ORIGINIAL RESEARCH


GBD 2016 Occupational Risk Factors Collaborators

ABSTRACT

Objectives This study provides an overview of the influence of occupational risk factors on the global burden of disease as estimated by the occupational component of the Global Burden of Disease (GBD) 2016 study.

Methods The GBD 2016 study estimated the burden in terms of deaths and disability-adjusted life years (DALYs) arising from the effects of occupational risk factors (carcinogens; asthmagens; particulate matter, gases and fumes (PMGF); secondhand smoke (SHS); noise; ergonomic risk factors for low back pain; risk factors for injury). A population attributable fraction (PAF) approach was used for most risk factors.

Results In 2016, globally, an estimated 1.53 (95% uncertainty interval 1.39–1.68) million deaths and 76.1 (66.3–86.3) million DALYs were attributable to the included occupational risk factors, accounting for 2.8% of deaths and 3.2% of DALYs from all causes. Most deaths were attributable to PMGF, carcinogens (particularly asbestos), injury risk factors and SHS. Most DALYs were attributable to injury risk factors and ergonomic exposures. Men and persons 55 years or older were most affected. PAFs ranged from 26.8% for low back pain from ergonomic risk factors and 19.6% for hearing loss from noise to 3.4% for carcinogens. DALYs per capita were highest in Oceania, Southeast Asia and Central sub-Saharan Africa. On a per capita basis, between 1990 and 2016 there was an overall decrease of about 31% in deaths and 25% in DALYs.

Conclusions Occupational exposures continue to cause an important health burden worldwide, justifying the need for ongoing prevention and control initiatives.

INTRODUCTION

A safe and healthy work environment is a fundamental right of all workers. Burden of disease studies are an important source of information on the level of ill health in communities and on the risk factors that contribute to this ill health.1 The results provide guidance to policymakers in terms of where resources might best be used and can provide insight into the effectiveness or otherwise of past interventions. The results can also be used to underpin studies of the cost of injury and illness.

Estimates of the worldwide burden of occupational disorders (diseases and injuries) suggest occupational risk factors make an important contribution to the burden of ill health,2–3 and there are large variations in and between countries in the estimated incidence of occupational disorders.4 Global estimates of economic costs arising from occupational disorders vary between 1.8% and 6.0% of gross domestic product.5 In principle, most occupational disorders can be prevented by means of control measures targeted at relevant risk factors.

Prior Global Burden of Disease (GBD) studies have estimated the global burden for 1990,6 and 2010,7 with the 2010 GBD study updated several times.8–11 Occupational risk factors formed one group of risk factors that was included in the GBD-related Comparative Risk Assessment (CRA) study, focused on 2000.9 The occupational risk factors included in GBD 2016 were carcinogens; asthmagens; particulate matter, gases and fumes (PMGF);
secondhand smoke (SHS); noise; ergonomic risk factors for low back pain; and risk factors for occupational injury. The study attempted to overcome some of the shortcomings associated with the earlier analyses, including some additional risk factors and associated outcomes and using modified methodology. The main GBD risk factors paper provides some high-level information on occupational risk factors. This paper and two companion papers describe in more detail the methods, results and strengths and limitations of the occupational risk factor analysis from GBD 2016.

METHODS
General approach
The GBD 2016 study evaluated the burden of disease (deaths or disability-adjusted life years (DALYs)) attributable to past exposure to various risk factors. Attributable burden was estimated by comparing observed health outcomes to those that would have been observed if a counterfactual level of exposure (the theoretical minimum risk exposure level (TMREL)) had occurred. ‘Occupational exposure’ was defined as being experienced in the course of an activity undertaken for pay, profit or kind. It excluded home duties. The burden of occupational disease for each risk factor–outcome pair was estimated using the population attributable fraction (PAF), that is, the proportion of deaths or DALYs that would not have occurred if exposure was at the TMREL; this was then used to estimate attributable numbers of deaths or DALYs. The PAF requires information on the relative risk of the disease due to the exposure of interest and the proportion of the target population exposed. The risk estimates (relative risks or ORs) were primarily obtained from published meta-analyses or pooled studies or, where these did not exist, key single studies were used. Where single studies were used, the chosen study was the best quality study (as judged by the Occupational Risk Factors Expert Working Group) with exposure circumstances that were assessed as most closely matching those assumed in the GBD study. For carcinogens, PMGF, noise and ergonomic risk factors related to low back pain, most relative risks used in the analysis compared occupationally exposed to non-occupationally exposed, assuming similar exposure durations and intensities across countries and regions. The same relative risks were assumed to apply for calculation of burden of deaths and of DALYs. High-income countries were defined as countries in the Australasia, high-income North America, Western Europe, and high-income Asia Pacific regions, and low and middle-income (LMI) countries as all other countries. Risk factor–outcome pairs were selected where there was evidence to suggest that the level of evidence supporting a causal association was sufficiently strong and the resulting burden was likely to be more than trivial.

