WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
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Vol. 45 No. 38 **15th– 21st September 2018**

WER SRI LANKA 2018

Aging and health

People worldwide are living longer. By 2050, 80% of all older people will live in low- and middle-income countries.

The pace of population ageing around the world is also increasing dramatically. France had almost 150 years to adapt to a change from 10% to 20% in the proportion of the population that was older than 60 years .However, places such as Brazil, China and India will have slightly more than 20 years to make the same adaptation.

While this shift in distribution of a country's population towards older ages – known as population ageing - started in high-income countries (for example in Japan 30% of the population are already over 60 years old), it is now low- and middle-income countries that are experiencing the greatest change. By the middle of the century many countries for e.g. Chile, China, the Islamic Republic of Iran and the Russian Federation will have a similar proportion of older people to Japan.

A longer life brings with it opportunities, not only for older people and their families, but also for societies as a whole. Additional years provide the chance to pursue new activities such as further education, a new career or pursuing a long neglected passion. Older people also contribute in many ways to their families and communities. Yet the extent of these opportunities and contributions depends heavily on one factor: health.

There is, however, little evidence to suggest that older people today are experiencing their later years in better health than their parents. While rates of severe disability have declined in high-income countries over the past 30 years, there has been no significant change in mild to moderate disability over the same period.

If people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative.

Ageing explained

At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately, death. But these changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. While some 70 year-olds enjoy extremely good health and functioning, other 70 year-olds are frail and require significant help from others.

Beyond biological changes, ageing is also associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and partners. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth.

Common health conditions associated with ageing

Common conditions in older age include hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia.

Furthermore, as people age, they are more likely to experience several conditions at the same time. Older age is also characterized by the emergence of several complex health states that tend to occur only later in life and that do not fall into discrete disease catego-

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ries. These are commonly called **geriatric syndromes**. They are often the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers.

Geriatric syndromes appear to be better predictors of death than the presence or number of specific diseases. Yet outside of countries that have developed geriatric medicine as a specialty, they are often overlooked in traditionally structured health services and in epidemiological research.

Factors influencing Healthy Ageing

Although some of the variations in older people's health are genetic, much is due to people's physical and social environments – including their homes, neighbor-hoods, and communities, as well as their personal characteristics – such as their sex, ethnicity, or socioeconomic status. These factors start to influence the ageing process at an early stage. The environments that people live in as children – or even as developing foetuses – combined with their personal characteristics, have long-term effects on how they age.

Environments also have an important influence on the development and maintenance of healthy behaviours. Maintaining healthy behaviours throughout life, particularly eating a balanced diet, engaging in regular physical activity, and refraining from tobacco use all contribute to reducing the risk of non-communicable diseases and improving physical and mental capacity.

Behaviours also remain important in older age. Strength training to maintain muscle mass and good nutrition can both help to preserve cognitive function, delay care dependency, and reverse frailty. Supportive environments enable people to do what is important to them, despite losses in capacity. The availability of safe and accessible public buildings and transport, and environments that are easy to walk around are examples of supportive environments.

Challenges in responding to population ageing

Diversity in older age

There is no 'typical' older person. Some 80 year-olds have physical and mental capacities similar to many 20 year-olds. Other people experience significant declines in physical and mental capacities at much younger ages. A comprehensive public health response must address this wide range of older people's experiences and needs.

Health inequities

The diversity seen in older age is not random. A large part arises from people's physical and social environments and the impact of these environments on their opportunities and health behaviour. The relationship we have with our environments is skewed by personal characteristics such as the family we were born into, our sex and our ethnicity, leading to inequalities in health. A significant proportion of the diversity in older age is due to the cumulative impact of these health inequities across the life course. Public health policy must be crafted to reduce, rather than reinforce, these inequities.

Outdated and ageist stereotypes

Older people are often assumed to be frail or dependent, and a burden to society. Public health, and society as a whole, need to address these and other ageist attitudes, which can lead to discrimination, affect the way policies are developed and the opportunities older people have to experience **Healthy Aging**.

A rapidly changing world

Globalization, technological developments (e.g. in transport and communication), urbanization, migration and changing gender norms are influencing the lives of older people in direct and indirect ways. For example, although the number of surviving generations in a family has increased, today these generations are more likely than in the past to live separately. A public health response must take stock of these current and projected trends, and frame policies accordingly.

Source:

WHO. Aging and Health . Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Compiled by :

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Table 1 : Water Quality Surveillance
Number of microbiological water samples August 2018

District	MOH areas	No: Expected *	No: Received
Colombo	15	90	**93**
Gampaha	15	90	**NR**
Kalutara	12	72	**NR**
Kalutara NIHS	2	12	**NR**
Kandy	23	138	**89**
Matale	13	78	**37**
Nuwara Eliya	13	78	**116**
Galle	20	120	**49**
Matara	17	102	**41**
Hambantota	12	72	**75**
Jaffna	12	72	**229**
Kilinochchi	4	24	**65**
Manner	5	30	**30**
Vavuniya	4	24	**64**
Mullatvu	5	30	**NR**
Batticaloa	14	84	**99**
Ampara	7	42	**39**
Trincomalee	11	66	**16**
Kurunegala	29	174	**71**
Puttalam	13	78	**6**
Anuradhapura	19	114	**23**
Polonnaruwa	7	42	**29**
Badulla	16	96	**113**
Moneragala	11	66	**87**
Rathnapura	18	108	**62**
Kegalle	11	66	**23**
Kalmunai	13	78	**82**

