



Quarterly NCD Report

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Introduction

How do we face two concurrent pandemics? Mitigating the burden of NCD in the background of COVID-19

The WHO has reported that services for NCD in many countries was disrupted during the COVID-19 pandemic response in availability and accessibility to NCD care and is tragic given that patients with NCD are at a higher risk of morbidity and mortality due to COVID 19. This is a threat to countries such as Sri Lanka where a significant proportion of the population are over 60 years of age and are likely to be living with multiple co-morbidities. It is a delicate balance between minimizing unnecessary exposure and providing essential services.

In addition to increased risk of severe COVID-19, people with asthma/COPD could have an acute exacerbation if infected with coronavirus. Therefore, continuation and full adherence to controller medication with proper inhaler technique should be reiterated. In addition to the best practices of optimal glycemic control, patients with diabetes should be provided self-management guidance on identifying symptoms of hypoglycemia, hyperglycemia, regular foot care and healthy coping strategies. Individuals with cardiovascular risk factors and disease have higher rates of depression and other mental health conditions. This is compounded by the stress and anxiety imposed by uncertainty and social isolation. It is important that healthcare providers inquire about and address problems related to emotional wellbeing of patients at risk of cardiovascular events. Individuals with chronic kidney disease (CKD) are three times more likely to develop severe symptoms of COVID-19 than others and provision of continued access to dialysis is critical.

Reassurance needs to be given to dialysis patients that precautions are in place to ensure their safety during dialysis. In addition, all patients with NCDs should be provided helpful information on adopting healthier lifestyle such as quitting smoking and alcohol, taking a healthy diet, being physically active, get enough sleep and doing things that keep them happy.

Medicine should be prescribed for a longer duration (two months) for those who do not require urgent consultations/investigations. Mechanisms should be established to home deliver medicines to extremely vulnerable patients using postal /pharmacy delivery services, or a young and healthy person could visit hospital clinic with clinic records and collect medicine on behalf of the patient. Telemedicine should be offered at all possible opportunities to minimize unnecessary crowding at NCD clinics. Patients with NCDs should continuously be encouraged on medication compliance, to contact their care provider if any concerns arise and reassured that if they need to visit the hospital in an emergency safety measures are in place.

During the pandemic situation, it is important to consider palliative care as having similar priority as emergency care, since patients with palliative care needs could deteriorate rapidly. It would be a timely effort to strengthen services such as wound dressing, measuring BP/blood sugar levels etc. to NCD patients with limited mobility living in the community. There is growing evidence about the effective use of task shifting/task sharing for NCD care such as blood pressure measurement in the community by allied health professionals e.g. nurses, and community health workers.

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Screening of eligible participants

Cumulative percentage of eligible participants screened

Screening for chronic NCDs is conducted in healthy lifestyle centers. The 35 years and above age group is considered as the target population eligible for screening, which is estimated as 40% of the mid-year population. A total of 264,265 participants were screened during 1st to 3rd quarter of 2020 and the estimated mid-year population for the year 2019 was used for the calculations.

Table 1 shows the cumulative number of eligible participants screened from the year 2011 to 2020.

Table 1: Eligible participants screened from the year 2011 to third quarter 2020

Year	Eligible participants screened (%)	Cumulative number of eligible participants screened	Cumulative % of eligible participants screened from the target population ¹
2011	131,144 (2.6 %)	131,144	2.6 %
2012	203,939 (4.0%)	335,083	6.6%
2013	336,446 (6.6%)	671,529	13.2%
2014	383,161 (7.5%)	1,054,690	20.7%
2015	391,260 (7.7%)	1,445,950	28.4%
2016	540,535 (10.6%)	1,986,485	39.0%
2017	493,965 (9.7%)	2,480,450	48.7%
2018	511,438 (10.0%)	2,991,888	58.8%
2019	605,148 (6.9%)	3,597,036	41.2%
2020 (Q1-Q3)	264,265 (3.0%)	3,861,301	44.3%

¹ This percentage is calculated from the cumulative number of all eligible participants screened from the year 2011 to 2019. Target population of 40 to 65 age group is calculated from the mid-year population as indicated by 2012 Census (5,089,860) up to 2018. From 2019, target population of 35 years and above group is calculated from the total estimated mid-year population for 2019 calculated based on the Census of Population and Housing 2012 (8,721,200).

Percentage of eligible participants screened in 1st-3rd quarters, 2020

Figure 1 shows the distribution of percentage of eligible participants screened by district while

Figure 2 depicts the distribution of percentages of eligible male and female participants screened by district in 1st to 3rd quarters in 2020. Of the target population, only 3.0 % (264,265) was screened which included 186,208 (70.0%) females and 78,057 (30.0%) of males. Polonnaruwa, Hambantota and Mannar were the districts with best coverage.