PAFs were estimated for each age-sex-country group using the equation based on Levin:

$$ PAF = \frac{\sum_{x=1}^{e} RR(x)P(x) - 1}{\sum_{x=1}^{e} RR(x)P(x)} $$

where $P(x)$ is the proportion of persons exposed at level $x$ in the relevant population and $RR(x)$ is the relative risk corresponding to exposure level $x$.

Relative risks based on high exposed and low exposed, relative to those with background exposure, were used in lieu of more sophisticated measures of risk because the necessary quantitative information on exposure was not available. The age-sex-country-specific PAFs were multiplied by the total number of deaths in 2016 in the relevant age-sex-country group to produce the number of deaths in the age-sex-country-specific group for the relevant risk factor–outcome pair. These deaths in specific groups were summed to produce the total number of deaths from a given outcome resulting from the relevant exposure. This total was divided by the total number of deaths from all causes for a given outcome to produce an all-age PAF for the relevant risk factor–outcome pair. This was done separately by sex and for both sexes combined, and separately by country and region and for all regions combined. PAFs based on DALYs were calculated in the same way. A combined PAF for an outcome with multiple contributing exposures was calculated using the standard product-sum approach.

$$ PAF_{combined} = 1 - \prod_{k}(1 - PAF_k) $$

A different approach was used for occupational injury risk factors and resultant injuries, with information on the number of injuries coming directly from International Labour Organization (ILO) information, and for pneumoconiotic dusts and pneumoconiosis, with information estimated as part of the overall GBD estimates of prevalence and deaths for each included cause.

Results were calculated for all years from 1990 to 2016, inclusive; the 2016 findings are the focus of this paper. Only attributable burden in persons 15 years and above is included. Region-specific, sociodemographic index (SDI)-specific and global results are reported here. The SDI is a composite indicator of development status based on total fertility rate, mean education for those aged 15 years and older and lag distributed income per capita. The PAFs presented were based on DALYs unless otherwise indicated and were based on all ages. Per capita rates (age and sex standardised) were based only on persons aged 15 years and above, unless otherwise stated. The number, rate and proportion of the various outcomes each provide insight into different aspects of the burden, with the number reflecting absolute burden and the rates more useful when comparing burden between countries or between different time periods.

Employment data
For carcinogens, PMGF, SHS and noise, the proportion of ever-occupied persons was based on the estimated proportion of each national population in the workforce, the proportion of the workforce in specific industries and the proportion of workers estimated to be exposed in that industry. For asthmagens and ergonomic risk factors, the proportion currently exposed was based on the proportion of the workforce in specific occupations rather than industries. Information on industry (nine categories), occupation (eight categories) and the proportion of the population which was working (the Economically Active Population (EAP)) for each country was obtained from the ILO Labour Force. Employment data from the year being examined were used for all risk factors except carcinogens, for which information on employment in previous years was also included to take account of latency and persistent risk. Available occupation and industry information was available by sex but not age. The EAP was available separately for males and females and for each GBD age group. Where the ILO data did not provide sufficient information for a country, information was obtained from subnational data sources, supplemented where necessary by modelling on a preselected list of covariates (such as log lagged distributed income, education per capita and urbanicity). In particular, for China, subnational data were extracted at the province level using census and national population sample surveys. For India, there were no national labour force data, resulting in the estimates being based on models driven by country-level covariates.
Table 1  Global occupation-attributable deaths, DALYs and PAFs by risk factor and sex, 2016 (number, per cent and proportion (95% uncertainty interval))

