University of Jordan

Faculty of medicine

Batch 2013-2019

Medical Committee
The University of Jordan

Global health

Slide # : 4

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Designed by Esraa Al-Salamin , dedication to Ghaida khraisat.

بسم الله الرحمن الرحيم

الحمد لله رب العالمين والصلاة
والسلام على نبينا محمد خاتم
الأنبياء وسيد المرسلين وعلى آله
وصحبه أجمعين وبعد

World Health Organization
Regional Office for the Eastern Mediterranean

NONCOMMUNICABLE DISEASES

Part Two

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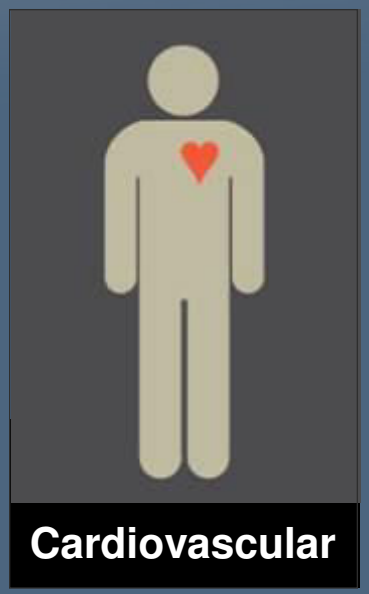
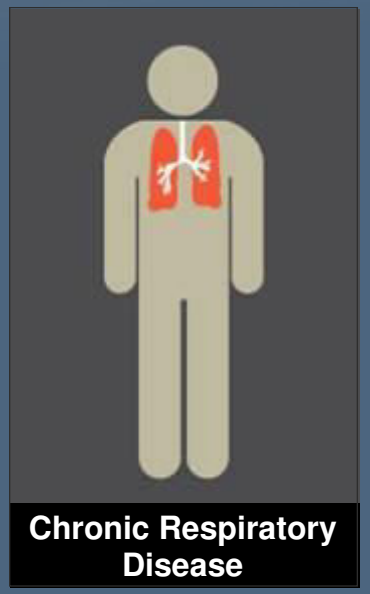
The Regional Situation

- In the WHO Region for the Eastern Mediterranean, Chronic Diseases (CVD, Cancer, Diabetes etc..) account for 52% of all deaths and 47% of the disease burden in EMR during the year 2005
- This burden is likely to rise to 60% in the year 2020.
- The conventional risk factors may explain 75% of chronic diseases.

4 Chronic Diseases result in 52 percent of deaths

EMR Adult Population





EMR/NCD RISK FACTORS

◆ Smoking	16-65%
◆ Hypertension	12-35%
◆ Diabetes	7-25%
◆ Over weight-obesity	40-70%
◆ Dyslipidemia	30-70%
◆ Physical Inactivity	80-90%

