The global burden of kidney disease and the sustainable development goals

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DOI: https://doi.org/10.2471/BLT.17.206441
Policy & practice

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Abstract Kidney disease has been described as the most neglected chronic disease. Reliable estimates of the global burden of kidney disease require more population-based studies, but specific risks occur across the socioeconomic spectrum from poverty to affluence, from malnutrition to obesity, in agrarian to post-industrial settings, and along the life course from newborns to older people. A range of communicable and noncommunicable diseases result in renal complications and many people who have kidney disease lack access to care. The causes, consequences and costs of kidney diseases have implications for public health policy in all countries. The risks of kidney disease are also influenced by ethnicity, gender, location and lifestyle. Increasing economic and health disparities, migration, demographic transition, unsafe working conditions and environmental threats, natural disasters and pollution may thwart attempts to reduce the morbidity and mortality from kidney disease. A multisectoral approach is needed to tackle the global burden of kidney disease. The sustainable development goals (SDGs) emphasize the importance of a multisectoral approach to health. We map the actions towards achieving all of the SDGs that have the potential to improve understanding, measurement, prevention and treatment of kidney disease in all age groups. These actions can also foster treatment innovations and reduce the burden of such disease in future generations.

Introduction

The 17 sustainable development goals (SDGs) were adopted by the United Nations, as successors to the millennium development goals, with the broad goal of achieving healthy people living on a healthy planet. Although only SDG 3, that is, to ensure healthy lives and promote well-being for all at all ages, is specifically focused on health, achievement of all of the SDGs should have health benefits via impacts on the environment, governance and society.

The Global action plan for the prevention and control of noncommunicable diseases 2013–2020 (hereafter called the 2013 action plan) outlined an approach to reduce the combined mortality from four major categories of noncommunicable disease, i.e. cancer, cardiovascular disease, chronic respiratory disease and diabetes, by 25% by 2025. Previously, these four categories had been prioritized in the 2008–2013 action plan because, collectively, they were believed to account for about 60% of global deaths and it was anticipated that a large proportion of these deaths could be prevented through elimination of shared risk factors, e.g. alcohol and tobacco use, poor diets and inadequate exercise. Although laudable, the 2013 action plan has been criticized for failing to acknowledge the broader drivers of the noncommunicable disease epidemics, other important noncommunicable diseases and the so-called causes of the causes of noncommunicable diseases and failing to place sufficient emphasis on the need for coordinated multisectoral action. We argue that kidney disease represents one of the important noncommunicable diseases missing from the 2013 action plan and that, given the many social and structural factors that directly affect risks and outcomes of kidney disease, multisectoral action to achieve the SDGs will help prevent and control such disease (Table 1).

Global burden

Although often considered a comorbidity of diabetes or hypertension, kidney disease has numerous complex causes. Importantly, such disease has an indirect impact on global morbidity and mortality by increasing the risks associated with at least five other major killers: cardiovascular diseases, diabetes, hypertension, infection with human immunodeficiency virus (HIV) and malaria. For example, the Global Burden of Disease (GBD) 2015 study estimated that 1.2 million deaths, 19 million disability-adjusted life-years (DALYs) and 18 million years of life lost from cardiovascular diseases were directly attributable to reduced glomerular filtration rates.

The GBD 2015 study also estimated that, in 2015, 1.2 million people died from kidney failure, an increase of 32% since 2005. In 2010, an estimated 2.3–7.1 million people with end-stage kidney disease died without access to chronic dialysis. Additionally, each year, around 1.7 million people are thought to die from acute kidney injury. Overall, therefore, an estimated 5–10 million people die annually from kidney disease. Given the limited epidemiological data, the common lack of awareness and the frequently poor access to laboratory services, such numbers probably underestimate the true burden posed by kidney disease. It is therefore possible that, each year, at least as many deaths are attributable to kidney disease as to cancer, diabetes or respiratory diseases, three of the four main categories targeted by the 2013 action plan.