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Deaths</th>
<th>DALYs</th>
<th>PAFs*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males†</strong></td>
<td><strong>Females</strong></td>
<td><strong>Total</strong></td>
<td><strong>%‡</strong></td>
</tr>
<tr>
<td>Carcinogens</td>
<td>274175</td>
<td>74566</td>
<td>348741</td>
</tr>
<tr>
<td>(215 339–333 928)</td>
<td>(60 870–89 775)</td>
<td>(282 253–414 071)</td>
<td>(4 375 804–6 734 491)</td>
</tr>
<tr>
<td>PMGF+SHS¶</td>
<td>343122</td>
<td>116958</td>
<td>460080</td>
</tr>
<tr>
<td>Injury risk factors</td>
<td>301043</td>
<td>31508</td>
<td>332550</td>
</tr>
<tr>
<td>Asthmagens</td>
<td>26103</td>
<td>11471</td>
<td>37574</td>
</tr>
<tr>
<td>(17 900–35 000)</td>
<td>(8000–15 200)</td>
<td>(28400–47 900)</td>
<td>(114100–207 300)</td>
</tr>
<tr>
<td>Pneumoconioses</td>
<td>18997</td>
<td>2491</td>
<td>21488</td>
</tr>
<tr>
<td>(15 500–22 700)</td>
<td>(2000–3200)</td>
<td>(17 900–25 400)</td>
<td>(149900–611 700)</td>
</tr>
<tr>
<td>SHS (excluding cancer and COPD***)</td>
<td>222933</td>
<td>109065</td>
<td>331998</td>
</tr>
<tr>
<td>Ergonomic risk factors</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Noise</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1186372</td>
<td>346058</td>
<td>1532431</td>
</tr>
<tr>
<td>(1 066 502–1 311 010)</td>
<td>(299 889–398 048)</td>
<td>(1 387 905–1 684 393)</td>
<td>(48 614 027–6 614 271)</td>
</tr>
</tbody>
</table>

*PAFs (%) based on DALYS.
†The numbers in parentheses are the 95% uncertainty interval.
‡Percentage of deaths due to occupational risk factors that were due to this risk factor.
§Percentage of DALYs due to occupational risk factors that were due to this risk factor.
¶Paclitaxel and epirubicin (PMGF) and second hand smoking (SHS) causing COPD.
**Carcinogens were responsible for the largest number of deaths in half the other regions. SHS and PMGF also were responsible for a considerable number of deaths (online supplementary table S1). This pattern was similar in terms of DALYs, with additional important contribution from ergonomic risk factors resulting in the greatest overall burden, as measured in DALYs, were injury risk factors (28%) and ergonomic risk factors (20%) (table 1).

The PAFs (based on DALYS) ranged from 3.4% for carcinogens to 19.6% for noise and 26.8% for ergonomic risk factors (table 1). The PAFs based on deaths ranged from 3.9% for carcinogens to 15.7% for PMGF and SHS resulting in COPD.

**Regions**
Carcinogens were responsible for the largest number of deaths in all high-income regions (primarily attributable to asbestos-related cancers, which comprised about 80% of all deaths due to carcinogens in these regions) but only one of the LMI regions (Central Europe). Injury risk factors caused the highest number of deaths in half the other regions. SHS and PMGF also were responsible for a considerable number of deaths (online supplementary table S1). This pattern was similar in terms of DALYs, with additional important contribution from ergonomic risk factors resulting in the greatest overall burden, as measured in DALYs, were injury risk factors (28%) and ergonomic risk factors (20%) (table 1).
factors resulting in low back pain. Carcinogens were responsible for the highest burden in three of the four high-income regions; in most other regions, injury risk factors were responsible for the highest or second-highest burden proportions (figure 2, online supplementary table S2).