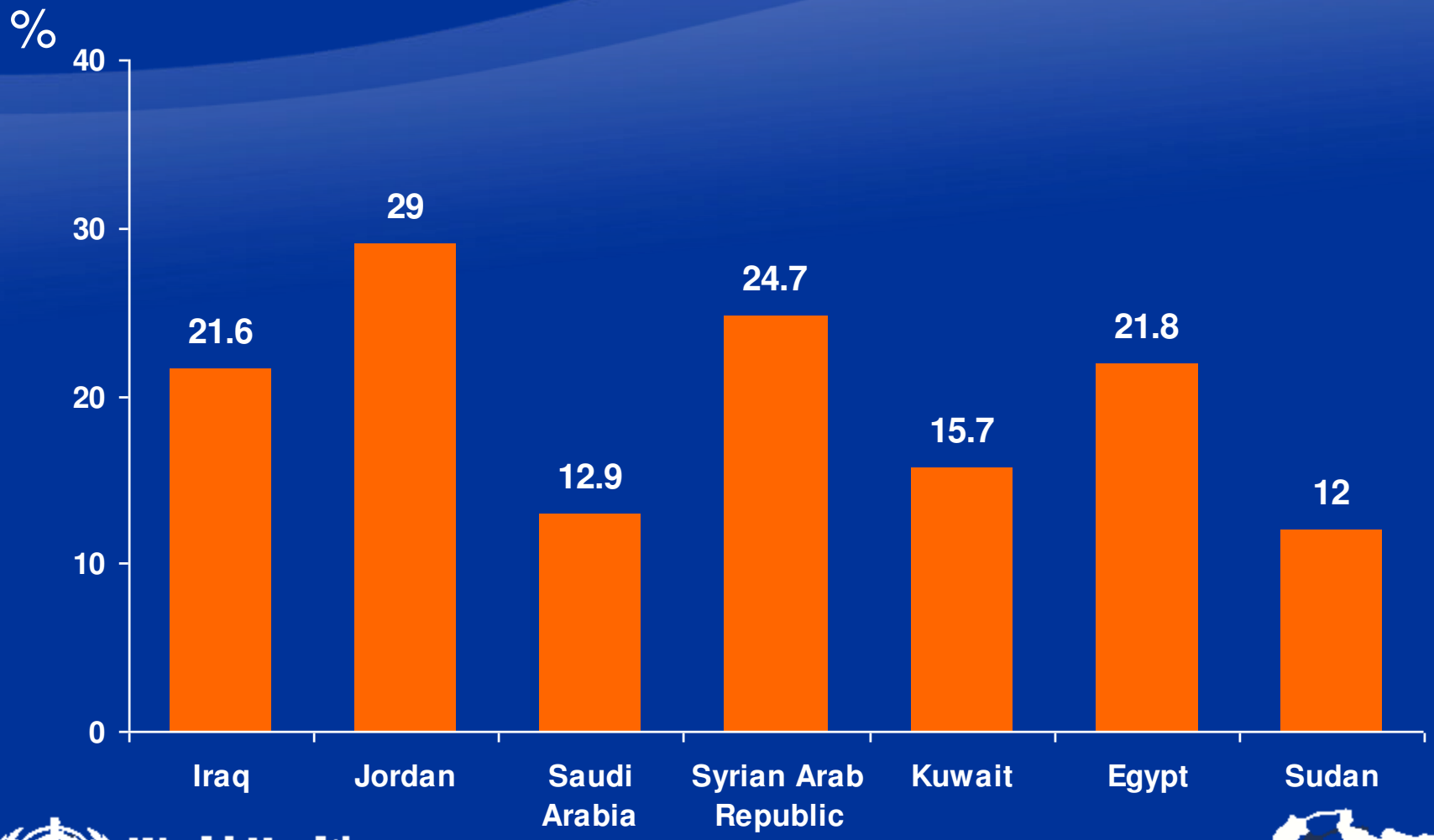
Stepwise data from some EM countries

Country	Year of field work	Diabetes %	Hypertension %	Overweight & Obesity %
Iraq	2006	10.4	40.4	66.9
Jordan	2007	16	25.5	67.4
Saudi Arabia	2005	17.9	26	
Syrian Arab Republic	2003	19.8	28.8	56.3
Kuwait	2005	16.7	24.6	81.2
Egypt	2005	16.5	33.4	76.4
Sudan	2005	19.2	23.6	53.9

Stepwise data from some EM countries

Country	Year of field work	Hyper-cholestrolemia %	Smoking %	Low physical activity %	Low intake of fresh fruit & vegetables %
Iraq	2006	37.5	21.6	56.7	92.3
Jordan	2007	26.2	29	5.2	14.2
Saudi Arabia	2005	19.3	12.9	33.8	91.6
Syrian Arab Republic	2003	33.5	24.7	32.9	95.7
Kuwait	2005	42	15.7	91.5	89
Egypt	2005	24.2	21.8	50.4	79
Sudan	2005	19.8	12	86.8	1.7/day

Prevalence of Smoking according to STEPwise Survey in EM countries



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Prevalence of diabetes based on stepwise surveys

- Jordan: 12%
- Iraq: 10.4%
- Syria: 20.5%
- Saudi Arabia: 17.9%
- Iran: 10.3%
- No available data from other EM countries

The Global burden of diabetes

- Diabetes accounts for more than 5% of the global deaths, which are mostly due to CVD.
- Diabetes is responsible for over one third of end-stage renal disease requiring dialysis.
- Amputations are at least 10 times more common in people with diabetes.
- A leading cause of blindness and visual impairment. Diabetics are 20 times more likely to develop blindness than nondiabetics.

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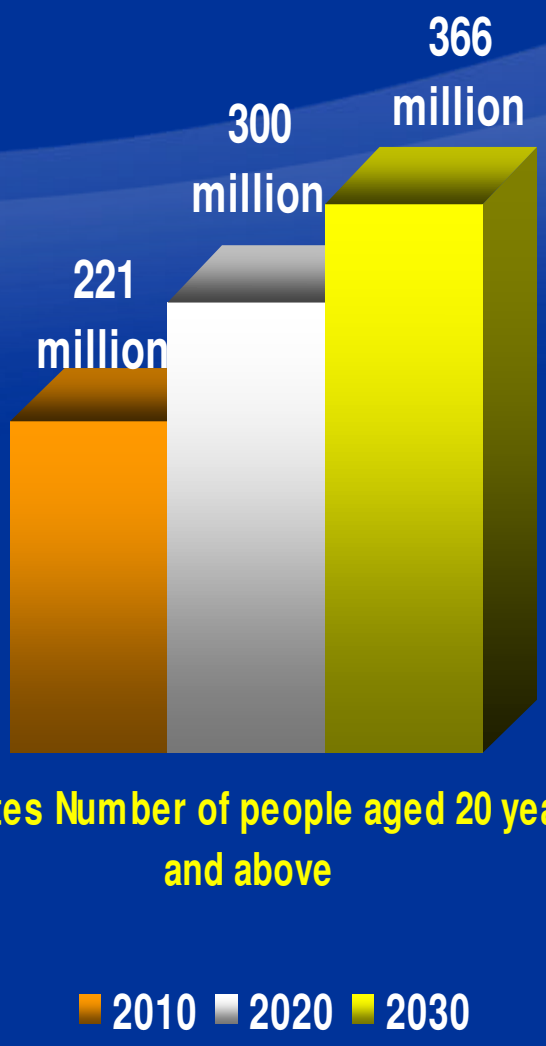
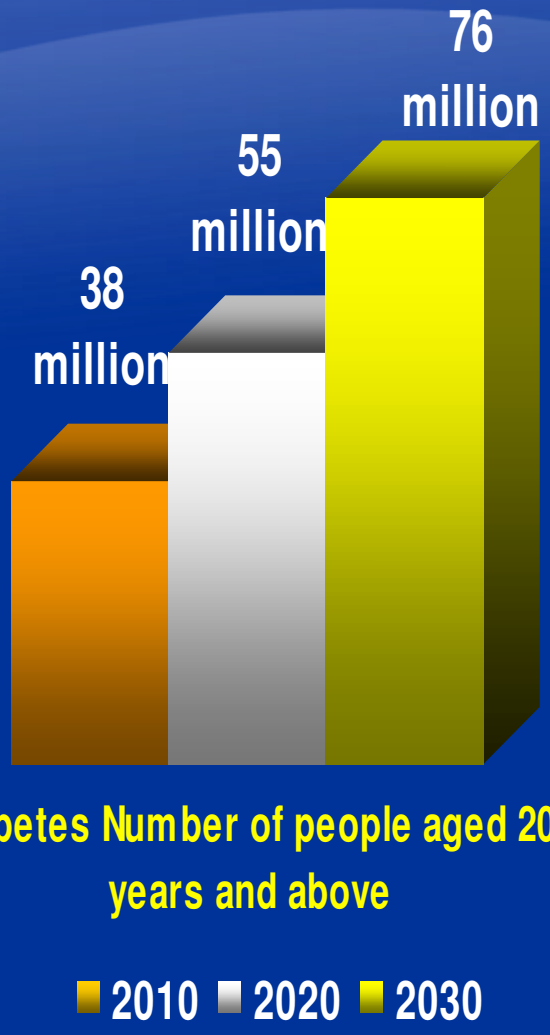
Globally



