Letter to the Editor

MDGs to SDGs

Malaria Count 2015

EM Wijerama Lecture

Care of the Elderly

Control of Rabies

Lessons learned

33 Imported cases to date

The way forward

Control of Rabies in Sri Lanka
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Foundation Sessions of the Sri Lanka Medical Association 07, 08

News

President’s Message 02
Letter to the Editor 02
MDGs to SDGs 03, 04
Malaria Count 2015 04
For Your Handphone Contact Numbers 04, 06
Malaria Free Sri Lanka 06
Foundation Sessions of the SLMA 07, 08
E M Wijerama Endowment Lecture 09, 10
Care of the Elderly 10, 12, 14, 16
Control of Rabies in Sri Lanka 17, 18, 20

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Dear friends and colleagues,

We finished yet another busy month of activities. The highlight of the month was the Foundation Sessions of the SLMA which was held in Anuradhapura in late October. The Anuradhapura Clinical Society and the Sri Lankan Medical and Dental Association of the UK were the collaborators. The active contributions by the expatriate faculty further enriched the scientific programme by adding a new dimension to the Foundation Sessions this year. The history of the Foundation Sessions of the SLMA dates back to the 1990’s and was inaugurated during the presidency of Dr. Ramachandran in honour of the greatest benefactor of SLMA, Dr. E. M. Wijerama, who donated his house to SLMA. The E. M. Wijerama Endowment Lecture was delivered by Dr. Sunil Seneviratne Epa, one of our distinguished Past Presidents.

The SLMA strategic plan was developed over the last few months and it is available on the SLMA website. A copy of the strategic plan can be made available to members on request. The mission of the SLMA is to control the rise of non communicable diseases with a special emphasis on the control of diabetes, in addition to continuing with functions related to continuous professional development activities and advocacy. I am grateful to our council member Dr. Sumithra Tissera for providing enthusiastic leadership for this activity.

In keeping with our mission, the SLMA brought in strong pressure on the food and beverages industry to reduce irresponsible marketing of unhealthy food through press statements and media briefings. I thank the Food Advisory Committee and Family Health Bureau of the Ministry of Health and all stakeholder medical and allied health professional organisations for supporting this cause through their active participation. Numerous supportive statements were published by the media personnel who participated at this media briefing.

The E. M. Wijerama House is being given a facelift as the SLMA believes it is important to preserve this historic edifice. The Finance and Management Committee has gone to great lengths in working out a cost effective plan for repairs and then implementing it. Mr. Rajasingham and the office staff have been very supportive in getting these repairs done. Any donations from the membership for this activity will be most welcome.

Preparations are currently underway for the Medical Dance which is to be held on the 12th of December 2015 at the Waters Edge Hotel. Tickets for the dance are available at the SLMA office. I invite all medical professionals and their families to join in this activity of camaraderie and fellowship. I assure you that it is going to be a night of fun and frolic.

The Annual General Meeting of the SLMA will be held on the 17th of December 2015 at 7.00 pm at the Lionel Memorial Auditorium and I invite all members of the SLMA to participate in this important activity as this is the main forum for members to express themselves.

Professor Jennifer Perera

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Dear Editor,

This gives reference to the article that appeared in the September edition of the SLMA Newsletter – ‘Seeking the origins of Forensic Medicine and charting its future’ by Dr. Sameera. A. Gunawardena. To begin with for any doctor practicing in clinical medicine an article on Forensic Medicine, normally, doesn’t interest him. As a General Practitioner myself I felt the same when I saw this article and more so when I saw it being lengthy and covered four full pages. However, as I finished reading all the other articles in the newsletter that interested me, and as I was fairly free at that time, I started reading this article. Once I started reading I realized what an interesting article it is. It was so good I didn’t put the newsletter down until I finished reading it. It is a well researched article and the author has taken a lot of trouble to unravel the relevant information and nicely elaborated here. Above all, true to his intention, it gave an important message to us doctors, as to how an autopsy performed well with all the necessary facilities being available, could help to get at the cause of death more accurately and the pathology behind same. This again will be valuable information for prevention of such diseases and complications, among the living. Unfortunately, he goes on to say that such facilities are not available in Sri Lanka and the health department gives a step motherly treatment for Forensic Medicine as it deals with the dead, not knowing the true potential behind it. This is where the health authorities and health policy makers should give a second thought to this matter and strengthen the Forensic Medicine department with the ideal. I fully agree with his last sentence in his article – ‘This is the place where death delights to help the living’. I too further emphasize with him – ‘where the death delights in the living’.

