

# Non-Communicable Diseases and Conditions

## ABSTRACT

Non-communicable diseases (NCDs) are the leading causes of death and the central issue in contemporary and future public health globally. NCDs are amenable to health promotion, prevention, and medical interventions. Improved social conditions, quality of diet, body weight, smoking cessation, and increased physical activity can greatly reduce the burden of NCDs. Dramatic reductions in mortality from heart disease, stroke, and cancers in the past half-century have extended length and quality of life. NCDs caused by infections include cancer of the stomach, liver, and cervix, opening up new methods for prevention. Scientific breakthroughs in genetics and molecular biology will provide new opportunities for success in detecting and treating NCDs. Increasing rates of obesity and diabetes mellitus pose serious challenges for NCD control through health promotion and reducing social inequalities. Astonishing success in the control of NCDs has made a New Public Health an actuality, providing great hopes for future success.

## SUPPORT MATERIAL

### Student Competencies: Transferable Knowledge and Skills

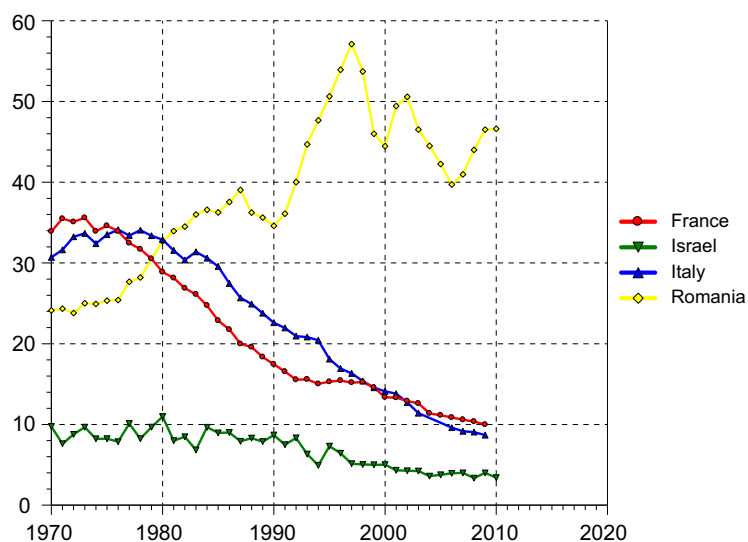
The following are points of emphasis highlighting key principles that public health graduates are expected to understand and apply into practice. The key points arise from this chapter and other studies in specialized courses, seminars, readings during public health education, and continuing education. The selected skills and knowledge are divided into two parts. The first consists of core questions pertaining to immediate student requirements, while the second refers to competencies essential for successful public health practitioners. These include competencies recommended by the American Public Health Association in 2007, as well as those of the European Association of Schools of Public Health and the Public Health Agency of Canada's 2008 Report on Core Competencies. For more detailed competencies please consult the Association of Schools of Public Health website at: <http://www.asph.org/document.cfm?page=851>

### Part I: Core Questions

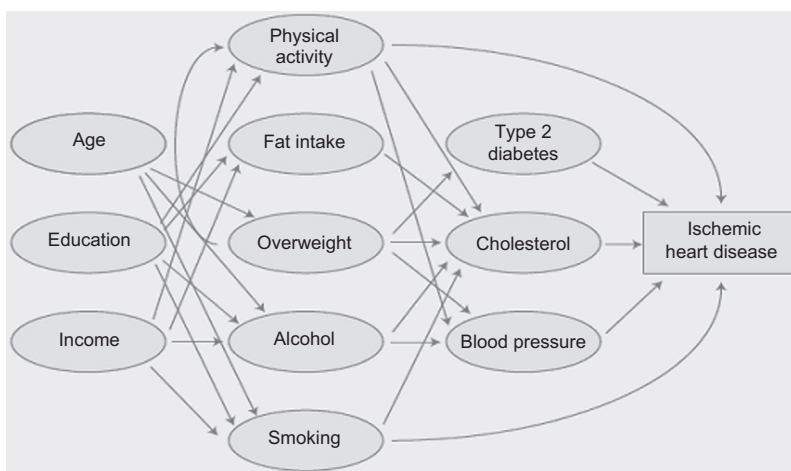
1. What are the most common causes of death in industrialized countries, and what trends have occurred in their prevalence over the past 30 years?
2. Chronic disease is the leading cause of morbidity and mortality globally. Discuss three demographic or epidemiological contributing factors.
3. Describe lifestyle-related risk factors for chronic disease and provide examples of public health intervention strategies to target these behaviors.
4. Discuss the link between chronic and infectious disease and describe future research directions.
5. What are the most common causes of death and illness in males and females between the ages of 15 and 44, and what are the potential public health interventions?
6. Describe major elements of preventive programs aimed at cardiovascular, liver, lung disease, and cancer.
7. Describe primary, secondary, and tertiary prevention for diabetes and its complications.
8. Describe the role of socioeconomic factors in chronic diseases. How do these factors apply even when there is universal access to medical care?
9. Describe primary, secondary, and tertiary prevention programs pertaining to:
  - (a) cardiovascular diseases
  - (b) cancer
  - (c) diabetes
  - (d) trauma
  - (e) disabling conditions.
10. How would you apply the changing patterns of chronic disease to health policy and resource allocation?