EMR



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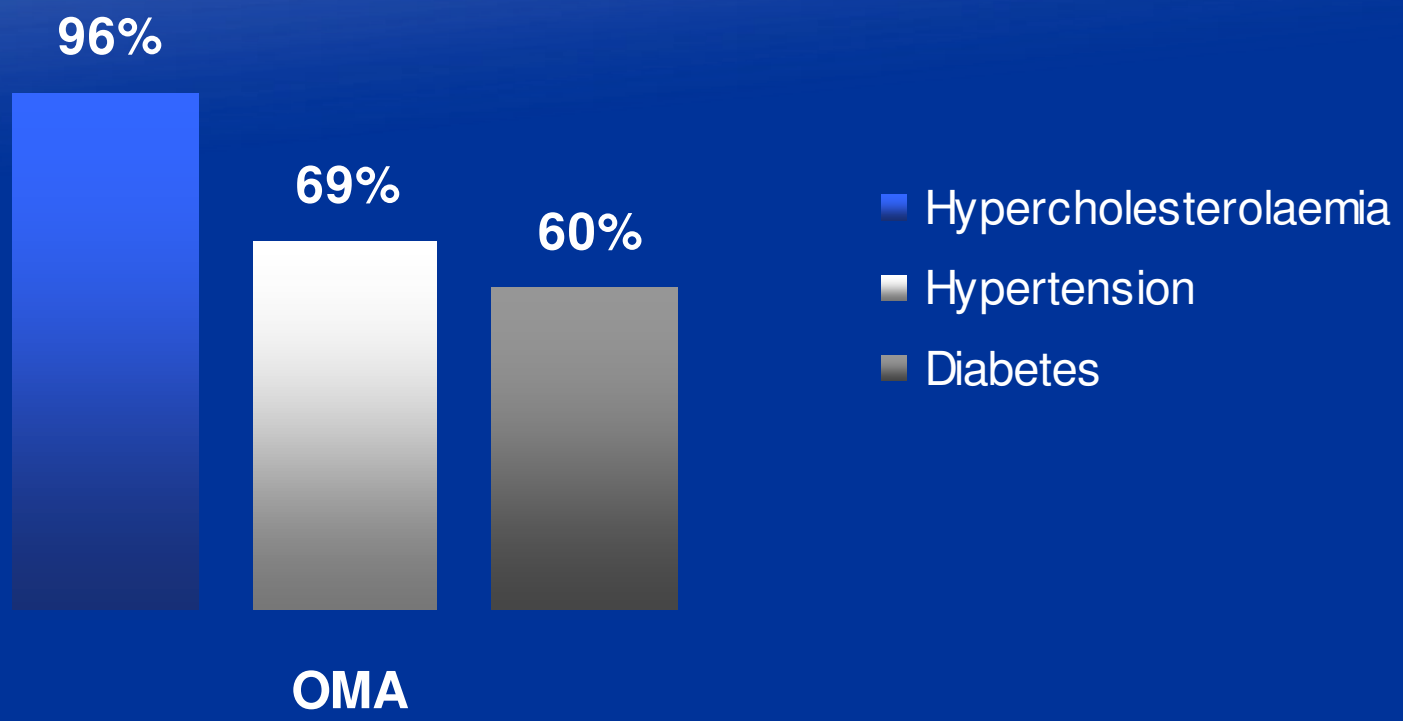
Prevalence of Undiagnosed NCD risk factors in Oman



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Cancer IN EMR

- In EMR, cancer is the 4th ranked cause of death after cardiovascular diseases, infectious/parasitic diseases and injuries.

- Cancer kills each year in the Region, more than HIV/AIDS, tuberculosis and malaria combined.

The global and regional strategic direction

- A 2% annual reduction in chronic disease death rates, over and above projected trends to 2015. This goal, if achieved, would result in aversion of 2.3 million deaths in EMR.

This goal was formally endorsed by the ministers of health in 2006 (RC 53).

Regional Strategy for cancer control

1. The burden of cancer is high in the EM region and is likely to increase fast in the coming years
2. There is a wide diversity among EM countries in terms of data available, programs, resources and capacities for cancer control. Many countries have already programmes, but at different levels of development.
3. In almost all countries, cancers are detected late. This means increase in cost and in mortality.
4. Access to treatment is limited in many countries of the Region
5. There is limited access to palliative care due to misconception, health providers attitude, legislations and availability.