In addition, the estimated number of DALYS attributable to kidney disease globally increased from 19 million in 1990 to 33 million in 2013. In 2016, the DALY’s associated with chronic kidney disease, along with those associated with cardiovascular disease, cancers, diabetes and neurological disorders, were found to have increased significantly between 1990 and 2015. A report from the GBD 2016 study highlighted the

Submitted: 28 November 2017 – Revised version received: 23 March 2018 – Accepted: 23 March 2018 – Published online: 20 April 2018

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### Table 1. The 17 sustainable development goals and their relevance to kidney health, 2015

| Goal | Description | Relevance to kidney health | Relevant SDG 3 targets |
|------|-------------|---------------------------|------------------------|
| 1    | End poverty in all its forms everywhere | • Improvements in access to nutrition, personal safety and health care should enhance the prevention, detection and management of kidney disease  
• Should reduce the incidence of catastrophic health expenditure resulting from treatment for kidney disease | 3.8 |
| 2    | End hunger, achieve food security and improved nutrition and promote sustainable agriculture | • Improvements in maternal nutrition and reductions in the frequencies of low birth weight and preterm birth should reduce the risk of CKD  
• Reductions in the incidence of obesity should cut the risk of CKD, diabetes and hypertension | 3.1, 3.2 |
| 3    | Ensure healthy lives and promote well-being for all at all ages | • Should improve screening for, and the prevention, diagnosis and treatment of, kidney disease  
• Public health programmes to promote community education, healthy lifestyles and vaccinations could also reduce the risk of AKI and CKD | All |
| 4    | Ensure inclusive and equitable quality education for all and promote life-long learning | • Should improve awareness and kidney-health-related knowledge  
• May reduce use of nephrotoxic remedies and preparations | 3.4, 3.5 |
| 5    | Achieve gender equality and empower women and girls | • Reductions in the numbers of teenage pregnancies and increases in pregnancy spacing may reduce the incidence of the low birth weight, prematurity and pregnancy-related complications that are all risk factors for CKD  
• There should also be improvements in overall family health | 3.1, 3.7 |
| 6    | Ensure access to water and sanitation for all | • There should be reductions in the incidence of the waterborne diseases and diarrhoeal illnesses that are major causes of AKI and in the incidence of the schistosomiasis that can cause CKD  
• There should also be reductions in water pollution that can cause CKD | 3.9 |
| 7    | Ensure access to affordable, reliable, sustainable and modern energy for all | • Should broaden opportunities to use mobile health in prevention and treatment and in community and health worker education  
• Improvements in access to electronic information sharing and data collection could lead to improvements in the epidemiology, monitoring and surveillance of kidney disease | 3.9 |
| 8    | Promote inclusive and sustainable economic growth, employment and decent work for all | • Improvements in personal access to health care, dignity and wealth could lead to improvements in the prevention and early treatment of kidney disease  
• Improvements in the retention of health-care workers could reduce the so-called brain drain  
• Task shifting in health care could be facilitated | 3.b, 3.c |
| 9    | Build resilient infrastructure, promote sustainable industrialization and foster innovation | • Could support innovations to improve the affordability and sustainability of access to diagnosis, facilitate early treatment and secondary prevention and foster cheaper and more efficient means to prevent, diagnose and treat both AKI and CKD  
• Could also facilitate investigation of the potential benefits of, or risks posed by, traditional remedies for kidney disease | 3.b |
| 10   | Reduce inequality within and among countries | • Could improve equity in the prevention, diagnosis and care of all forms of kidney disease  
• Could improve access to expensive therapies, e.g. dialysis, hepatitis C therapy and transplantation  
• Could improve geographical access to all forms of kidney care | 3.1, 3.2, 3.7, 3.8, 3.b, 3.d |
| 11   | Make cities inclusive, safe, resilient and sustainable | • Improved warning and protection from disasters could reduce crush-injury-related AKI  
• Levels of preparedness in mass disasters, including for patients with AKI, CKD or ESKD, should improve  
• Urban planning to eliminate food deserts and increase physical activity could help reduce diabetes and obesity-related kidney disease  
• Reductions in exposure to alcohol, drugs and tobacco could also reduce the risk of kidney disease | 3.5, 3.6, 3.d |
| 12   | Ensure sustainable consumption and production patterns | • Promotion of the environmentally friendly and sustainable local production of dialysis supplies could reduce dialysis costs, create jobs and support the local economy  
• Any reductions in the need for dialysis should reduce the carbon footprint from dialysis  
• There may also be adverse effects on kidney health as increasing access to cars and unhealthy processed foods could lead to an increasing prevalence of obesity and access to cigarettes may also increase | 3.4, 3.5, 3.9 |

(continues . . .)
important omission of focus on chronic kidney disease and suggested that “the SDG agenda offers at best a minimal platform for drawing attention to the health care and monitoring needs of [chronic kidney disease].”

