



Quarterly NCD Report

A publication of the *Strategic Management and Information Unit*,
Non-Communicable Disease Unit
Ministry of Health
No. 385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10, Sri Lanka.
Tele/Fax: +94 11 2669599, Email: ncdunit@gmail.com



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Introduction

Has the impact of injuries on the spread of COVID 19 been adequately considered?

Injuries are the leading cause of hospitalization in Sri Lanka. It has been estimated that millions of people seek medical care due to injuries every year. Injuries has no boundaries; any individual is at risk for injuries irrespective of age, gender, cultural and economic status, health condition etc. Of all injuries, most of the injuries occur at home, on roads and at work places.

COVID 19 is the major public health issue of global concern today. It infects millions and kills thousands of individuals daily. Available statistics shows that the number of home injuries has increased during the period when public movements in the country were restricted as part of the Covid 19 pandemic prevention strategy. If more people are unnecessarily subjected to home injuries, the strategies adopted to prevent Covid 19 may be challenged, and people may be exposed to COVID 19 unnecessarily. As people seek treatment at health facilities, they are at higher risk for exposure to COVID 19, and the virus can be transmitted by asymptomatic individuals in health care facilities. If public transport is used especially Three-wheels of which the public mostly consider bringing patients to hospitals, it may put themselves in to a higher risk for exposure to COVID 19.

People may fail to follow guidelines imposed on prevention of COVID 19 if people gather at the place, where the injury has taken place. People may not help the injured or may not give appropriate first aid due to the fear of exposure to COVID 19; hence the condition of the victim may get worsened. If the victim needs emergency care, it is not possible to measure the COVID risk adequately (especially, if details of the victim cannot be obtained), health care workers may be more at risk for exposure to COVID 19 unnecessarily. If the vulnerable groups are infected with COVID 19 after injuries, they may be at higher risk for development of dangerous consequences. As more resources at hospitals are utilized for the management of patients with COVID 19, there may be limitations in hospital resources for victims of injuries. Due to the disruption of social services, there is a higher possibility of worsening the disease conditions and disabilities.

Although almost all injuries are predictable and preventable when proper safety measures are taken, injuries are not given adequate priority. Therefore, it is essential to take immediate action to implement a better injury prevention and management program before the problem becomes uncontrollable.

Dr Samitha Siritunga, Consultant Community Physician, National Programme Manager (injury prevention and management), Directorate of NCD

Health Message: "All physical activity counts"; Physical activity can be done as part of work, sport and leisure or transport (walking, wheeling and cycling), as well as every day and household tasks.

Screening of eligible participants for chronic NCDs

Screening for chronic NCDs is conducted in healthy lifestyle centers. There are 1022 Healthy Life Centers in Sri Lanka with majority of them functioning in primary care institutions. 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 62,094 participants were screened during 1st quarter of 2021 and the estimated mid-year population for the year 2020 was used for the calculations. *Table 1* shows the cumulative number of eligible participants screened from the year 2011 to first quarter 2021.

Table 1: Eligible participants screened from the year 2011 to first quarter 2021

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	321,055 (3.7%)	3,918,091	44.2%
2021 Q1	68,039 (0.78%)	3,986,130	45.5%

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). From 2020, target population of 35 years and above group is calculated from the total estimated mid-year population for 2020 calculated based on the Census of Population and Housing 2012 (8,767,600).

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 quarter in 2021. Of the target population, only 0.78 % (68,039) was screened which included 50,191 (69.08%) females and 22,462 (30.92%) of males. Polonnaruwa, Batticaloa and Kalmunai were the districts with best coverage.

Figure 1: Distribution of percentage of eligible participants screened by district in 1st quarter, 2021.