The Regional Strategy Guide Countries to

1. Establish the National Cancer Control Committee (NCCC),

2. Develop and implement the NCCP, which is an integrated set of activities covering:

   - → Primary prevention
   - → Early detection
   - → Diagnosis and treatment
   - → Palliative care
   - → Registries
   - → Research

DPAS regional framework for country action

- The Global Strategy on Diet, Physical Activity and Health (DPAS) was adopted by the 57th World Health Assembly (WHA) in 2004 but EM Region only OMAN has a national strategy based on DPAS

- Implementing DPAS in the EM Region will lead to a significant reduction in the mortality and morbidity of major NCDs and the NCD risk factors.
- The regional framework will support countries to develop culturally sensitive programs for DPAS implementation

Specificity in EM Region

Physical Activity

- In most countries it would be considered little out of place even for men are jogging on the side of the road-a normal practice witnessed in European and some Asian countries
- A culture of regularly going to the parks or open spaces and gymnasiums to engage in physical activity is not prevalent
- Opportunities (jogging tracks, Gyms, etc) for PA are also not available (or scanty) in many countries of the Region
- In case of women, in most countries, culturally it is not acceptable that women should resort to any form of physical activity in places where men are also present
- Even if women are convinced that regular physical activity is essential for improving quality of life and preventing NCDs, supportive environments to promote physical activity among women rarely exist.

Integration of NCD in PHC

- Avoidance of fragmentation of services and provision of services in a comprehensive approach rather than a collection of different diseases

- Health promotion, prevention and care services can be provided at the same place.

- High percentage of population use PHC(80%).

- PHC is more accessible and affordable and hence it has a drive to reach vulnerable populations

Package of essential NCD interventions

- For different Setting
- Different levels of resources
- To cover the complete spectrum of health needs
  - promotion,
  - prevention,
  - acute,
  - long-term,
  - rehabilitation,
  - palliative,

Challenges

- Lack of enough national policies for NCD prevention and control
- Poor Fundings
- Re orientation of the health system from acute to chronic diseases.
- Dealing with NCDs is beyond the capacity of the health sector alone. Necessary interventions should come from other sectors, e.g. ministries of industry, commerce, agriculture, justice, etc.

- The lack of sufficiently effective, safe, easy to use, and inexpensive medications is another important challenge Lack of financing PHC
- Skills of PHC providers
- Equipment, medicines
- deficiency/ nonexistence of inter sectoral collaboration **within Health system**

Challenges

- Strengthen community participation, and intersectoral action .
- Re orientation of the health system
- Dealing with NCDs is beyond the capacity of the health sector alone. Necessary interventions should come from other sectors, e.g. ministries of industry, commerce, agriculture, justice, etc.

Conclusions

1. We Lack of reliable data for advocacy
2. Resources / funding
3. Political instability
4. We need to create supportive environment
5. We need to focus on training health professional
6. We Lack of guidelines, tool
7. We need to change community / society perception

The epidemiologic transition
(Omran, 1971)