Kidney disease is associated with a tremendous economic burden. High-income countries typically spend more than 2–3% of their annual health-care budget on the treatment of end-stage kidney disease, even though those receiving such treatment represent under 0.03% of the total population. In 2010, 2.62 million people received dialysis worldwide and the need for dialysis was projected to double by 2030. Globally, the total cost of the treatment of the milder forms of chronic kidney disease appears to be much greater than the total cost of treating end-stage kidney disease. In 2015, in the United States of America, for example, Medicare expenditures on chronic and end-stage kidney disease were more than 64 billion and 34 billion United States dollars, respectively. Much of the expenditure, morbidity and mortality previously attributed to diabetes and hypertension are attributable to kidney disease and its complications.

Worldwide, important risk factors for kidney disease include diarrhoeal diseases, HIV infection, low birth weight, malaria and preterm birth, all of which are also leading global causes of DALYs. Risks of kidney disease span the life-course and environmental, infection and lifestyle etiologies. If risk factors are identified early, acute kidney injury and chronic kidney disease can be prevented and, if kidney disease is diagnosed early, worsening of kidney function can be slowed or averted by inexpensive interventions, several of which are on the World Health Organization’s (WHO’s) so-called best buys list for noncommunicable disease management. Such interventions include counselling for cardiovascular disease, diabetes and hypertension, drug therapy, tobacco control, promotion of physical activity and the reduction of salt intake through legislation and food labelling. The timely identification and management of acute kidney injury and chronic kidney disease represent the most effective strategy to address the growing burden of such disease. By advocating for a multisectoral approach, as a means to achieving the SDGs, it should be possible to reduce the incidence of kidney disease globally. We discuss the kidney-health-related opportunities offered by attempts to achieve each SDG (Table 1).

### SDGs and kidney health

**SDGs 1, 3.8, 3.b and 10**

In high-income countries, lower socioeconomic status is associated with greater risk of end-stage kidney disease because of behavioural and metabolic risk factors and reduced access to care. In low- and middle-income countries, the burden posed by such poverty-related kidney disease is even greater, because of associated infections, hazardous work, poor education and poor maternal health. In all countries, poverty is associated with lack of social protection and transportation, poor housing and unemployment. Lack of transportation restricts access to care even when treatment costs are not a major barrier. Poverty and lower socioeconomic status have been specifically identified as independent risks for both incident chronic kidney disease and the more rapid progression of such disease. In low-income countries where treatment costs have to be paid directly by patients, a month’s supply of essential medications for the treatment of chronic kidney disease can cost up to 18 days’ wages and the corresponding out-of-pocket costs of dialysis, for acute kidney injury or end-stage kidney disease, are much higher. In South Africa, where limited access to dialysis is government-funded, patients who are otherwise eligible for dialysis are frequently declined access because of their socioeconomic circumstances.

For those who do access dialysis, the financial burden is exacerbated because they cannot be employed while receiving dialysis or travelling to and from the provider.
Promotion of universal health coverage should reduce the financial hardship of patients with kidney disease and improve access to kidney care. The goal of eradicating poverty spans all of the other SDGs and is fundamental to improving kidney health. In turn, achievement of each SDG promises to promote equity and reduce poverty.

**SDG 2**

Many low-income countries have problems with undernutrition and overnutrition, both are risk factors for kidney disease. Malnutrition predisposes young children to infections, e.g. diarrhoeal diseases and pneumonia, that are important risk factors for acute kidney injury. Among girls and female adolescents, undernutrition leads to underweight mothers and low-birthweight offspring. Low birth weights, preterm births and pregnancies affected by diabetes and pre-eclampsia, which, combined, may represent up to 20% of pregnancies worldwide, are all associated with increased lifetime risk of chronic kidney disease in both mothers and children. Obesity increases the lifetime risk of end-stage kidney disease and maternal obesity is associated with adverse outcomes in pregnancy, including the gestational diabetes and preterm births that are associated with increased risk of chronic kidney disease.

