the same fear of the near reality of NCDs becoming a national issue. The hospital's weekly diabetic clinic regularly hosts over 200 patients, many of whom are unable to afford routine treatments. In addition, he has witnessed firsthand the rapid increase in the incidence of NCDs in the country. According to him, in 2010, the hospital's monthly supply of NCD medication (i.e. hypertensive and diabetic drugs) would last a little more than three weeks. In contrast, in 2018, that same supply of drugs barely lasts a week, leaving a three-week window which the hospital has no drug supply.

Third, there is an inefficient linkage between community members and health professionals for NCD management. This has caused many people with NCDs, like Martin, to present to health clinics with late-stage complications that are often resistant to medical treatment.

The rise in NCD incidence and prevalence is not new to Uganda, and there have been many proposals in the past aiming to address this pressing issue.[21[22[23[24[25 However, based on my observations, the primary barriers against NCD-focused initiatives are the lack of documented surveillance and a national action plan on NCDs [26Without surveillance and community support at the grassroots level, the poorest members of the population are left in a vacuum without government support, further proliferating the socioeconomic gap in NCD prevention.

Task-Shifting with Community Health Workers (CHWs)

A potential way to highlight the importance of recognizing, preventing, and managing NCDs is through community outreach and engagement. As such, one proposed strategy has been to empower CHWs to address this important and growing issue. This concept has been documented in several existing initiatives in LMICs settings, which have suggested success when employing CHWs in NCD prevention and management.[27[28[29[30[31

While in Uganda, I met Rose*, a CHW who also supervises the NGO's Hypertension Program. She has seen firsthand the crippling effects of hypertension within her village, often feeling frustrated about how easily preventable hypertension can be with the availability of appropriate resources. Currently, she has helped lead the training of over 100 CHWs on hypertension awareness and develop a screening protocol with manual blood pressure cuffs. She states in reference to the growing prevalence of hypertension, "[CHWs'] referral logs to the health centers are filling and running out pages."

Training CHWs on NCD prevention and management could possibly help curtail the rising NCD prevalence in not only Uganda, but other settings devoid of appropriate resources. Although this approach is promising, and the will to establish greater community support is strong at the grassroots level, it is important to note that any type of CHW involvement

would require multiple stakeholders (i.e. government, international donors, development banks, NGO funding partners) to commit to consistent training and stable funding.

CHWs have the potential to bring about a three-tiered change in NCD management in Uganda: prevention/screening, referral to health centers, and adherence to medication. NCDs have been described as the social justice issue of our time and if we continue to neglect their causes and devastating effects, we are in danger of failing some of the most vulnerable members of society.

*Name has been changed to preserve confidentiality.

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