WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health

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Vol. 38 No.34 **20th – 26th August 2011**

WER SRI LANKA - 2011

Health inequities and Social determinants of health

Health inequities

Health inequities are avoidable inequalities of health in people. These inequities can exist between countries and in the same country, within and between segments of the society. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent or treat illnesses.

Examples of health inequities between countries:

- Infant mortality rate is 2 per 1000 live births in Iceland and over 120 per 1000 live births in Mozambique
- Lifetime risk of maternal death during or shortly after pregnancy is only 1 in 17 400 in Sweden but it is 1 in 8 in Afghanistan.

Examples of health inequities within countries:

- In Bolivia, Infant mortality rate is greater than 100 per 1000 live births in babies whose mothers have no education, while it is less than 40 per 1000 live births in babies whose mothers have had at least secondary education
- In Australia, indigenous population's Life expectancy at birth is substantially lower (59.4 for males and 64.8 for females) than that of non-indigenous Australians (76.6 and 82.0, respectively)

Social gradient

The poorest of the poor, around the world, have the worst health. Within countries, it is evident that in general, the lower an individual's socioeconomic position, the worse his/her health is. This is a global phenomenon, seen in low, middle and high income countries. For example, consider under 5 mortality rates by levels of household wealth. The poorest have the highest under 5 mortality rates, and people in the second highest quintile of household wealth have higher mortality in their offspring than those in the highest quintile. This is the social gradient in health.

Social determinants of health

The social determinants of health are the circumstances in which people are born, grow up, live, work and age and the systems put in place to deal with illness. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities. Social determinants are in turn shaped by a wider set of forces: economics, social policies and politics.

Drivers of health inequities

The global context affects the prosperity of the societies through its impact on international relations and domestic norms and policies. These in turn shape the way society, both at national and local level organizes its affairs, giving rise to forms of social position and hierarchy. Therefore populations are organized according to income, education, occupation, gender, race/ethnicity and other factors. The position of people in the social hierarchy affects the conditions in which they grow, learn, live, work and age, their vulnerability to ill health and the consequences of ill health.

Benefits of the economic growth that has taken place over the last 25 years are unequally distributed. In 1980 the richest countries, containing 10% of the world's population, had gross national income 60 times that of the poorest countries, containing 10% of the world's population. By 2005 this ratio had increased to 122.

International flows of aid-grossly inadequate in themselves (and well below the levels promised)-are dwarfed by debt repayment obligations poor countries. In many cases, there is a net financial outflow from poorer to richer countries – an alarming state of affairs.

The poorest quintile of the population in many countries has a declining share in national consumption. This trend has continued over the last 15 years. In Kenya, for example, at current economic growth rates and with the present levels of income inequality, the median family in poverty would not cross the poverty line until 2030. Doubling the share of income growth enjoyed by Kenya's poor would mean that reduction in poverty would happen by 2013.

Gender bias in power, resources, entitlements, norms and values and the way in which organizations are structured and programmes are run damage the health of millions of girls and women. The position of women in society is also associated with child health and survival of the offspring.

Health equity depends vitally on the empowerment of individuals to challenge and change the unfair and steeply graded distribution of social resources to which everyone has equal claims and rights. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included.

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Health equity in all policies

Every aspect of government and the economy has the potential to affect health and health equity – finance, education, housing, employment, transport and health to name just a few. They have strong bearing on health and health equity, even though health may not be the main aim of policies in these sectors.

Policy coherence is crucial – policies of different government departments must complement rather than contradict each other in relation to health equity. For example, trade policy that actively encourages the production, trade, and consumption of foods high in fats and sugars instead of fruit and vegetable production is contradictory to health policy

Obesity is becoming a real public health challenge in transitioning countries, as it already is in high-income countries. Obesity prevention requires approaches that ensure a sustainable, adequate, and nutritious food supply; a habitat that encourages consumption of healthier food and participation in physical activity; a family, educational and work environment that positively reinforces healthy living. Only a very few of these fall within the purview of the health sector. Positive advances have been made – for example infant formula milk advertisements have been banned. However, a significant challenge remains: to engage with the multiple sectors outside health, such as trade, agriculture, employment and education, if we were to control the global obesity epidemic.

WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce widening social inequities. The Commission's final report was launched in August 2008, and contained three overarching recommendations:

- Improve daily living conditions
- Tackle the inequitable distribution of power, money and resources
- Measure and understand the problem and assess the impact of action

Strategies to improve daily living conditions

- Equity from the beginning-At least 200 million children globally are not achieving their full potential. This has huge implications for their health and for society at large. Investment in early years provides one of the greatest potentials to reduce health inequities. Policy coherence for early child development, a comprehensive package of quality programmes for all children, mothers and caregivers and provision of quality compulsory primary and secondary education for all children are necessary.
- Healthy places, healthy people-Majority of the world population live in urban settings. Almost 1 billion live in slums. Urban slums have to be upgraded on a priority basis by providing them with water, sanitation and electricity.
- Promotion of healthy eating styles, physical activity should be done on an equitable basis.
- Reduction of violence and crime is to be done through good environmental design and regulatory controls, including control of alcohol outlets.
- Sustained rural development
- Economic and social policy responses to climate change and other environmental degradation that take into account of health equity.
- Fair employment and decent work-Provision of full and fair employment and decent work needs to be a central goal of social and economic policy (national and international) making. Economic and social policies must ensure a wage that takes into account the real and current cost of healthy living.
- Social protection throughout life, including special protection in case of specific shocks, such as illness, disability and loss of income or work. Comprehensive social protection policies for all the people globally including those who are doing precarious work, informal work, household and care work are necessary.
- Universal Health Care
- Healthcare systems are to be based on principles of equity, disease prevention and health promotion with universal coverage. Its' focus must be on primary health care, regardless of the ability to pay.

Strategies to tackle the inequitable distribution of power, money and resources

The inequity is systematic, produced by social norms, policies and practices, and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources.

- Health equity to become a marker of government performance;
- National capacity for progressive taxation to be built
- Existing commitments to be honoured by increasing global aid to 0.7% of GDP;
- Health equity impact assessments of major global, regional and bilateral economic agreements.
- Strengthening of public sector leadership in the provision of essential health related goods/services and control of health damaging commodities
- Gender equity to be promoted through enforced legislation and creation and financing of a gender equity unit.
- Economic contribution of housework, care work, and voluntary work to be included in national accounts
- All groups in society to be empowered through fair representation in decision-making;
- Civil society to be enabled to organize and act in a manner that promotes and realizes the political and social rights affecting health equity
- UN to adopt health equity as a core global development goal and use social determinants of health framework to monitor progress.

Strategies to measure and understand the problem and assess the impact of action

Action on the social determinants of health will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the social determinants of health are put in place so that more effective policies, systems and programmes can be developed. Education and training for relevant professionals is vital.

Government and the public sector should take the main part in these activities, but support and action of global institutions and agencies, civil society, research and academic communities and the private sector is advocated.

Sources

Social determinants of health, available from,
http://www.who.int/social_determinants/en/
http://www.who.int/social_determinants/thecommission/finalreport/closethegap_how/en/index1.html
http://www.who.int/social_determinants/thecommission/finalreport/closethegap_how/en/index2.html
http://www.who.int/social_determinants/thecommission/finalreport/closethegap_how/en/index3.html
http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 1: Vaccine-preventable Diseases & AFP

13th – 19th August 2011 (33rd Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	01	00	01	01	00	00	00	00	03	00	60	58	+ 03.4 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	00	02	00	00	00	00	00	00	00	02	00	98	65	+ 50.76 %
Tetanus	00	00	00	00	00	01	00	00	00	01	03	15	16	- 06.2 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	25	20	+ 25.0 %
Tuberculosis	51	06	06	03	08	14	07	03	29	127	212	5775	5580	+ 03.4 %