Change in the balance of disease in a population

from

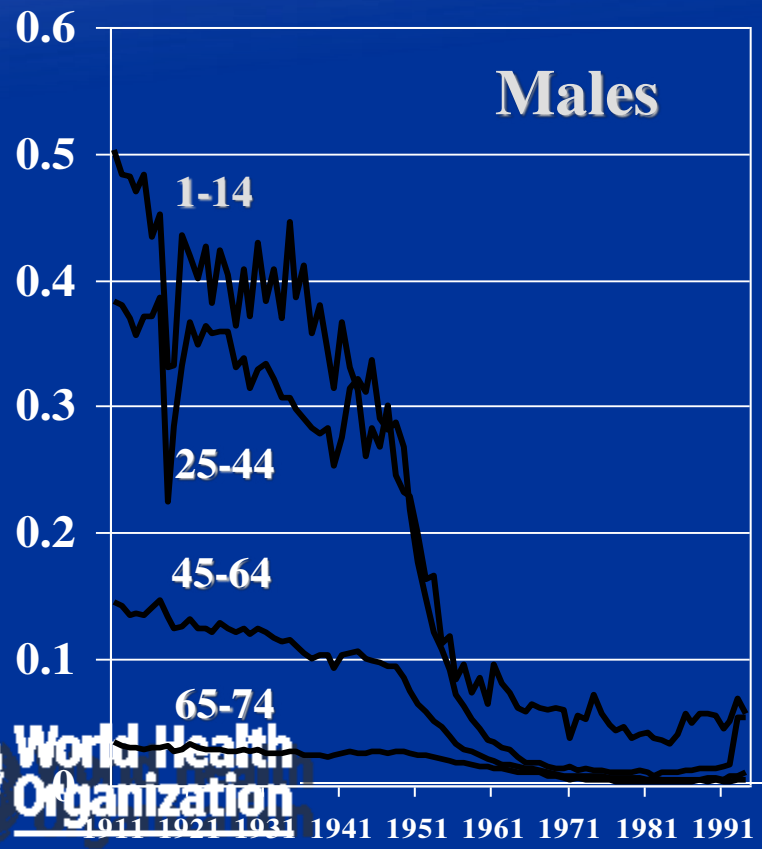
communicable diseases

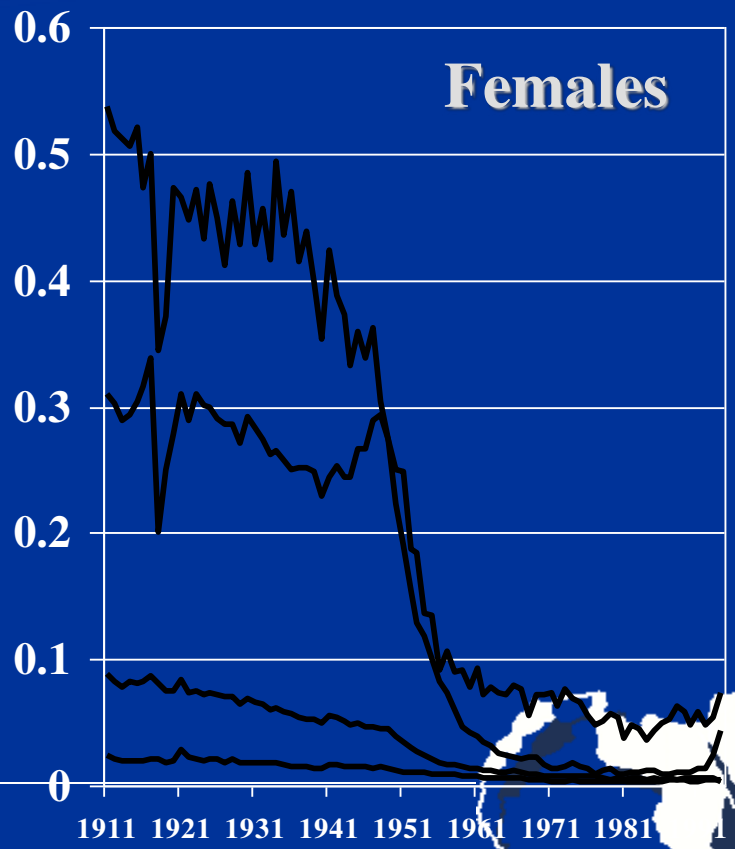
to

non-communicable disease

Decline in proportion of total mortality due to infectious diseases

England & Wales, 1911-94, by age





Non-communicable diseases as % of all deaths by global region (all ages)

WORLDWIDE	**59%**
N.America; W Europe	88%
China, W Pacific, + some SE Asia	75%
Latin America + Caribbean	67%
S E Asia including India	51%
Sub-Saharan Africa	21%

Drivers of the epidemiological transition in low and middle income countries

- Population ageing
- Major socio-economic changes (especially urbanisation)
  - changes in risk factors such as diet, physical activity, smoking etc.