The highest number of deaths and DALYs was in the regions with the largest populations—East Asia and South Asia. The highest rates of deaths were in Oceania, East Asia and South Asia, but rates were also high in most high-income regions, whereas for DALYs the highest rates were in Oceania, Southeast Asia and Central sub-Saharan Africa, and high-income regions had the lowest rates. Rates of both were highest in low and low-middle SDI regions (figure 3).

**Changes over time**

Between 1990 and 2016 there was a 16% increase in deaths and a 22% increase in DALYs attributable to occupational risk factors. However, rates provide more useful information as they take into account population changes. On a per capita basis, there was an overall decrease of about 31% for deaths and 25% for DALYs, and a considerable percentage decrease in burden, whether measured in deaths or DALYs, for most individual risk factors. The exceptions were SHS-related disease (excluding cancer and COPD), ergonomic risk factors and noise, all of which changed little (table 2).

The rates of deaths and DALYs fell across all regions, but the proportionate fall varied considerably between regions, ranging from 15% (Southern Latin America) to 54% (East Asia) for deaths and from 6% (Southern Latin America and Western sub-Saharan Africa) to 43% (East Asia) for DALYs (online supplementary table S3).

**DISCUSSION**

This analysis shows that occupational risk factors are responsible for a sizeable proportion of all ill health and injury across the world as measured by deaths (2.8%) and DALYs (3.2%). This is notwithstanding that it was not possible to include all potentially important occupational risk factors (considered below). Injury risk factors and ergonomic risk factors resulting in low back pain were responsible for the biggest overall burden, and PMGF and...
SHS resulting in COPD were the largest single category in terms of deaths related to occupational exposures. The total burden has risen considerably since 1990. However, when taking into account increases in the population, the per capita burden for all risk factors has actually decreased, though to varying extents. Since the exposure assessments are primarily based on occupation or industry, most of the changes reflect changes in the occupational and industrial distribution of workers as opposed to changes in exposure.

Other estimates of global occupational burden
The overall methods of the CRA 2000 study and the current study were similar, but there were some important differences in terms of the exposures and outcomes included, the risk measures (due to updates in the literature), the population numbers, the approach to estimating the population at risk (which was more detailed in the current study than was possible for the CRA 2000 study) and the approach to estimating the prevalence of exposure to asbestos. The CRA study estimated there were 820,000 deaths in 2000 from exposure to occupational risk factors, compared with the estimates in the current study—1.42 million deaths in 2000 and 1.53 million deaths in 2016. The differences arise mainly from the current study estimating twice as many deaths from cancer and 50% more deaths from COPD, and including SHS-associated outcomes apart from cancer and COPD (such as cardiovascular disease). Other estimates of global burden estimate a considerably larger burden of deaths, primarily attributable to a much broader inclusion of exposures and outcomes arising from less restrictive criteria for the strength of the required evidence and not including the equivalent of a counterfactual.

Implications and uses of the data
There are several clear implications of the results arising from this study. Most importantly, exposures at work remain an important risk factor for a number of outcomes in all regions of the world. The burden arising from carcinogens and noise, and to a lesser extent PMGF and SHS causing COPD, primarily reflects the effects of occupational exposures in past decades, but many of these exposures still occur. Published information does suggest average levels for many exposures have decreased over time, particularly in high-income countries, but much of the data are for inhalational exposures and many instances of high exposure remain. With the transition of much heavy industry and manufacturing from high-income to LMI countries, the adverse experience of high-income countries is likely to be reflected in the future burden for LMI countries unless significant steps are taken to eliminate the problem exposures where possible, and otherwise to control them effectively. Asbestos is a striking example, where current exposures continue in LMI countries, with a clearly predictable and devastating future burden if current and future exposures are not prevented.
addition, concerns regarding new exposures (e.g., nanoparticles) and new exposure situations (e.g., silica exposure from artificial stone bench tops) suggest that just controlling the exposures that are included in the current analysis will not eliminate all future ill health arising from occupational exposures.