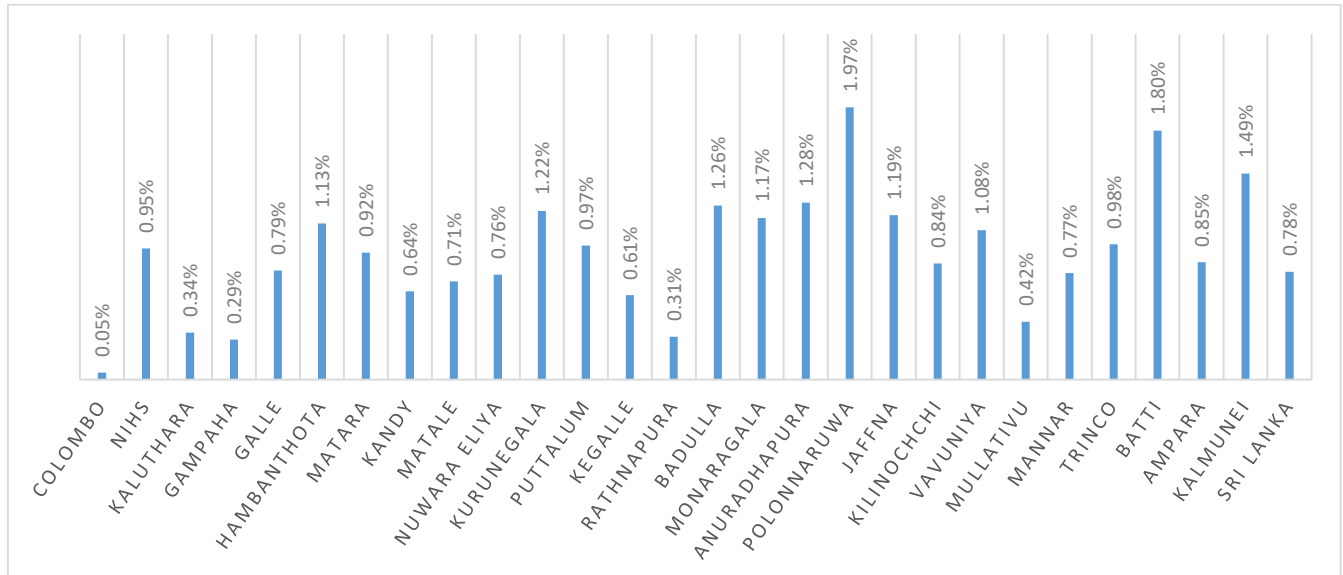
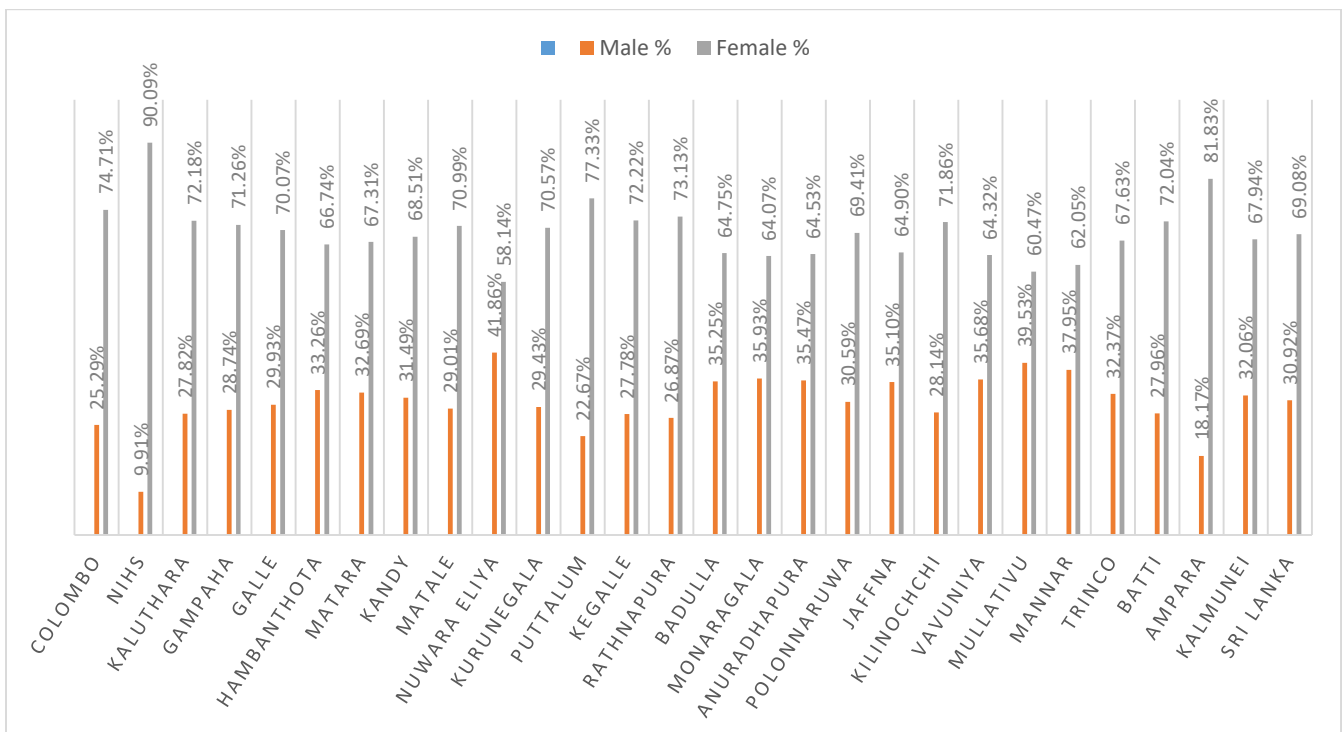