Thank you Sameera,
Dr. Percy Motha,
General Practitioner,
Borella.
MDGs to SDGs

Dr. Jacob Kumaresan
WHO Representative to Sri Lanka

In September 2015, Heads of State and Government adopted the Sustainable Development Goals (SDGs) at the UN Sustainable Development Summit held in New York, USA. A set of 17 SDGs and 169 targets succeeded the Millennium Development Goals (MDGs) to guide global development until 2030. Conceived to be more inclusive of development issues in every sector, the SDGs are a product of extensive global consultation and negotiation. It is acknowledged by many for its comprehensiveness, ambition and universal applicability; however, criticized by others for lacking precision and proposing an unattainable utopia. It represents a valuable and exciting opportunity for global health to achieve equity in health, universal coverage and human development. This paper describes the development of SDGs, highlights the key differences with the MDGs and describes the lessons learned from this process.

Legacy of MDGs

In general, MDGs are considered a success, having galvanized concerted action on a limited number of time-bound measurable and easy-to-communicate goals. They achieved wide public recognition and were more influential than any other attempt at international target setting in the field of development. However, they are criticized for ignoring many aspects of development, fostering inequity by focusing on aggregates, and monitoring progress in developing countries only. Perhaps the biggest legacy of the MDGs is that the world is now able to track progress through measurement and the development of robust monitoring systems. Political leaders are able to announce achievement of targets, and civil society and media are holding leaders accountable for their performance.

Remarkable progress was made in reducing poverty – number of people living on less than $1.25 per day declined by more than half. Proportion of under-nourished people in developing countries fell significantly. School enrollment for boys and girls exceeded 90%, and in 2015 the proportion of the global population using an improved drinking water source reached 91%. Dramatic outcomes were achieved in child and maternal mortality – reductions by 53% and 43% respectively, although these figures fell short of the two-thirds and three-quarters declines that were targeted. Global MDG targets for HIV, tuberculosis and malaria were met. In sum, outstanding gains were made in health during the last 15 years due to collective global action by governments, civil society, private and public sector foundations.

In Sri Lanka, tremendous achievements were made in the health sector regarding child and maternal mortality rates, and the education sector with school enrollment of almost all primary school age children resulting in 98% youth literacy. Notably there is no disparity against females in the education system and the MDG target for poverty was achieved 7 years ahead of the deadline in national and rural areas. Some unmet challenges are in the areas of nutrition with more than 20% of children under-five being underweight, gender inequality in employment, and income inequality in household income and expenditures.

Globally, there was limited progress in targets for improved sanitation and use of family planning. Progress within and between countries is highly uneven, resulting in unacceptable inequality. Links between health and the effects of human consumption and activity on the environment are yet to be defined. An “unfinished agenda” remains from the MDGs. The SDGs reflect these shortcomings and were developed to ensure that everyone counts, ‘leaving no one behind’.

Development of the SDGs

The mandate to start work on the post-2015 development agenda was given in 2010 by the member states, and further reiterated at the 2012 UN Conference on Sustainable Development in Rio de Janeiro. The Rio+20 outcome document ‘The future we want’ established an Open Working Group (OWG) composed of member states to develop a set of sustainable development goals. Following an elaborate consultative process through 2013 and 2014, the OWG defined a set of proposed goals and targets in July 2014. In support, the UN Secretary-General convened a High-level Panel of Eminent Experts in 2012, which submitted a report one year later. The UN Development Group agencies led a ‘global conversation’ to solicit views through web-based portal and face-to-face thematic and sectoral meetings at national, regional and global levels. Finally, outcomes of other meetings in 2015 - the Sendai Framework on disaster risk reduction and the Addis Ababa Action Agenda on Financing for Development – fed into the final text.