Global Burden of Disease (GBD) Study

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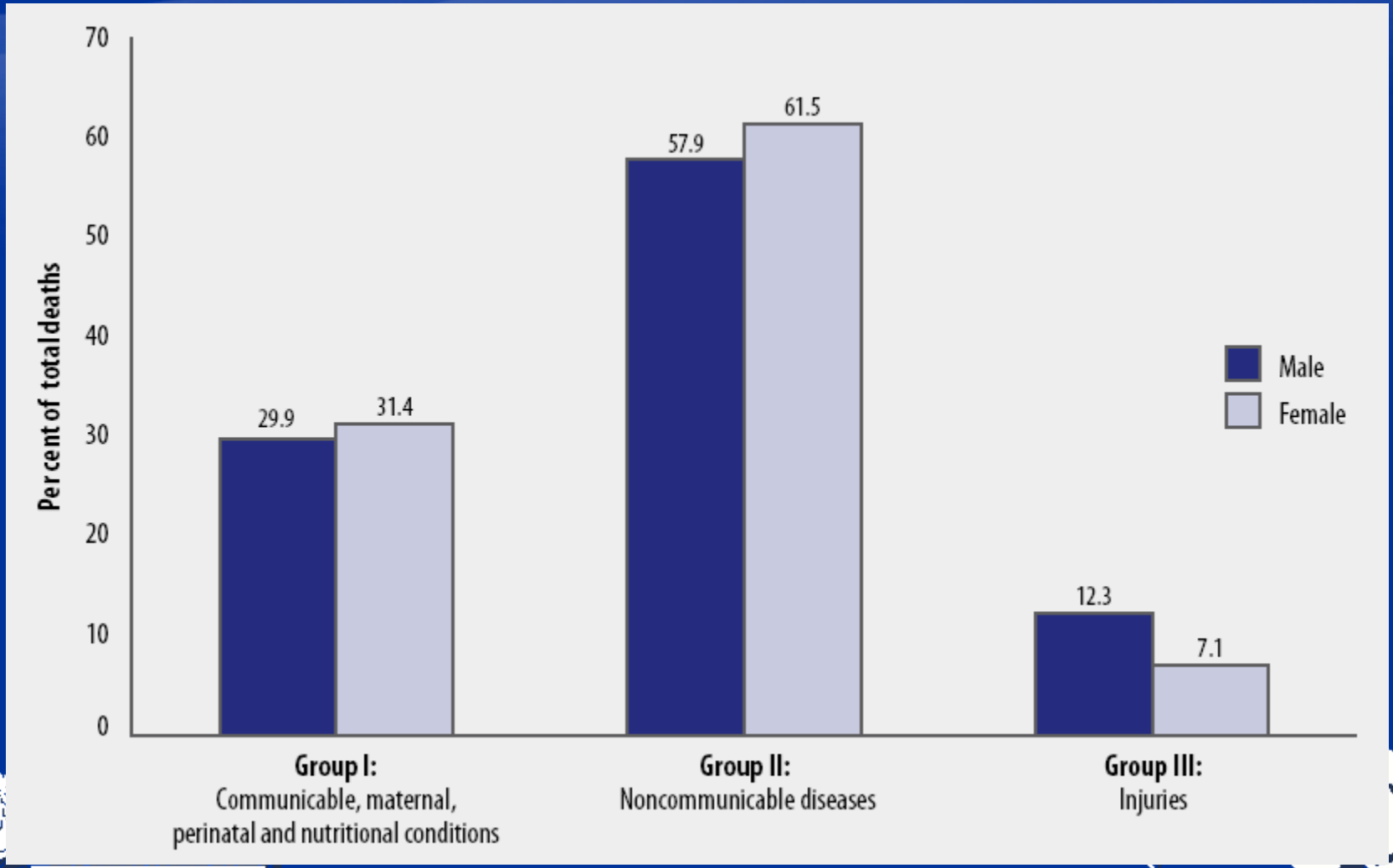
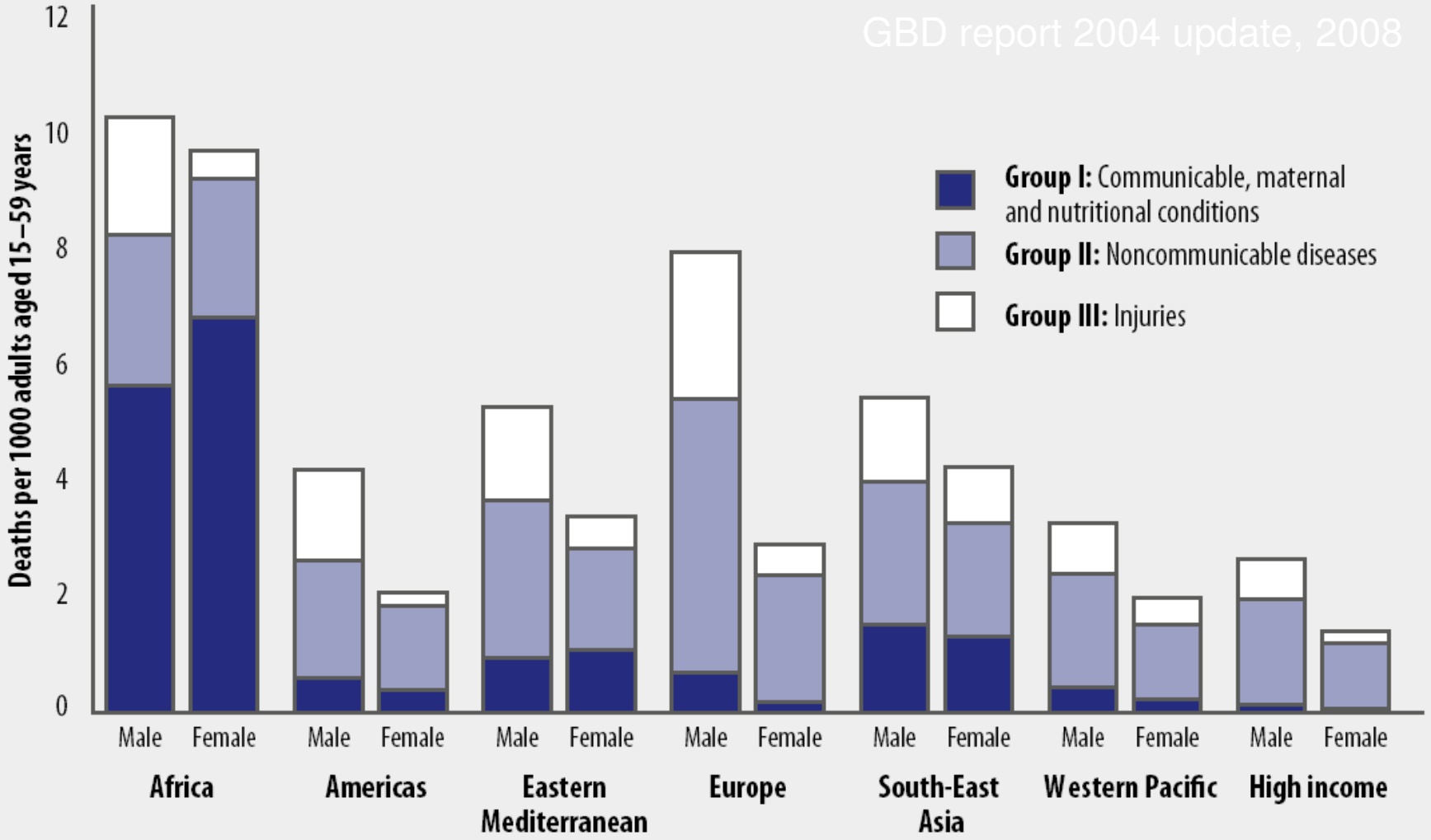
GBD 2001 mortality estimates

- 107 countries had collected “useable” information on cause of death from registration systems
- 55 countries (42 in sub Saharan Africa) no information on adult mortality
- Estimates based on many assumptions and extrapolations