Figure 2: Distribution of percentage of eligible male and female participants screened by district in 1st quarter, 2021.

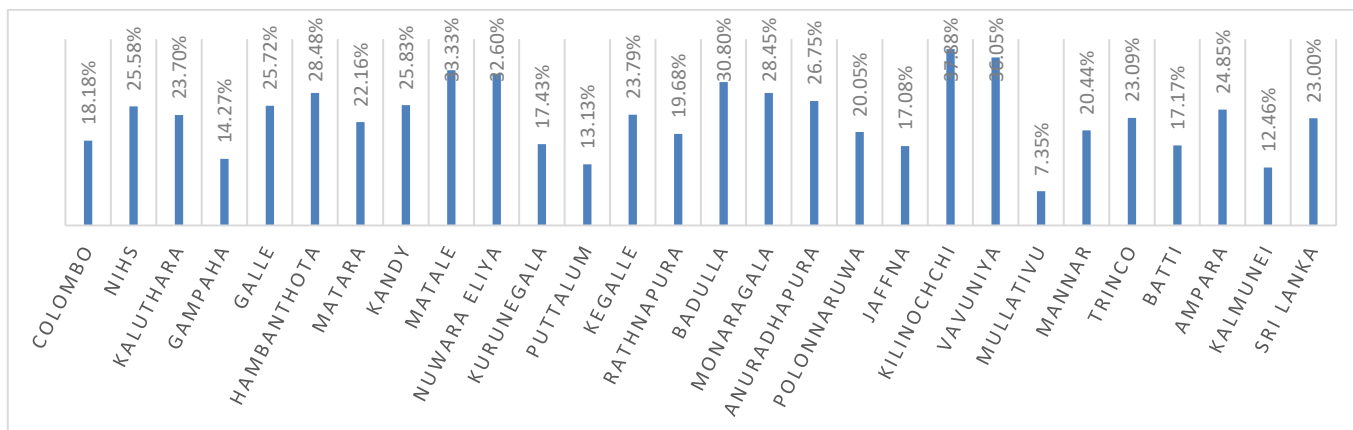


Screening for risk factors

Tobacco Smoking

Out of the total eligible population screened, 7.26% (n=5,275) were tobacco smokers². From the eligible male population screened 5,166(23.0%) were tobacco smokers while among the eligible female population screened only 109 (0.22%) were tobacco smokers.

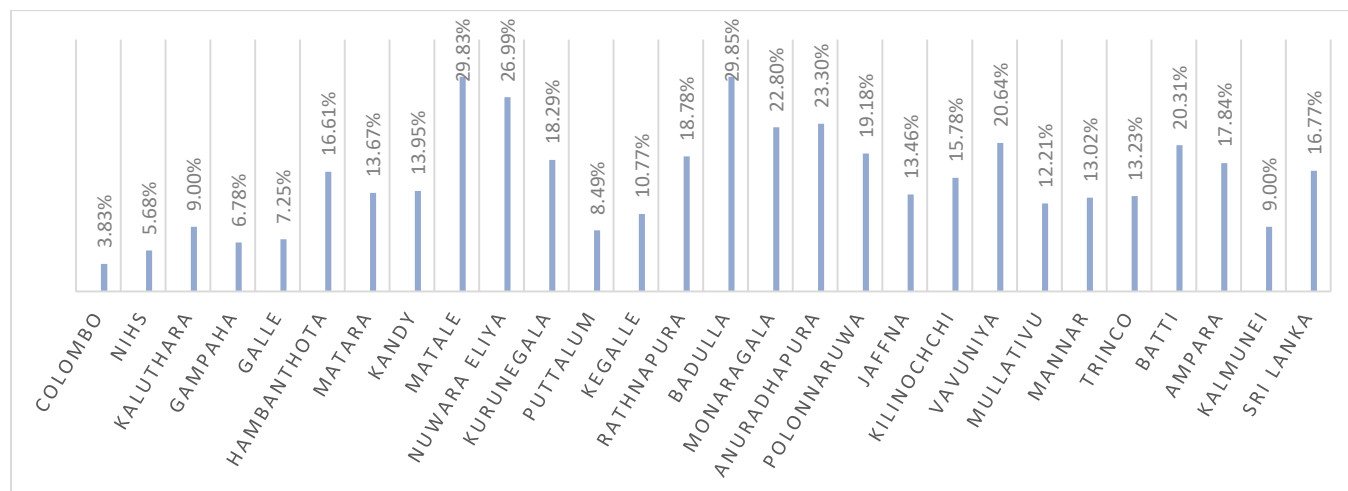
Figure 3: Distribution of percentage of male tobacco smokers among the total eligible male population screened by district in 1st quarter, 2021