Adequate nutrition is a key tool for reducing the burden of chronic kidney disease. Groups with very low incomes often live in areas where access to healthful foods is very limited or non-existent. Some population-level strategies, e.g. public education about healthful food choices, regulation of the fat, salt and/or sugar contents of food and the regulation of programmes for the provision of public and/or school meals, can all improve kidney health. Reduction in dietary salt is proposed as a cost-saving best buy with great potential to avert deaths from kidney disease. Similarly, a tax on high-sugar beverages, as introduced in Mexico, where chronic kidney disease is more common among women than men, fewer women than men receive dialysis. Child marriage and lack of access to family planning contribute to poor maternal health and increased risk of obstetrical complications, including acute kidney injury. Among urban adults in the United States, both gender and race appeared to affect glomerular filtration rates. Achievement of equity for women worldwide should reduce the burden of kidney disease.

**SDG 6**

Globally, almost 800 million people lack access to safe water and 2.5 billion lack access to optimal sanitation. In low- and middle-income countries, waterborne and pestilent diseases associated with poor hygiene and sanitation are major causes of acute kidney injury and chronic kidney disease. Enteric diarrhoeal deaths, associated with lack of safe water, cause over 1 million deaths annually. Most of these deaths occur in children younger than five years and many can be attributed to dehydration-related acute kidney injury. Non-enteric diseases caused by waterborne pathogens, e.g. leptospirosis and schistosomiasis, are also major causes of kidney disease in low- and middle-income countries.

Local availability of clean water would be expected to reduce the risk of diarrhoea-related acute kidney injury. Beyond infection-related kidney complications from contaminated water and poor sanitation, additional challenges exist. Water containing organic perfluoroalkyl acids and heavy metals has been associated with chronic kidney disease in several settings and pesticide-contaminated well water may contribute to the risk of some chronic kidney disease observed in Sri Lanka. Dehydration, in conjunction with heat stress, may have contributed to the epidemic of chronic kidney disease observed among young, economically productive male labourers in Central America and South-East Asia. The global burden of kidney disease should be reduced by ensuring the availability of clean water and adequate sanitation.

**SDGs 7 and 12–15**

Climate change, degradation of biodiversity, forest and land, and loss of marine resources, all likely increase the risk of kidney disease through multiple mechanisms, e.g. increases in food insecurity, the incidences of heat-related illness and infectious diseases and pollution. Deforestation and land degradation can bring humans into greater contact with vector-borne and waterborne pathogens, such as enteric bacteria and other pathogens that can directly cause kidney disease, e.g. those causing dengue fever, leishmaniasis, leptospirosis, malaria, schistosomiasis, trypanosomiasis and yellow fever.

Reducing the global burden of kidney disease in turn will also be critical for mitigating some of the environmental impacts of dialysis. Each year, for example, the haemodialysis given to more than 2 million people requires 160 billion litres of water and generates over 900 000 tonnes of, predominantly plastic waste. Clean, local production of dialysis supplies, the reprocessing of dialysis filters, the reuse of dialysis water, solar-powered dialysis and waterless dialysis are all promising strategies that could reduce the environmental footprint of dialysis as well at its costs.

**SDGs 8, 10 and 17**

Within low- and middle-income countries, access to dialysis is highly inequitable. Despite its relative cost-effective-

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Bull World Health Organ 2018;96:414–422C. doi: http://dx.doi.org/10.2471/BLT.17.206441

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ness, access to transplantation is even more inequitable because of cultural, financial and legislative barriers and infrastructural limitations.\textsuperscript{40} In the face of extreme social inequalities and a demand for transplants that markedly exceeds the supply, the trafficking of kidneys and other human organs remains a major concern.\textsuperscript{40}

Disparities in the burden of kidney disease, which are particularly complex, arise from biological, environmental, genetic, lifestyle and sociocultural factors\textsuperscript{20} and need to be addressed via multilevel, systematic interventions.\textsuperscript{43} An example of the complexities involved has been described in the United States. There, in general, compared with other patients with similar disease, patients with chronic kidney disease from ethnic and racial minorities have delayed referral for care, lower incomes, report poorer physician–patient relationships and have less access to health care in general.\textsuperscript{20} The pervasive disparities in kidney disease will have to be addressed before SDGs 8, 10 and 17 can be achieved.