Figure 1: Distribution of percentage of eligible participants screened by district in 1st-3rd quarters, 2020

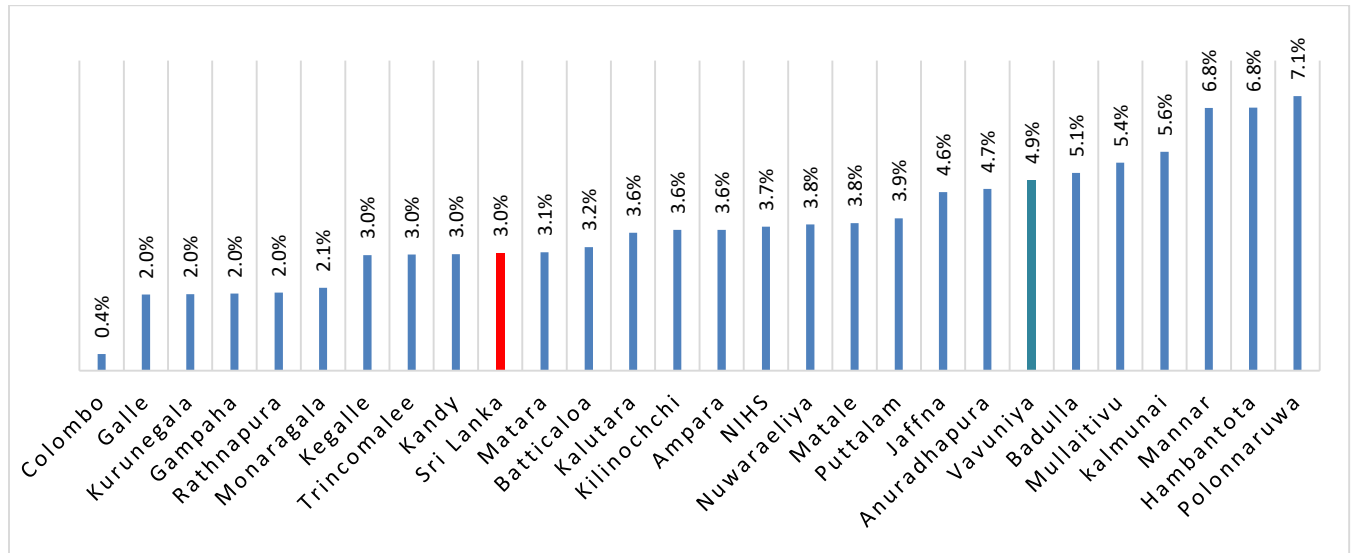
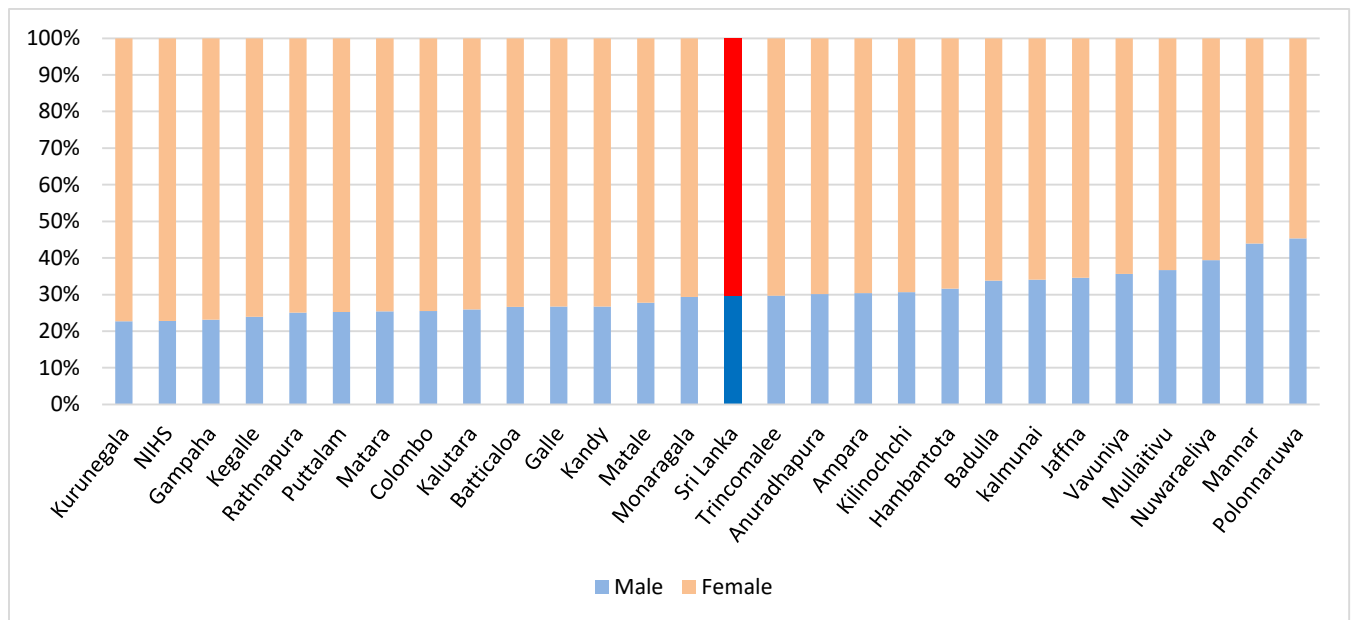


