REORIENT HEALTH SERVICES

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NCD IN MALAYSIA

- About 70% of total MOH's health clinic attendances are related to NCD
- NCD accounts for over 20% of total hospitalization in MOH hospitals (excluding normal deliveries)
- Heart disease and stroke are in top five most common cause of death in MOH hospitals
- Heart disease and stroke also most common cause of premature death (<60 yrs)
- Malaysia ranks 6th among Asian countries with high adult obesity rate

PREVALENCE OF SELECTED NCD & NCD RISK FACTORS IN MALAYSIA

	NHMSII (1996)	MANS (2003)	NHMSIII (2006)
Age group	≥18 yrs	≥18 yrs	≥18 yrs
Smoking	24.8%	NA	21.5%
Physically inactive	88.4%	85.6%	43.7%
Overweight (BMI ≥ 25kg/m^2 & <30kg/m^2)	16.6%	27.4%	29.1%
Obesity (BMI 30kg/m^2)	4.4%	12.7%	14.0%
Hypercholesterolaemia	NA	NA	20.6%

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Prevalence of Physical Inactivity : 43.7% or 5.5 million Malaysians

* Previous data cannot be compared as methodology differed between surveys

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Increasing trend of over-weight among Malaysians from 1996 to 2006.
Indians > Malays > Chinese

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In 2006, prevalence of obesity among adults 18 years & above is 14.0% or 1.7 millions, a relative increase of over 200% from that of 10 years earlier (4.4%)

PREVALENCE OF DIABETES IN MALAYSIA (1986-2006)

	NHMS I (1986)	NHMS II (1996)	NHMS III (2006)	NHMS III (2006)
Age group	≥ 35 yrs	≥ 30 yrs	≥ 18 yrs	≥ 30 yrs
Prevalence	6.3%	8.3%	11.6%	14.9%
Known diabetes	4.5%	6.5%	7.0%	9.5%
Newly diagnosed	1.8%	1.8%	4.5%	5.4%
Impaired glucose tolerance*/Impaired fasting glucose**	4.8%*	4.3%*	4.3%*	4.7% **

Prevalence of diabetes among adults 30 yrs & above is 14.9% or 1.4 million Malaysians (≥30 yrs). Relative increase of 80% from 10 yrs earlier (8.3%)

PREVALENCE OF HYPERTENSION IN MALAYSIA (1986-2006)

	NHMS I (1986)	NHMS II (1996)	NHMS II (1996)	NHMS III (2006)	NHMS III (2006)
Age group	≥25 yrs	≥18 yrs	≥30 yrs	≥18 yrs	≥30 yrs
Definition (mmHg)	160/95	140/90	140/90	140/90	140/90
Prevalence	14.4%	29.9%	32.9%	32.2%	42.6%

Prevalence among adults ≥30 yrs and above is 42.6%. A relative increase of 30% from that of 10 yrs earlier (32.9%). Estimated 4.8 million Malaysians (≥30 yrs)

OTTAWA CHARTER REVISITED

- Build healthy public policy – *health is incorporated into all public policy decisions*
- Create supportive environments – *conserve & capitalise health maintenance enabling resources*
- Strengthen community action – *empower them to make informed choices*
- Develop personal skills – *develop skill to influence community decisions (health literacy)*
- Reorient health services – *operate from a base of evidence on what works best to foster health*

Health promotion priorities

- Promoting physical activity and active communities
- Promoting healthy eating, accessible and nutritious food
- Promoting mental health and wellness
- Reducing tobacco-related harm
- Reducing harm from alcohol

Roles of health sector

- Move increasingly in a health promotion direction beyond clinical and curative services/illness oriented perspective of care delivery
- Stress the social, economic & environmental aspects of health
- Support the needs of individuals and communities for healthier life
- Stronger attention to health promotion research
- Change professional education and training to respond to prevailing health problems