**SDGs 3.6, 3.d, 9 and 11**

Rapidly occurring urbanization has contributed to the rise of kidney disease and other noncommunicable diseases in low- and middle-income countries.\textsuperscript{41} In addition to the commonly associated lifestyle changes, e.g. a switch to high-calorie, sodium-rich diets and decreased physical activity, rapid urbanization has led to crowded cities with environmental pollution, a limited infrastructure and poor levels of sanitation and waste disposal.\textsuperscript{42} Such urbanization also means that more and more people are living in settings where a growing prevalence of noncommunicable diseases, e.g. diabetes, hypertension and obesity, is juxtaposed with environmental toxins and numerous infectious diseases.\textsuperscript{43} These changes portend a synergistic growth in the global burden of kidney disease. There may already be evidence of such growth in the ever-higher ranking of chronic kidney disease among leading cause of deaths, across all country income categories, between 1990 and 2016.\textsuperscript{44}

By building resilient infrastructure while promoting sustainable industrialization, it should be possible to enhance health-care access while simultaneously reducing the risk of kidney disease. In low- and middle-income countries, urban planning, to improve hygiene and sanitation and reduce population densities and the transmission of the pathogens causing enteric infections, schistosomiasis and tuberculosis, should reduce the incidence of acute kidney injury and chronic kidney disease.\textsuperscript{17} At the same time, by promoting the development of parks, paths and efficient transport systems, urban planning could increase general levels of physical activity and so help reduce the risk of obesity-related kidney disease.\textsuperscript{42}

The effective prevention of chronic kidney disease will require engagement with the corporate sector, whose interests may be in conflict with those of public health.\textsuperscript{45} Novel strategies are required to create incentives for the corporate sector to promote public health.\textsuperscript{44} Even under optimal circumstances, kidney disease cannot always be prevented and strategies to reduce the economic, physical and social burdens of end-stage kidney disease are needed. Innovative mechanisms to reduce dialysis costs and make dialysis less dependent on electricity and water could multiply opportunities for access to dialysis, especially in low- and middle-income countries.\textsuperscript{39} Innovation is also required to improve access to transplantation. Although opt-out or presumed-consent strategies have been proposed as a way of increasing the supply of organs from deceased donors, they remain contentious.

Acute kidney injury after a road-traffic collision may result from rhabdomyolysis and multi-organ failure as well as blunt or penetrating kidney injury.\textsuperscript{45} Natural disasters are associated with increased rates of crush-injury-induced acute kidney injury and frequently lead to life-threatening interruptions of treatment among those with end-stage kidney disease.\textsuperscript{46} Similarly, forced migrants with chronic or end-stage kidney disease can face dangerous interruptions in their treatment or receive inadequate care,\textsuperscript{47} even in a high-income country such as the United States.\textsuperscript{48} Continued action on reducing the burden of road-traffic injuries and supporting efforts to integrate noncommunicable disease management into humanitarian relief efforts should help to reduce the burden of chronic and end-stage kidney disease.\textsuperscript{49}

**SDG 16**

Exposure to armed conflict can result in acute kidney injury caused by crush injury and rhabdomyolysis and the severity of injuries sustained in combat strongly correlates with the subsequent risk of chronic kidney disease.\textsuperscript{49} Kidney disease is common in incarcerated populations and, in terms of their kidney health, prisoners may face a triple burden: of excess risk of kidney disease and its risk factors, of barriers to preventive care for established chronic kidney disease and of the suboptimal management of end-stage kidney disease.\textsuperscript{50} As an important step towards improving global health, much work is required globally to reduce conflict and disparities and enhance peace.

**Policy perspective**

The net health burden of kidney disease is substantial, growing and driven by complex interactions, between communicable and noncommunicable diseases, that are shaped by upstream environmental and socioeconomic disparities. Although kidney disease, whether acute, chronic or end-stage, can be extremely costly, it is also potentially preventable and adverse outcomes can often be delayed or prevented by inexpensive interventions. Kidney disease is highly prevalent, spans the life course and has substantial financial implications. Our response to such disease requires a systematic policy approach, to strengthen all relevant aspects of the health system and to facilitate integration of the promotion of kidney health within a comprehensive horizontal programme for the prevention and treatment of noncommunicable diseases (Table 2).

Within each country, the local burden and prevalence of kidney disease and its risk factors and the local capacity to identify and manage such disease must be determined, as a prerequisite for fair priority setting and appropriate policy development. Diagnosis of kidney disease is often hampered by a lack of awareness among health-care workers and at-risk communities and by inadequate and often erratic access to laboratory testing. Broad policies are increasingly being adopted globally to curb dietary intakes of fat, salt and sugar. Such policies all promise to reduce the burden of chronic kidney disease. The burden of acute kidney injury could be reduced through the ongoing commitment to reduce the transmission of the pathogens causing infectious diseases.