The SDG declaration sets out 17 goals and 169 targets, focusing on the new agenda, the means of implementation and its follow-up.

Contd. on page 04
MDGs to...

Endorsed by resolution at the UN Sustainable Development Summit in September 2015 in New York, they will come into effect in January 2016. A global indicator framework, under development by the UN Statistical Commission, will be released in March 2016. Subsequently each government is envisaged to set its own national targets guided by the global level of ambition but taking into account national circumstances. As a middle-income country, Sri Lanka is well positioned to a new and higher set of development goals, by developing human resources for an inventive economy while enabling energy security and environmental resilience.

Lessons learned

Despite resulting in a longer list of goals and targets, the SDGs are global in nature, universally applicable, integrated and indivisible. As with MDGs they are focused on development, but not only about developing countries, covering the economic, environmental and social pillars of development. The notion of equity - ‘no one being left behind’ - is addressed by a range of issues facing nations today and if addressed will achieve the goals on sustainable development. The context of the political and economic environment is very different from the beginning of the millennium. The Addis Ababa Action Agenda on Financing aptly gives more attention to domestic and private financing while emphasizing the role of international public finance as a catalyst to additional financial assistance and an important assistance to the economies of a decreasing number of poor and often fragile countries. Finally, the ownership of the process and outcome of the SDGs by the member states gives tremendous hope that we can aspire to ‘Transforming Our World: the 2030 Agenda for Sustainable Development’.

FOR YOUR HANDPHONE CONTACT NUMBERS

ICE – In Case of Emergency

We all carry our mobile phones with names & numbers stored in its memory but nobody, other than ourselves, knows which of these numbers belong to our closest family or friends.

If we were to be involved in an accident or were taken ill, the people attending us would have our mobile phone but wouldn’t know whom to call. Yes, there are hundreds of numbers stored but which one is the contact person in case of an emergency?

Hence this "ICE" (In Case of Emergency) Campaign.

The concept of "ICE" is catching on quickly. It is a method of contact during emergency situations. As cell phones are carried by the majority of the population, all you need to do is store the number of a contact person or persons who should be contacted during an emergency under the name "ICE" (In Case Of Emergency).

The idea was thought up by Bob Brotchie, a British paramedic, who found that when he went to the scenes of accidents, there were always mobile phones with patients, but they didn’t know which number to call. He therefore thought that it would be a good idea if there was a nationally recognized name for this purpose. In an emergency situation, Emergency Service personnel and hospital staff would be able to quickly contact the right person by simply dialling the number you have stored as "ICE."
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Dr. B. J. C. Perera
MBBS(Cey), DCH(Cey), DCH(Eng), MD(Paed), FRCP(Edin), FRCP(Lon), FRCPCH(UK), FSLCPaed, FCCP, FCGP(SL)
The SLMA Foundation Sessions were held jointly with the Anuradhapura Clinical Society and in collaboration with the Sri Lankan Medical and Dental Association (SLMDA), UK, from 28th – 30th October 2015. The inauguration was on the 28th of October 2015 at the Auditorium of the Teaching Hospital, Anuradhapura. In keeping with tradition, the E M Wijerama Endowment Lecture 2015 was delivered at this event by Dr. Sunil Seneviratne Epa, Consultant Physician and a Past President of the SLMA. The scientific programme conducted on the following two days was very stimulating and included three plenary sessions and three symposia that addressed a variety of topics. The sessions were enriched by the presence of many SLMDA, UK, delegates and speakers.

The Sir Marcus Fernando Oration was delivered by Dr. Chandika Liyanage, Consultant Surgeon and Senior Lecturer of the Faculty of Medicine, University of Kelaniya, on the topic entitled “Laporoscopic cholecystectomy – simple yet complicated”, while the Anuradhapura Clinical Society Oration was delivered by Dr. S. B. Agampodi, and the oration was entitled “Diagnostic challenges of leptospirosis in Sri Lanka: validity and utility of different diagnostic tools”.