Figure 2: Distribution of percentage of eligible male and female participants screened by district in 1st-3rd quarters, 2020

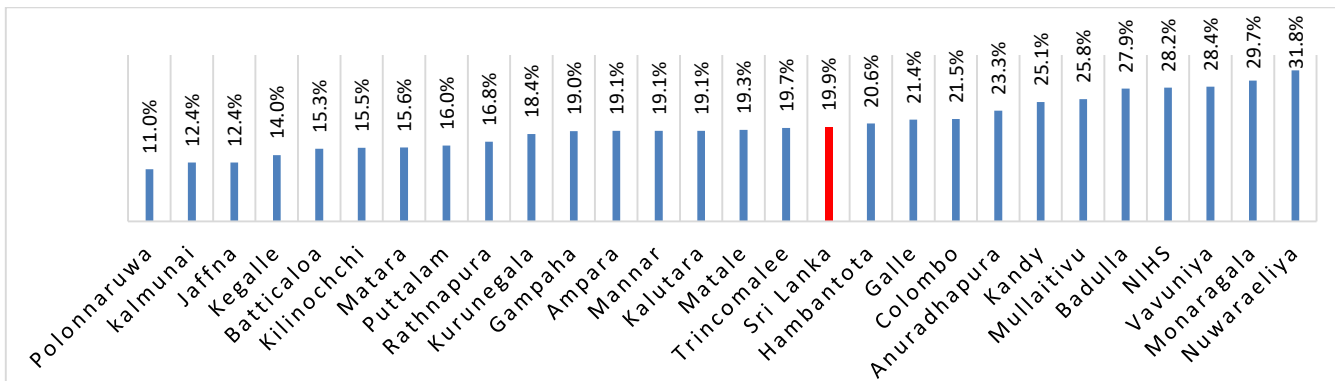


Screening for risk factors

Tobacco Smoking

Out of the total eligible population screened, 6.4% (n=18,307) were tobacco smokers². From the eligible male population screened 17,050 (19.9%) were tobacco smokers while among the eligible female population screened only 1,257 (0.6%) were tobacco smokers.

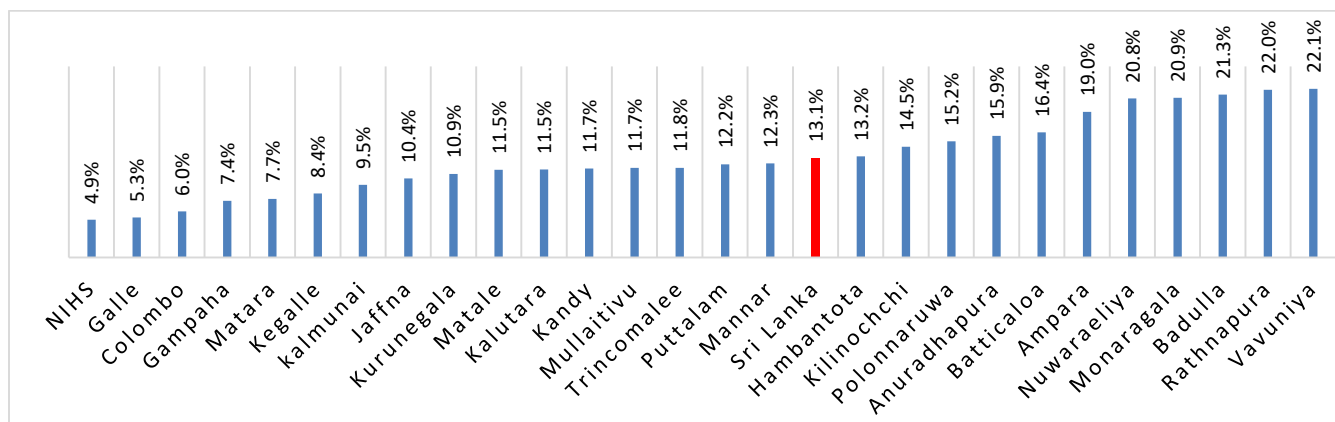
Figure 3: Distribution of percentage of male tobacco smokers among the total eligible male population screened by district in 1st-3rd quarters, 2020



Chewing Tobacco (with or without betel)

Among the eligible population screened 37,686 (13.1%) chew tobacco (with or without betel)³ while 25.3% (n=21,687) males and 7.9% (n=15,999) females chew tobacco among the respective eligible populations screened.

Figure 4: Distribution of percentage of participants chewing tobacco among the eligible population screened in the districts in 1st-3rd quarters, 2020



² Current tobacco smokers or those who have quit tobacco smoking less than a year before the assessment were considered as tobacco smokers. Since tobacco smoking among females was very low, the percentage of male smokers out of the eligible males screened is described to prevent the underestimation of the prevalence of smoking where the majority of eligible screened were females

³ Current tobacco chewers (with or without betel) and those who had quit tobacco chewing within a year of the assessment were considered as tobacco chewers.