We need universal health coverage to tackle kidney disease successfully
Global kidney burden and sustainable development goals

Kidney disease is described as the chronic disease that is most neglected. Global kidney disease burden seems to increase, thanks to the increasing incidence, the risk factors and the lack of access to care and treatment. Effective and transparent policies to govern access to care for end-stage kidney disease should only be developed after there has been a thorough attempt to determine the local health priorities, especially in resource-poor settings. Engagement with all relevant stakeholders and innovative financing strategies will be required to maximize equitable access to care. The bidirectional and synergistic interplay between kidney disease and all of the SGDs must be acknowledged in the development of a multisectoral approach. Policies that foster domestic and international collaboration, improve occupational and road safety, limit organ trafficking, promote access to education and gender equality, reduce unemployment and tackle the predicted adverse effects of climate change may all reduce kidney disease and/or the disparities in the care for such disease. However, as noted by the United Nations Secretary-General in December 2017, in the control and prevention of noncommunicable diseases, “political commitments have not often been translated into concrete action.”

On its own, policy-making is insufficient. Monitoring the impact of policies on kidney disease and the risk factors for such disease needs to be integrated into existing surveillance activities. Health workers and communities must be empowered to advocate for, and hold policy-makers accountable for, health, as an important step towards achievement of the SDGs.

Funding: MT is supported by the David Freeze Chair in Health Services Research.

Competing interests: None declared.
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Table 2. Relevance of the targets of sustainable development goal 3 to kidney disease, 2015

| Target | Description | Relevant kidney condition | Strategies or actions to reduce risk of kidney disease | Policies facilitating improved kidney health |
|--------|-------------|---------------------------|------------------------------------------------------|-----------------------------------------------|
| 3.1    | By 2030, reduce global maternal mortality to less than 70 deaths per 100 000 live births | Pregnancy-related AKI and pre-eclampsia | Improve access to antenatal care and institutional deliveries and the recognition of pregnancy complications, e.g. eclampsia, pre-eclampsia and peripartum haemorrhage | UHC Promotion of gender equity Public health promotion of healthy lifestyles through education and regulation of unhealthy food and tobacco consumption Promotion of the consumption of healthy food |
|        |             |                           | Identify, during antenatal care or at delivery, mothers at risk, for education and follow-up to reduce long-term risk of maternal CKD and cardiovascular disease associated with pre-eclampsia | Policies facilitating improved kidney health |
|        |             |                           | • Reduce prematurity | UHC Education of health-care workers |
|        |             |                           | • Avoid or reduce perinatal use of nephrotoxins, e.g. aminoglycoside antibiotics and non-steroidal anti-inflammatory drugs | Enhancement of the capacity and infrastructure for detection and surveillance |
|        |             |                           | • Optimize neonatal nutrition | UHC Development of public health policy to improve disease surveillance and response to outbreaks |
| 3.2    | By 2030, end preventable deaths of neonates and children under 5 years of age, with all countries aiming to reduce neonatal mortality to no more than 12 deaths per 1000 live births and mortality among children under 5 years of age to no more than 25 deaths per 1000 live births | Perinatal AKI | Diarrhoea-associated and HUS-associated AKI, post-infectious glomerulonephritis | UHC Improvement of access to healthcare for the prevention and treatment of HIV infection Enactment of protections for women victims of domestic violence and sexual assault Taking action, including legal, policy and regulatory reforms, to ensure full political enfranchisement for women Legislation for the protection of sex workers |
|        |             | CKD and hypertension in later life | Avoid or reduce perinatal use of nephrotoxins, e.g. aminoglycoside antibiotics and non-steroidal anti-inflammatory drugs | Development of public health policy to improve disease surveillance and response to outbreaks |
|        |             |                           | • Reduce prematurity | Reforming of pharmaceutical supply chains and enhancement of regulations to combat fake medicines |
|        |             |                           | • Avoid or reduce perinatal use of nephrotoxins, e.g. aminoglycoside antibiotics and non-steroidal anti-inflammatory drugs | Development of public health policy to improve disease surveillance and response to outbreaks |
|        |             |                           | • Optimize neonatal nutrition | Development of innovative interventions to improve labour conditions and conditions in prisons |
| 3.3    | By 2030, end the epidemics of AIDS, malaria, neglected tropical diseases and tuberculosis, and combat hepatitis, waterborne diseases and other communicable diseases | HIV nephropathy | Malaria-associated AKI, black water fever | Provision of public health education and UHC Development of care models integrating traditional healers. Legislation on alcohol consumption to reduce high-risk drinking |
|        |             |                           | • Prevent and provide early treatment of malaria and combat both availability of fake medication and emergence of resistance to antimalarials | Development of innovative interventions to improve disease surveillance and response to outbreaks |
|        |             |                           | • Increase awareness of risk | Development of public health policy to improve disease surveillance and the effectiveness of diagnosis and treatment |
|        |             |                           | • Adapt medication doses according to kidney dysfunction | Development of innovative interventions to improve disease surveillance and response to outbreaks |
|        |             |                           | CKD – a risk factor for tuberculosis | Hepatitis-associated glomerulonephritis, and hepatorenal syndrome |
|        |             |                           | • Improve access to vaccination and treatment for hepatitis B and C | Reduce hepatitis-associated inflammation and immune-complex deposition |
|        |             |                           | • Reduce kidney-disease-associated cirrhosis and liver failure | Development of public health policy to improve disease surveillance and the effectiveness of diagnosis and treatment |
|        |             |                           | CKD from infections | Development of public health policy to improve disease surveillance and the effectiveness of diagnosis and treatment |
|        |             |                           | • Prevent and treat Hantavirus, leptospirosis and scrub typhus | Development of public health policy to improve disease surveillance and the effectiveness of diagnosis and treatment |
|        |             | Urinary obstruction | • Reduce schistosomiasis | Development of public health policy to improve disease surveillance and the effectiveness of diagnosis and treatment |
|        |             |                           | Diagnose and treat kidney tuberculosis adequately, to reduce long-term obstruction of urinary tract | Development of innovative interventions to improve disease surveillance and response to outbreaks |