Development

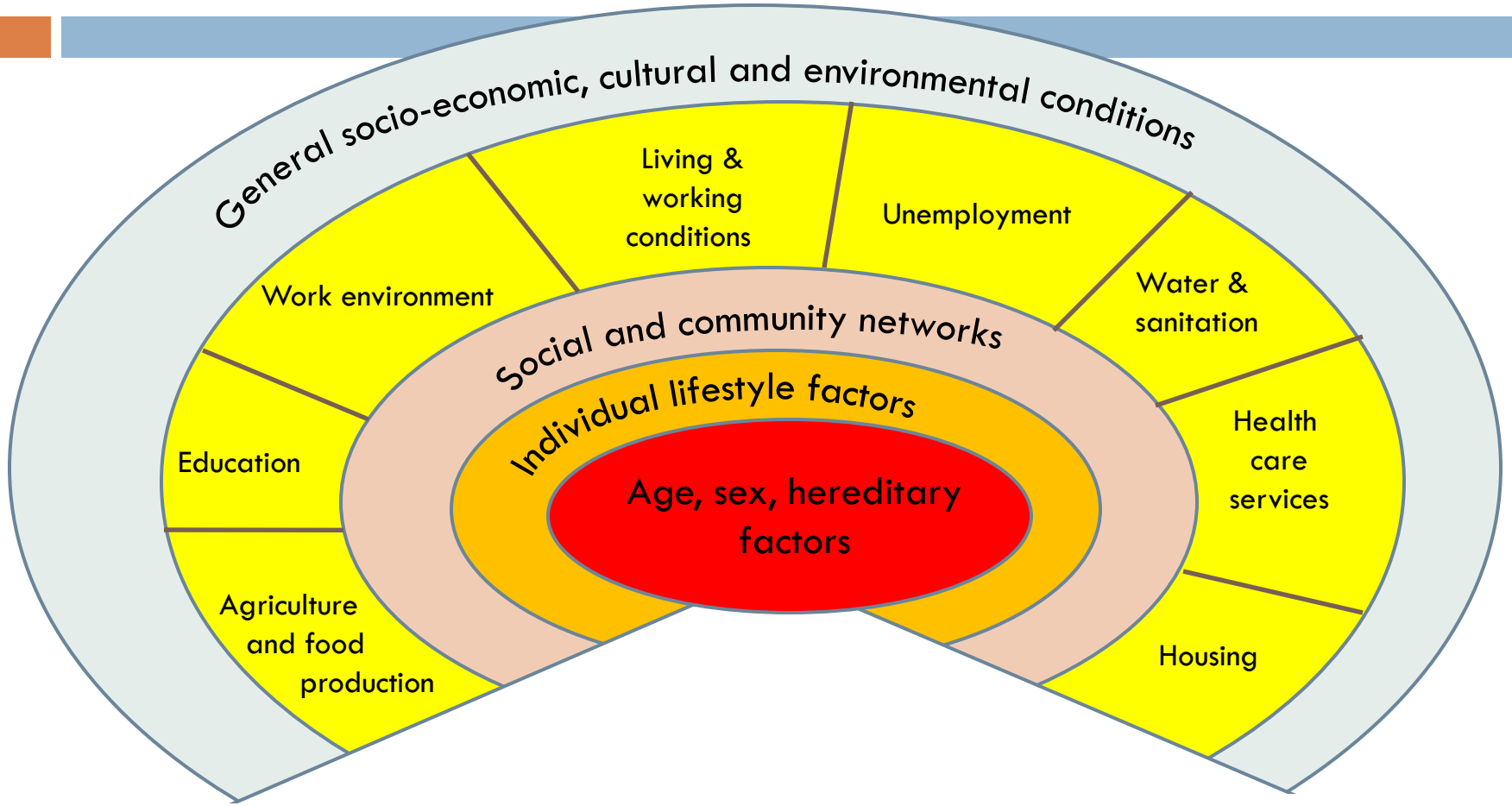
- Increasing recognition of multi-factorial influences on health
- Basic approaches to improve health (Labonte, 1992)

  - medical – *cure disease*

  - behavioral – *promote healthy lifestyles*

  - socio-environmental – *totality of health experiences*
- Limited contribution of medical & behavioral model to more equitable health outcomes between groups
- More emphasis on environmental variables

SPHERES OF INFLUENCE TO HEALTH



Source : Dahlgren & Whitehead, 1999

APPROACHES TO PROMOTIONG HEALTH

	Medical	Behavioural	Socio-env
Focus	Individuals, unhealthy lifestyle	Individuals & group conditions	Communities & living
How problems are defined	Diseases (physiological RF – CVD, Cancer Medical definition	Behavioral RF – smoking, poor eating habit Expert definition	Socio-env RF – poverty, stressful living Psychosocial Risks- isolation, low self-esteem Community involved in problem definition
Main strategies	Illness care, screening	Mass media campaigns, SM, policy advocacy	Encourage community organisation, action & empowerment. Political action & advocacy
Success criteria	Decreased morbidity, mortality, physiological RF	Behavior change, decline in RF for disease	Individuals have more control, stronger social network, collective action for health, decreased inequity between population groups

Priority actions

- Promote social responsibility for health
- Increase investment for health development
- Consolidate and expand partnership for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

Community development

- Major obstacles to health are structural – economic & political conditions of people's lives
- Shift from provider-consumer (power differential)
- Emphasis on partnership, collaboration, negotiation
- *Foster community competence*
- *Advocate decision making skills & encourage indigenous leadership*

INTERSECTORAL COLLABORATION

- Health, education, housing, social services, transportation, environmental planning, local government
- Fluid and flexible network of coalitions
- Also provide health information & programs to other sectors
- Health issues contribute to “value added” effect

PUBLIC PARTICIPATION

- Work in partnership with community long before programs are implemented
- Respect individual preference for decision- making
- Build community self-confidence
- Play advocacy, mediator & facilitator role
- Equity in relationship – partner
- Work towards making their concerns and issues visible

EVIDENCE-BASED PRACTICE

- Strengthen research capacity and capability
- Target group profiling
- Intervention studies – “upstream” and “downstream” interventions
- Support for policy development and evaluation
- Dissemination and applicationof research findings

TRAINING

- Strengthen training to meet the needs of HP practitioners
- Prepare them to shape programs and policies for improving population health
- Outcomes expected :

  - educate educators, practitioners and researchers as well as to prepare HP leaders and managers
  - contribute to policy that advances HP for public health
  - serve as focal point for HP to improve public health
  - work collaboratively with others
  - engage actively with communities to improve health
  - assure life-long learning for HP workforce

THANK YOU