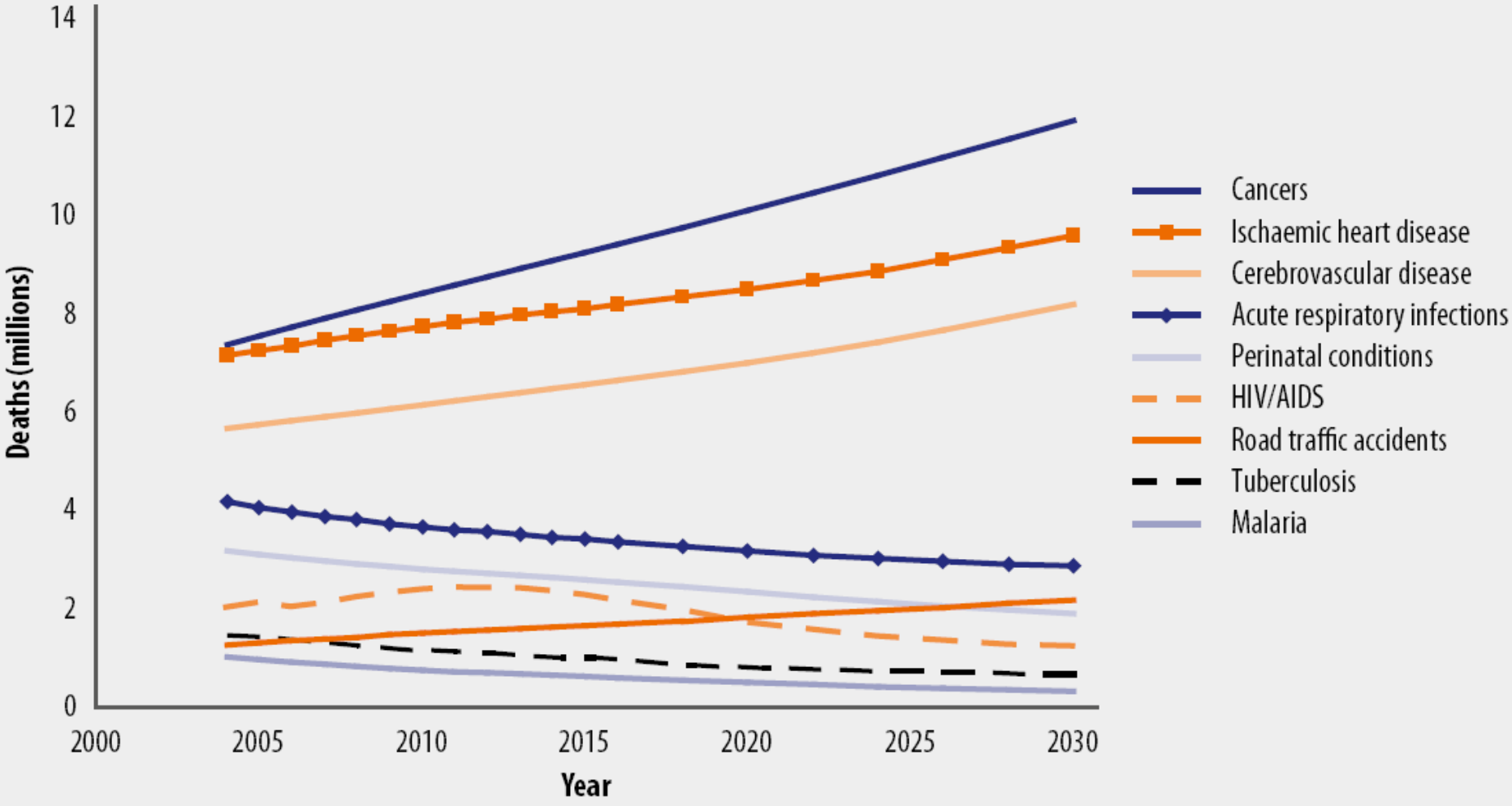
Distribution of deaths in the world by sex, 2004



Mortality rates among men and women aged 15–59 years, region and cause-of-death group, 2004