Chewing betel (with or without tobacco)

Among the eligible population screened 12,187 (16.77%) chew betel (with or without tobacco)³ while 32.14% (n=7,220) males and 9.90% (n=4,967) females chew betel among the respective eligible populations screened.

Figure 4: Distribution of percentage of participants chewing betel with or without tobacco among the eligible population screened in the districts in 1st quarter, 2021



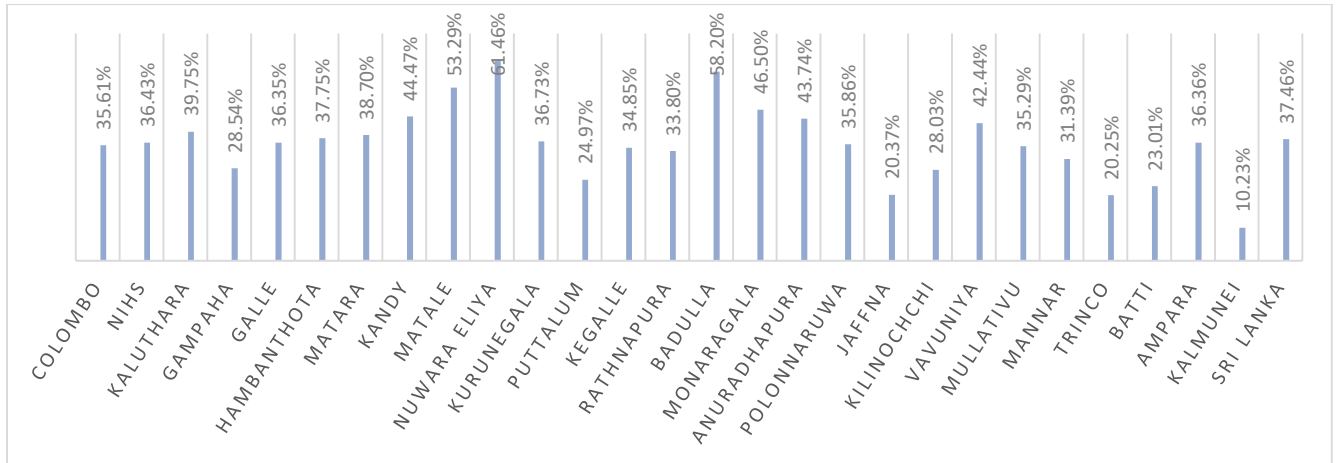
² All current tobacco smokers and those who have quit tobacco smoking less than a year before the assessment were considered as tobacco smokers. Since tobacco smoking among females was very low, the percentage of male smokers out of the eligible males screened is described to prevent the underestimation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

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

Alcohol use

Of the eligible population screened 11.75% (n=8,538) were alcohol users⁴. There were 0.25% (n=123) female and 37.46% (n=8,415) male alcohol users among the respective eligible populations screened.