(continues...
| Target | Description | Relevant kidney condition | Strategies or actions to reduce risk of kidney disease | Policies facilitating improved kidney health |
|--------|-------------|--------------------------|-----------------------------------------------------|---------------------------------------------|
| 3.4    | By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being | CKD | • Prevent and screen for CKD, improve access to early diagnosis and effective treatment for CKD, provide equitable access to treatment for kidney failure, i.e. dialysis and transplantation, and strengthen access to options for lifestyle improvement  
  • Reduction in CKD could reduce morbidity and mortality associated with some other diseases, e.g. cancer, diabetes and liver disease  
  • Reduce CKD, this should reduce the burdens posed by global hypertension and cardiovascular disease and the associated mortality  
  • Prevent AKI through improved access to sanitation and vaccination, decrease reliance on toxic traditional remedies, improve access to early diagnosis and effective treatment for AKI and provide equitable access to dialysis  
  • Reduction in AKI could reduce morbidity and mortality associated with some other conditions, e.g. heart failure, liver disease, sepsis and surgery | UHC  
  Enactment of protections for women victims of domestic violence and sexual assault  
  Taking action, including legal, policy and regulatory reforms, to ensure full political enfranchisement for women  
  Promotion of healthy lifestyles through education and regulation of unhealthy food consumption  
  Adoption and implementation of FCTC  
  Enhancement of capacity and infrastructure for detection and surveillance  
  Development of care models integrating traditional healers. Enhancement of occupational safety standards  
  Development of transparent policies governing access to expensive therapies such as dialysis and transplantation |
| 3.5    | Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol  
  Strengthen prevention and treatment of HIV and hepatitis-associated kidney disease, infectious glomerulonephritis  
  Rhabdomyolysis | CKD and hypertension in later life  
  HIV and hepatitis-associated kidney disease, infectious glomerulonephritis  
  Rhabdomyolysis | • Reduce low birth weight associated with alcohol use, smoking and substance abuse in pregnancy  
  • Alcohol use and smoking are risk factors for CKD progression  
  • Reduce infections transmitted by intravenous drug use  
  • Prevent rhabdomyolysis by increasing awareness and providing treatment for drug withdrawal and delirium tremens | UHC  
  Enactment of protection for women victims of domestic violence and sexual assault  
  Taking action, including legal, policy and regulatory policy reforms, to ensure full political enfranchisement for women  
  Promotion of urban safety  
  Legislation and regulation of alcohol consumption  
  Adoption and implementation of FCTC  
  Legislation for the protection of sex workers |
| 3.6    | By 2020, halve the number of global deaths and injuries from road traffic accidents | AKI  
  CKD | • Prevent trauma-related crush injury or blunt kidney trauma  
  • Prevent accident-related losses in employment, increases in poverty and reductions in access to health care | Enforcement of existing traffic laws and reform of traffic laws to reduce road trauma  
  Promotion of occupational safety  
  Development and building of infrastructure and safe roads, with capacity to absorb urban growth  
  Promotion of access to education for all and family planning, gender equity and UHC  
  Strengthen legislation on access to safe abortion and the protection of sex workers |
| 3.7    | By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes  
  Ensure universal access to AKI, CKD | Pregnancy-related AKI, CKD | • Empower women, increase spacing of pregnancies and reduce teenage pregnancies  
  • Reduce risk of low birth weight and preterm birth, as these can adversely affect kidney health of the child | Promotion of innovative financing, regulation of the pricing of medical products and UHC  
  Monitoring of catastrophic health expenditure |
| 3.8    | Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | AKI, CKD | • Provide universal access to basic health care and services for the diagnosis, prevention and treatment of all kidney disease and its risk factors, e.g. diabetes and hypertension | |
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