This study does not provide information on the cost or technological feasibility of eliminating or reducing exposures, or on the uptake of known effective prevention strategies. Thus, it cannot fully inform priorities for resource allocation to decrease the burden from the risk factors considered in this study, assuming that deaths or DALYs preventable per unit expenditure would be taken into account. Nevertheless, the elimination of asbestos exposure is already well recognised as a priority, and the results presented here serve to further emphasise the importance of this. Excessive noise, many ergonomic exposures, injury risk factors and SHS exposures are clearly eminently preventable in many settings, and better control of them would be expected to lead to significant reduction in the burden of disease arising from occupational exposures affecting the global population. Most of the assessed exposures and the resulting burden are entirely or largely avoidable and in many instances the individual worker has little influence over the level of exposure experienced, emphasising the need for and importance of controls at the organisational and societal level.

Methodological considerations and limitations
In any study of the type presented here there are uncertainties arising from shortcomings in the data that necessitate significant assumptions. Those made in this study were based on available data and, where necessary, expert opinion of GBD authors. The main uncertainties in the data, and the potential implications of these, are briefly considered below. Where they could be quantified to some extent, they were incorporated into the uncertainty intervals. More detailed consideration of some of these issues is provided in the companion papers.

Workforce data
The workforce data came from the ILO database, supplemented, where necessary, by information from other sources such as regional surveys. For South Asia (which is predominantly India) and East Asia (which is predominantly China)—the two largest regions—there were limited available data. Some countries did have available data but only for broad industry and occupation...
briefly, the principal uncertainties are that there is a general lack and/or occupation were used as the sole or main basis for the
A major source of uncertainty stems from the fact that industry
Using industry and occupations as proxy measures for risk factors

Population at risk
The carcinogen analyses attempted to take into account the latency between exposure and occurrence of the related cancer when estimating the population at risk, and the fact that workers remain at risk of developing cancer long after they change jobs or leave the workforce, using estimates of workforce turnover and information on life expectancy for each region. The strengths and limitations of this approach, and of the approach to estimating exposure prevalence, are considered elsewhere.13,14 Briefly, the principal uncertainties are that there is a general lack of information on the latency of specific cancers and uncertainty about variation in turnover worldwide.

Using industry and occupations as proxy measures for risk factors
A major source of uncertainty stems from the fact that industry and/or occupation were used as the sole or main basis for the

Risk measures
The relative risk estimates came primarily from working cohorts of males in high-income countries and from a range of calendar time periods. The workers within the cohorts had a range of exposures and outcomes, but only for high-income countries and only on the basis of exposure prevalence, rather than on absolute exposure levels or cumulative exposures. For PMGF, prevalence data were based on limited published information modified by expert opinion. For noise, information was available for absolute exposure levels within different industries, but only for one (high-income) region, and the analysis did not take into account the likely latency of noise-induced hearing loss.

Exclusion of exposures and outcomes
There are many occupational exposures that are probably related to adverse health outcomes that were not included in the study reported here. These include International Agency for Research on Cancer Group 2A carcinogens (‘probably carcinogenic to humans’) associated with occupational exposures; infections arising from occupation; occupational exposures (apart from SHS) linked to ischaemic heart disease; pesticides; psychological and psychosocial

Table 2  Change in global occupation-attributable deaths and DALYs between 1990 and 2016 (per 100 000 persons) (number (95% uncertainty interval) and per cent)

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Deaths per 100 000 persons*</th>
<th>DALYs per 100 000 persons*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinogens</td>
<td>15.0 (12.1–18.1)</td>
<td>13.5 (11.0–16.0)</td>
</tr>
<tr>
<td>PMGF + SHS†</td>
<td>31.0 (25.8–36.5)</td>
<td>18.2 (15.0–21.9)</td>
</tr>
<tr>
<td>Injury risk factors</td>
<td>22.6 (22.1–23.2)</td>
<td>12.0 (11.8–12.3)</td>
</tr>
<tr>
<td>Asphmagens</td>
<td>2.2 (1.5–3.0)</td>
<td>1.4 (1.0–1.8)</td>
</tr>
<tr>
<td>Pneumoconioses</td>
<td>1.4 (1.1–2.1)</td>
<td>0.8 (0.7–1.0)</td>
</tr>
<tr>
<td>SHS (excluding cancer and COPD)§</td>
<td>12.8 (8.7–17.2)</td>
<td>12.6 (8.2–17.3)</td>
</tr>
<tr>
<td>Ergonomic risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noise</td>
<td>246 (172–338)</td>
<td>260 (182–358)</td>
</tr>
<tr>
<td>Total</td>
<td>84.9 (71.3–100.1)</td>
<td>58.6 (47.7–70.2)</td>
</tr>
</tbody>
</table>