Table 2: Newly Introduced Notifiable Disease

13th – 19th August 2011 (33rd Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	14	04	07	03	05	08	03	05	06	55	35	2906	2214	+ 31.3 %
Meningitis	00	00	02 GL=1 MT=1	00	00	01 KN=1	00	00	01 KG=1	04	11	563	685	- 17.8 %
Mumps	08	11	10	07	13	12	03	03	15	82	31	2053	1231	+ 66.8 %
Leishmaniasis	00	01 ML=1	01 MT=1	00	00	00	09 AP=9	00	00	11	27	475	496	+ 04.2 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

DPDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

You have a duty and a responsibility in preventing dengue fever. Make sure that your environment is free from water collections where the dengue mosquito could breed.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

13th – 19th August 2011 (33rd Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	135	6563	8	146	0	6	9	123	0	48	5	286	0	6	4	47	0	2	**85**
Gampaha	63	2504	0	97	0	14	1	47	0	27	4	383	0	20	7	191	0	6	**60**
Kalutara	15	892	3	103	0	4	1	42	0	21	1	202	0	2	0	5	0	1	**67**
Kandy	19	562	4	301	0	7	0	22	0	36	6	129	0	82	0	43	0	0	**78**
Matale	8	234	4	123	0	3	0	24	0	18	1	149	0	13	0	6	0	0	**92**
Nuwara	1	131	1	289	0	3	2	41	0	89	6	41	2	53	0	17	0	1	**69**
Galle	22	555	3	70	0	6	0	9	0	6	2	119	0	29	1	9	0	5	**79**
Hambantota	6	322	1	40	0	4	0	3	0	20	5	427	3	48	0	7	0	1	**67**
Matara	4	327	0	59	0	2	1	11	0	28	4	207	0	52	1	15	0	1	**100**
Jaffna	12	223	6	163	0	3	1	189	0	68	0	2	1	190	0	19	0	1	**82**
Kilinochchi	1	43	0	15	0	3	0	9	0	12	0	2	0	8	0	3	0	0	**75**
Mannar	1	26	0	15	0	0	1	24	0	78	0	12	0	32	0	2	0	0	**100**
Vavuniya	1	64	0	24	1	11	0	8	0	47	4	43	0	2	0	1	0	0	**100**
Mullaitivu	0	15	2	40	0	1	0	3	0	9	0	5	0	1	0	2	0	0	**75**
Batticaloa	0	680	3	522	0	4	0	5	0	25	0	25	0	3	0	2	0	5	**71**
Ampara	2	103	1	89	0	1	0	9	0	28	0	54	0	1	0	7	0	0	**57**
Trincomalee	1	129	2	553	0	2	0	5	1	9	3	87	0	7	0	7	0	0	**75**
Kurunegala	14	642	3	248	0	10	3	75	1	69	11	1398	3	64	2	26	0	4	**91**
Puttalam	8	363	2	146	0	1	0	23	0	9	0	98	0	17	0	6	1	2	**50**
Anuradhapu	4	197	7	100	0	1	0	3	0	33	0	236	0	16	0	14	0	1	**84**
Polonnaruw	5	228	0	94	0	1	0	9	0	22	1	77	0	1	0	15	0	0	**57**
Badulla	15	431	6	256	0	5	2	46	0	9	2	58	2	61	2	47	0	0	**65**
Monaragala	5	167	2	69	0	4	3	29	0	10	0	170	3	56	1	46	0	0	**73**
Ratnapura	14	638	3	399	0	5	1	39	0	17	4	379	0	25	1	32	0	2	**72**
Kegalle	14	485	2	88	0	12	2	55	0	22	3	259	1	25	8	136	0	0	**82**
Kalmune	0	27	4	493	0	0	0	1	0	19	0	5	0	2	0	2	0	1	**77**
SRI LANKA	**370**	**16551**	**67**	**4542**	**01**	**113**	**27**	**854**	**02**	**779**	**62**	**4853**	**15**	**816**	**27**	**707**	**01**	**33**	**77**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 19th August , 2011 Total number of reporting units =327. Number of reporting units data provided for the current week: 251
A = Cases reported during the current week. **B** = Cumulative cases for the year.

PRINTING OF THIS PUBLICATION IS FUNDED BY THE WORLD HEALTH ORGANIZATION (WHO).

Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.**

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