| Target | Description | Relevant kidney condition | Strategies or actions to reduce risk of kidney disease | Policies facilitating improved kidney health |
|--------|-------------|---------------------------|-------------------------------------------------------|-------------------------------------------|
| 3.9    | By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination | CKD of unknown origin, observed in Egypt, India and Sri Lanka, and Balkan nephropathy | • Reduce exposure to environmental toxins that may be associated with CKD, e.g. aristolochic acid and cadmium and others | Promotion of environmental protection and safety  Promotion of sustainable agriculture and fishing  Commitment to combat climate change |
| 3.a    | Strengthen the implementation of WHO's FCTC in all countries, as appropriate | CKD | • Reduce tobacco smoking, a risk factor for cardiovascular disease and mortality, haematuria, low birth weight and proteinuria | Adoption and implementation of FCTC |
| 3.b    | Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the TRIPS Agreement on Public Health, which affirms the right of developing countries to use the full, the provisions in the TRIPS Agreement regarding flexibilities to protect public health and, in particular, provide access to medicines for all | AKI | • Provide and support the uptake of vaccines that can prevent diarrhoeal illness, sepsis and other infections that can cause AKI and can prevent low birth weight in pregnancy  • Support prompt access to the intravenous fluid and appropriate antibiotics that can prevent AKI and glomerulonephritis  • Vaccination in pregnancy can reduce the risk of low birth weight  • Vaccination during pregnancy can reduce the incidence of low birth weight  • Provide affordable and sustainable access to basic medications for CKD, diabetes and hypertension and so reduce burden of end-stage kidney disease | Promotion of budget allocation for locally relevant research  Strengthening and empowerment of local research ethics committees  Utilization of TRIPS Agreement exemptions  Enhancement of the regulation of generic medication  Monitoring of medication supply and use  Promotion of health technology assessments  Development of transparent policies governing access to expensive therapies, e.g. dialysis and transplantation  Development of innovative financing models to reduce costs of dialysis and transplantation  Implementation and enforcement of the Istanbul Declaration against organ trafficking  Development of legislation regarding brain death and organ donation  Opt-out or presumed-consent policies for organ donation |
| 3.c    | Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states | Kidney disease awareness and capacity to treat | • Improve awareness and capacity to diagnose, prevent and treat kidney disease  • Train and retain health-care workers with knowledge of kidney disease | Development of innovative financing models to reduce costs of dialysis and transplantation  Promotion of the education, licensing and registration of health-care workers and researchers  Promotion of the fair remuneration of health-care workers  Legislation to define the scope of practice of community health workers and any associated task shifting |
| 3.d    | Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks | Crush syndrome | • Improv e disaster planning and responses to earthquakes and other major disasters  • Promote peace  • Prevention of wars should reduce both the burden of kidney disease associated with low birth weight and malnutrition and the conflict-related disruption of care | Promotion of international collaboration to respond to natural disasters  Commitment to equality and peace  Promotion of democracy  Strengthening of intersectoral communication and collaboration |

AIDS: acquired immunodeficiency syndrome; AKI: acute kidney injury; CKD: chronic kidney disease; ESKD: end-stage kidney disease; FCTC: Framework Convention on Tobacco Control; HIV: human immunodeficiency virus; HUS: haemolytic uraemic syndrome; TRIPS: Trade-related Aspects of Intellectual Property Rights; UHC: universal health coverage; WHO: World Health Organization.