*These rates are age and sex standardised.
†The numbers in parentheses are the 95% uncertainty interval.
‡Particulate matter; gases and fumes (PMGF) and secondhand smoke (SHS) causing chronic obstructive pulmonary disease (COPD).
§Diseases caused by SHS, excluding cancer and COPD.
DALY, disability-adjusted life year.
stresses; work organisation factors; and occupational exposures leading to musculoskeletal disorders (other than those affecting the lower back). These were excluded because there did not appear to be reliable data on one or both of the exposures or the associated risk measures; and/or because the level of evidence supporting a causal association was not considered sufficient. If a causal connection was accepted, many of these exposure-outcome pairs would be expected to result in a considerable underestimation of deaths and/or DALYs. Their exclusions might therefore be expected to have resulted in a considerable underestimation of the total burden arising from occupational risk factors. The most important exclusions in terms of numbers of deaths is likely to be shift work, with breast cancer the associated outcome; occupational exposure to the ultraviolet component of sunlight, leading to skin cancer; exposures such as psychosocial factors resulting in ischaemic heart disease; and possibly occupational exposure to herbicides and insecticides in relation to non-Hodgkin’s lymphoma. In terms of DALYs, psychological and psychosocial stresses leading to adverse mental health outcomes, occupational exposures leading to musculoskeletal disorders and heat-related disorders worsened by climate change would be expected to result in considerable burden.

Injury risk factors and injuries
Our estimates assumed the percentage (by age group and sex) of non-fatal injuries that were occupational equalled the percentage of fatal injuries that were occupational. Lack of data precluded a more refined estimation approach, but aggregate US data suggest that the assumption may severely underestimate non-fatal injuries (eg, in 1999, at ages 15–64, US occupational injuries accounted for 5.7% of injury deaths and 19.9% of medically attended injuries). Also, note that the estimates are likely to omit occupational injuries (and diseases) of sex workers and trafficked workers (who experience high rates of violent injury, sexually transmitted diseases and unintentional injury) and most active-duty military injury deaths.

Overall effect of the limitations
The extent and direction of bias potentially arising from the major limitations is difficult to estimate with confidence for most of these exclusions. Exclusion of some of the informal workforce, exclusion of some potentially important exposures and outcomes and use of fatal injury PAFs for non-fatal injury would all be expected to lead to an underestimation of the associated burden. The approach used to estimate the population at risk and using industry and occupation as proxy measures for the prevalence of exposure to risk factors could result in bias in either direction. The use of CAREX for LMI countries might be expected to lead to an underestimation of exposure prevalence, and the use of relative risks from high-income countries for all countries might be expected to lead to an underestimation of risk in LMI countries, any error from these sources being expected to lead to an underestimation of the burden in LMI countries.

Recommendations for further work
This analysis has identified several areas where further research could improve the accuracy and usefulness of the burden estimates. Several potentially important risk factor-outcome pairs were not included for various reasons, as mentioned earlier. Ongoing appraisal of the literature is being undertaken to address some of these, but better evidence regarding causal link will be required before decisions to include or exclude can be made confidently. There is also considerable scope for improvement in the assessment of the prevalence of exposure to those risk factors that were included in this study. Maximising the inclusion of the unofficial workforce is important to overcome a potentially important source of underestimation of the exposed population. Data to support these approaches will be sought for upcoming GBD iterations.

CONCLUSION
Occupational exposures are an important cause of largely preventable disease and injury burden in all regions of the world. Changes in the burden over the last two decades, as highlighted through burden of disease studies, have varied considerably among risk factors and regions. The results provide guidance to assess priorities, as well as justification for prevention and control initiatives.

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REFERENCES