### Part II: Knowledge and Skills

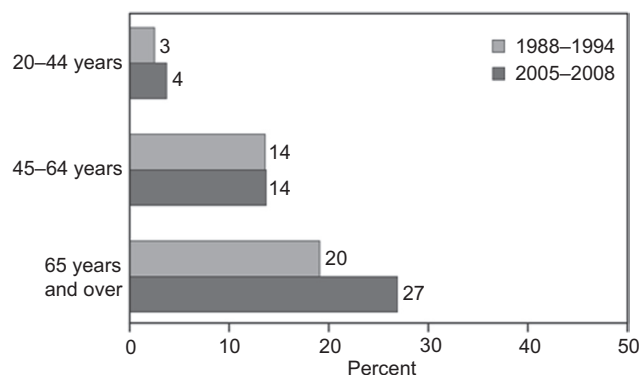
1. Recognize the centrality of non-communicable disease as a major cause of death in developing and developed countries.
2. Conceptualize and execute targeted educational public health campaigns for cross-cutting risk factors such as smoking, unhealthy diet, and physical inactivity.
3. Recognize the increasingly understood link between infectious and chronic disease and be able to translate this knowledge into public awareness campaigns (e.g., human papillomavirus and cervical cancer, cancer of colon and colonoscopy).



**FIGURE 5.14** Standardized mortality rates (per 100,000 population) from chronic liver disease and cirrhosis, selected European countries, 1970–2010. Source: World Health Organization, European Region. Health for All database (HFA-DB). Copenhagen: WHO Regional Office for Europe; January 2013. Available at: <http://data.euro.who.int/hfad/>



**FIGURE 5.21** Ischemic heart disease: major causative agents and factors. Note: Arrows indicate interactions between causes. Source: World Health Organization. Global health risks: mortality and burden of disease attributable to selected major risks. Geneva: WHO; 2009 Available at: [http://www.who.int/healthinfo/global\\_burden\\_disease/GlobalHealthRisks\\_report\\_full.pdf](http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf) [Accessed 21 October 2012].



**FIGURE 5.23 Diabetes prevalence among adult age groups, USA, 1988–1994 and 2005–2008.** Source: Centers for Disease Control and Prevention. Health, United States, 2010: with special feature on death and dying. Table 50. Hyattsville, MD: US DHHS, NCHS; February 2011. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK54380/#morbidity.s3> and <http://www.ncbi.nlm.nih.gov/books/NBK54380> [Accessed 21 October 2012].

4. Appreciate the role of community collaborations in promoting population health.
5. Advocate for evidence-based social changes that improve the health of individuals and communities.
6. Champion the role of prevention in promoting a healthy community.
7. Endorse lifestyle behaviors that promote individual and population health and well-being.
8. Understand and value multicultural perspectives and sensitivities on health.

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### Box 5.16 Impact of Targeted Pesticide Bans in Sri Lanka

Sri Lanka experienced an eight-fold increase in suicides between 1950 and 1995, with pesticides used in over two-thirds of cases. Importation of highly or very hazardous pesticides was gradually reduced starting in 1991, with a total ban on importation and sale in 1995, which resulted in a sharp decline in suicide deaths; but hospital admissions and the in-hospital death rate for self-poisoning increased. With the ban, farmers began to use endosulfan, a class II moderately hazardous insecticide, resulting in an increase in self-poisoning which is harder to treat. In 1998 endosulfan was banned, leading to a decrease in suicide deaths including in-hospital deaths. Between 1996 and 2005, compared to 1986–1995, there was a reduction of 20,000 suicides, which was not associated with other societal factors, and there was no decrease in agricultural output.

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