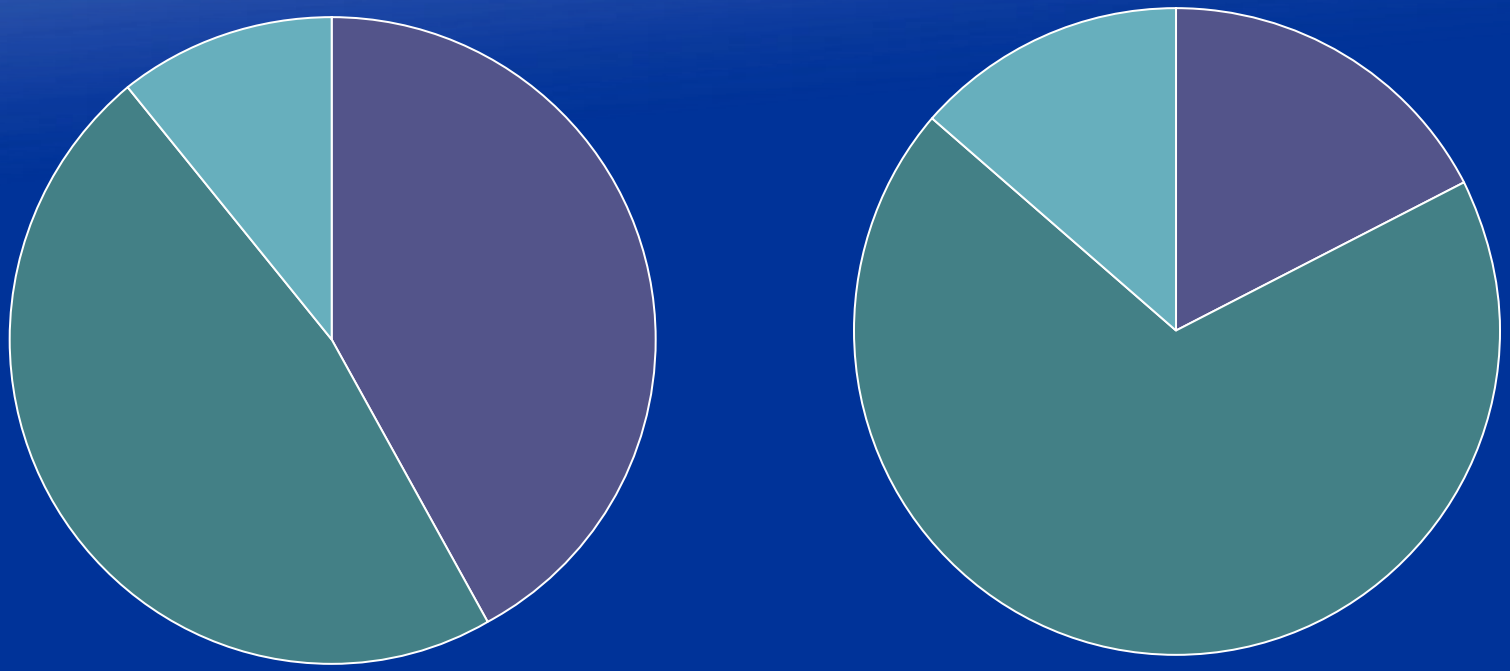


Projected global deaths for selected causes, 2004–2030

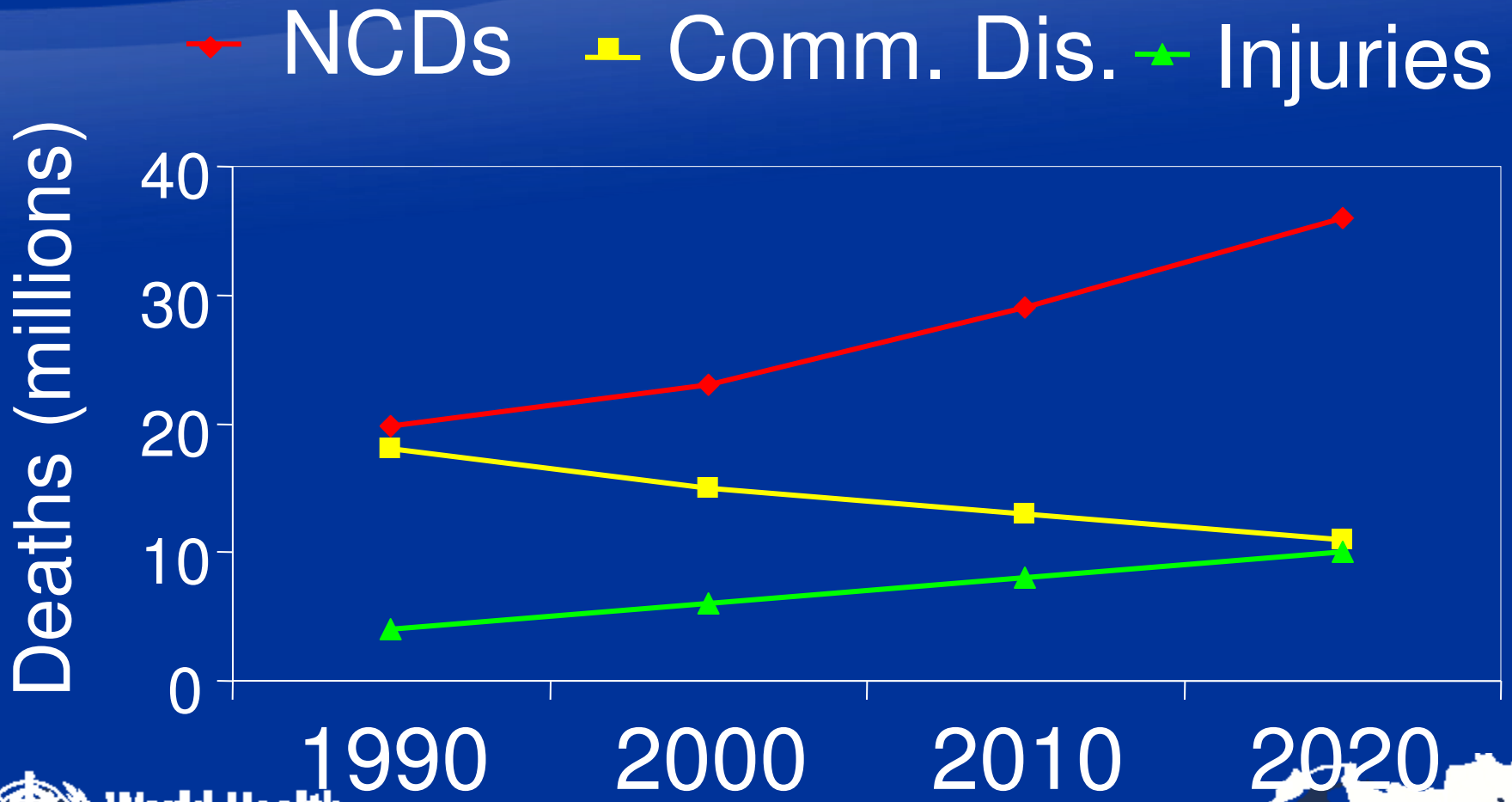


GBD report 2004 update, 2008

DALYs in Developing Areas (Disability-adjusted life year)



Trends in Death in Developing Areas



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Global Burden of Disease

Things are getting worse not better

World tobacco deaths, if current smoking patterns continue

2000-2025	**~150M**
2025-2050	**~300M**
2050-2100	**>500M**
TOTAL for the 21st century	**~1000M (1 billion)**
Compare with 20th century total	~100M (0.1 billion)

Summary

- Non-communicable diseases are now the most common cause of death world wide
- Increasing rates in low and middle income countries because of change in lifestyles (urbanisation)
- Key risk factors have very large effects
- Interventions are effective and can reduce burden
- Tools needed to combine results and have la studies

Thank you for your attention!

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