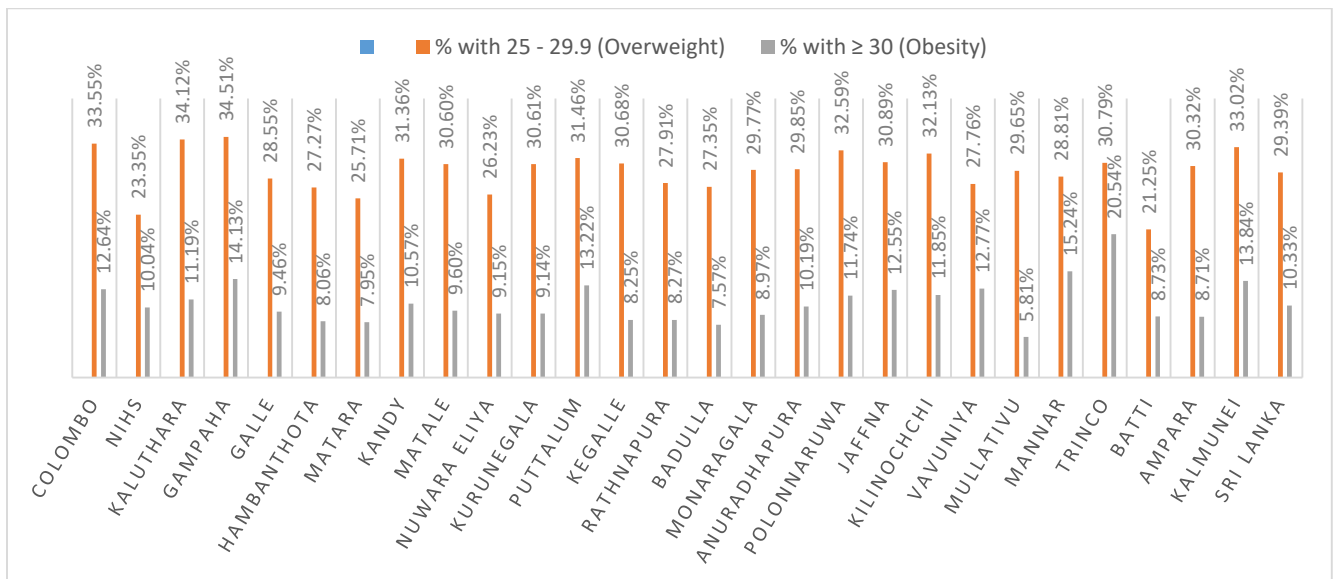
Figure 5: Distribution of percentage of male alcohol users among the eligible males screened by the districts in 1st quarter, 2021



Overweight and obesity

Of the eligible population screened 21,206 (29.39%) and 7,449 (10.33%) were found to be overweight⁵ and obese⁶ respectively. Prevalence of obesity was 6.18% (n=1,380) among males and 12.18% (n=6,069) among females screened.

Figure 6: Distribution of percentage of participants with overweight and obesity among the eligible population screened by districts in 1st quarter, 2021



⁴ Current alcohol users and those who had quitted alcohol use within a year of the assessment were considered as alcohol users. Since alcohol usage among females was very low, the percentage of male alcohol users out of the eligible males screened is described to prevent the underestimation of the prevalence of alcohol use where the majority of eligible screened were females.

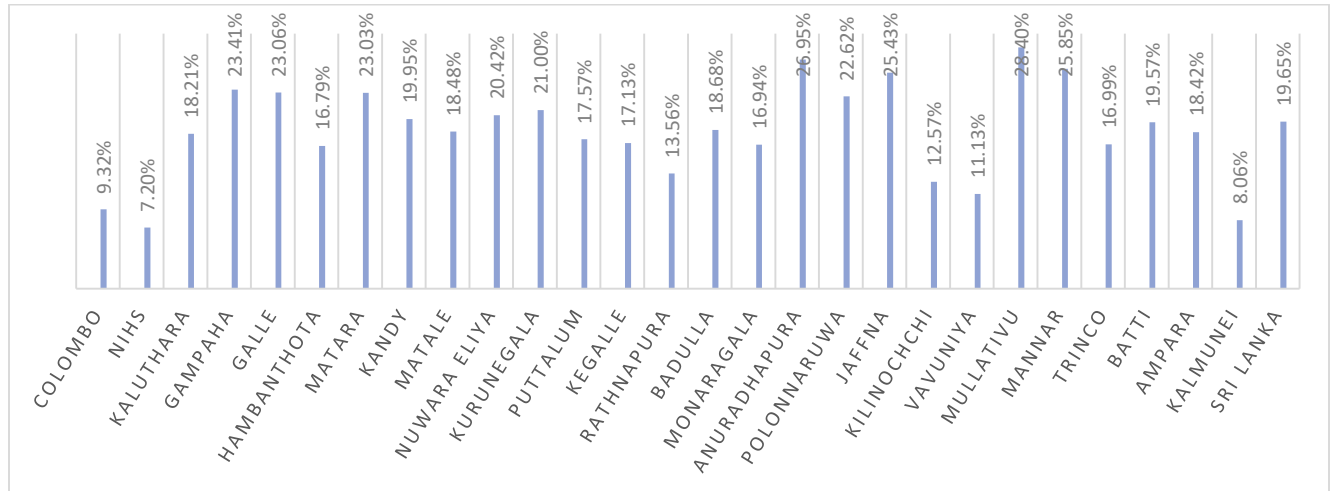
⁵ BMI between 25 to 29.9 kg/m² was considered as overweight.