* No of samples expected (6 / MOH area / Month)
NR = Return not received

Table 1: Selected notifiable diseases reported by Medical Officers of Health 08th– 14th Sept 2018(37th Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmania-sis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	97	7388	2	65	2	9	2	36	0	29	5	154	0	11	1	5	0	0	23	537	5	47	1	3	**62**	**100**
paha	92	4135	3	58	0	8	1	19	1	17	9	179	0	4	0	12	0	0	13	559	3	38	2	37	**65**	**100**
Kalutara	28	2431	2	67	0	4	0	11	1	54	15	437	0	6	1	12	0	0	10	485	3	80	0	9	**53**	**100**
Kandy	73	2836	2	92	0	5	0	3	2	18	4	62	2	83	2	18	0	0	6	263	0	29	2	24	**60**	**100**
Matale	7	770	0	16	0	1	0	4	0	31	2	74	0	2	1	7	0	0	1	33	2	13	4	91	**62**	**100**
NuwaraEliya	1	162	0	48	0	3	2	12	0	47	1	36	1	113	2	23	0	0	1	184	2	29	0	0	**28**	**100**
Galle	7	777	2	41	0	10	0	4	0	9	3	304	1	44	1	3	0	1	13	256	0	46	0	5	**24**	**100**
Hambantota	7	707	0	13	0	4	0	2	1	5	3	57	4	61	0	2	0	1	2	208	2	10	37	594	**71**	**100**
Matara	21	851	0	32	0	6	0	6	0	22	4	186	1	39	0	12	0	0	4	223	0	12	20	341	**55**	**100**
Jaffna	38	2343	0	118	0	4	0	37	0	213	0	10	0	253	0	1	0	2	5	222	0	9	0	3	**38**	**93**
Kilinochchi	14	265	1	25	0	1	0	16	0	2	0	4	0	16	0	0	0	1	2	31	0	2	0	1	**50**	**100**
Mannar	2	188	0	17	0	0	0	3	0	2	0	1	0	0	0	0	0	0	0	27	0	4	0	3	**37**	**100**
Vavuniya	4	473	0	15	0	4	0	37	0	12	0	31	0	7	0	0	0	1	0	38	0	5	0	8	**59**	**100**
Mullaitivu	1	89	0	6	0	0	0	10	0	11	0	8	0	5	0	0	0	1	1	8	0	1	0	2	**25**	**100**
Batticaloa	20	4247	5	134	0	5	0	4	2	26	0	39	0	1	0	2	0	3	3	131	0	17	0	0	**65**	**100**
Ampara	3	198	1	53	0	3	0	2	0	5	0	33	0	0	0	6	0	1	17	233	1	22	0	2	**66**	**100**
Trincomalee	7	923	0	36	0	2	0	4	0	13	0	47	0	22	1	2	0	0	3	166	0	9	0	18	**28**	**100**
Kurunegala	20	1939	1	104	0	13	0	13	0	3	1	112	1	21	0	18	0	2	13	409	3	76	16	278	**63**	**100**
Puttalam	17	1401	0	34	0	6	0	4	6	10	1	35	0	11	0	2	0	0	4	111	2	65	0	2	**62**	**100**
Anuradhapura	6	725	3	46	0	7	0	3	0	38	0	107	0	17	1	10	1	2	4	325	0	32	8	332	**45**	**95**
Polonnaruwa	5	254	4	31	0	2	0	0	0	16	0	93	0	0	0	4	0	1	8	204	1	17	11	188	**57**	**88**
Badulla	18	433	3	98	1	8	1	8	0	13	2	130	4	68	2	32	0	0	6	371	2	89	0	7	**47**	**100**
Monaragala	7	721	2	60	0	2	0	1	0	2	1	229	4	115	4	29	0	0	6	142	5	107	0	34	**66**	**100**
Ratnapura	13	1801	3	141	0	36	0	21	0	5	16	536	0	22	1	21	0	2	5	232	2	93	1	172	**47**	**100**
Kegalle	17	1145	0	48	0	8	0	6	1	80	19	211	4	62	1	12	0	0	16	294	2	42	2	13	**65**	**100**
Kalmune	10	1534	4	35	0	3	0	2	0	31	0	6	0	1	0	1	0	0	4	156	1	11	0	1	**51**	**100**
SRILANKA	**535**	**38736**	**38**	**1433**	**3**	**154**	**6**	**268**	**14**	**714**	**86**	**3121**	**22**	**984**	**18**	**234**	**1**	**18**	**170**	**5848**	**36**	**905**	**10**	**2168**	**53**	**99**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 14th September , 2018 Total number of reporting units 353 Number of reporting units data provided for the current week: 351 C**-Completeness

A = Cases reported during the current week. **B** = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

08th – 14th Sept 2018(37th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2018	Number of cases during same week in 2017	Total number of cases to date in 2018	Total number of cases to date in 2017	Difference between the number of cases to date in 2018 & 2017
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	02	43	50	- 14 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	00	01	00	02	00	00	00	01	04	02	251	232	8.1 %
Measles	01	00	00	00	00	00	01	00	00	02	02	91	171	- 46.7 %
Rubella	00	00	00	00	00	00	00	00	00	00	03	04	09	- 55.5 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	01	0%
Tetanus	00	00	00	00	00	00	00	00	00	00	02	16	14	14.2 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	24	21	14.2 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	01	37	14	164.2 %
Tuberculosis	81	10	08	03	06	12	17	11	14	163	200	6090	6004	1.4 %

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.

RDHS 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, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS =**Congenital Rubella Syndrome

NA = Not Available

Influenza Surveillance in Sentinel Hospitals - ILI & SARI

Month	Human				Animal		
	No Total	No Positive	Infl A	Infl B	Pooled samples	Serum Samples	Positives
September	67	9	00	09	495	887	0

Source: Medical Research Institute & Veterinary Research Institute

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. Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

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