⁶ BMI of 30 kg/m² or above was considered as obese.

High Blood pressure⁷

Of the eligible population screened, 13,838 (19.65%) had hypertension. Among the participants screened 21.95% (n=4,817) males and 18.61% (n=9,021) females had high blood pressure among the respective eligible populations screened.

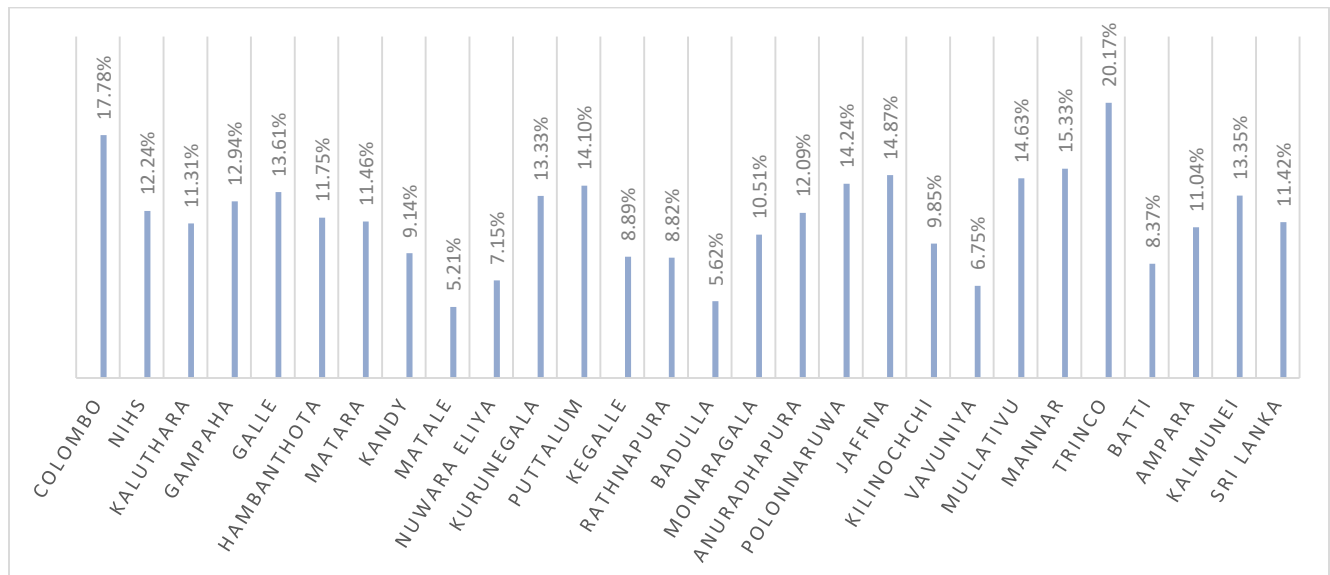
Figure 7: Distribution of percentage of participants with high blood pressure among the eligible population screened by districts in 1st quarter, 2021



High blood sugar (diabetic range)⁸

Of the eligible population screened, 8,524 (11.42%) had FBS (Fasting Blood Sugar) or RBS (Random Blood Sugar) values in the diabetic range. Among the participants screened 11.07% (n=5,711) females and 12.18% (n=2,813) males had high blood sugar values.

Figure 8: Distribution of percentage of participants with high blood sugar among the eligible population screened by districts in 1st quarter, 2021



⁷ Blood pressure of $\geq 140/90$ mmHg was considered as high blood pressure.

⁸ FBS values ≥ 126 mg/dl or RBS values ≥ 200 mg/dl were considered as high blood sugar values or blood sugar values in the diabetic range.