The sessions were preceded by 5 parallel workshops held on the 28th of October 2015, which catered to the needs of doctors, both medical and dental, as well as nursing officers. Many resource persons shared their expertise and experiences at these workshops.
Contd. from page 07

Foundation sessions of...
Emotional and spiritual intelligence and its relevance to medicine

Dr. Sunil Seneviratne Epa
Consultant Physician and
Past President of SLMA

Albert Einstein said, “The intuitive mind is a sacred gift, and rational mind a faithful servant. We have created a society that honours the servant, and forgotten the gift”. My speech today is on this intuitive mind. The Purpose of my lecture is to show you the vast potential of this intuitive mind and how best we can put it to good use. Emotional and Spiritual Intelligence is a function of this intuitive mind. Some people refer to this intuitive mind, as the subconscious mind. According to some classifications, as much as 88% of our mind is subconscious. What is Intelligence? A simple way to understand this abstract term is to think of it as an ability to apply skills. We now have a definition of Intelligence which is as follows.

“Intelligence is the ability to apply appropriate skills, at the right time for the right purpose.” We have 4 different types of intelligence. a) Physical b) Cognitive c) Emotional d) Spiritual. If we are to place them in a pyramid, Physical Intelligence is at the bottom and is the most basic level. Next is the Cognitive and above that is Emotional, and Spiritual Intelligence is at the peak and is the highest form.

Traditionally, Cognitive Intelligence or Intelligence Quotient (IQ) is what we have been referring to as intelligence, at least up to a few decades ago. However this trend is now fast changing. Over the years, we have realized that after reaching a certain level of IQ, there is no direct correlation between IQ level, and the actual achievements or success in life. The concept of Emotional Intelligence or EQ emerged as an explanation for this observation. Emotional Intelligence basically means how skilled you are in handling emotions, your own or other peoples’ emotions. EQ is defined as follows.

“Ability to make healthy choices based on the ability to recognize, understand and manage, your own feelings and the feelings of others”.

Daniel Goleman described EQ as a combination of four different skills under two groups. a) Ability to recognize your own emotions (Recognition) and control them (Impulse control). b) Ability to recognize other peoples’ emotions (Empathy) and ability to manage them (Soft skills or Social skills). One may be good at one skill but may be poor in another, so if we are to improve our EQ we need to know in which respect we are weaker. EQ can be enhanced by training and as a result it is now a big industry in the US. Studies have shown that EQ level is directly related to success in business. Being a good doctor too means having good EQ. Empathy or the ability to understand another person’s emotions, is considered to be the father of electromagnetic engineering said “Everything is vibration and everything is energy”.

Different emotions have different vibration frequencies ranging from 20 - 700 plus Hertz. Negative emotions such as fear and anger have lower frequencies while positive emotions such as peace and joy have the highest frequency.

Empathy is the ability to perceive another person’s emotions. The secret of empathy may lie in the energy waves of emotions. So it seems, we now have a scientific basis for explaining empathy – the ability to perceive another person’s emotions. How strange? You may have heard of people who can read other peoples’ minds. This may be the secret of that too. These emotional vibrations producing energy waves may explain the mechanism of transfer of merit or blessings on to another person by us performing spiritual activities. This is totally a new dimension connecting spirituality with science. Isn’t that strange again?

Spiritual Intelligence (SQ) is a kind of extension of EQ and is the highest form of human intelligence. We have a definition for Spiritual Intelligence too.

Contd. on page 10
CARE OF THE ELDERLY: NOW MORE THAN EVER

Dr. Ruvaiz Haniffa, MBBS., DF., PGDip., MSc., MD (Family Medicine - Col.), FCGP(SL), MRCPG (INT)
Family Physician, Family Medicine Unit, Faculty of Medicine, University of Colombo

“At a time of unpredictable challenges for health, whether from changing climate, emerging infectious diseases or the next microbe that develops drug resistance, one trend is certain: the ageing of population is rapidly accelerating worldwide. For the first time in history, most people can expect to live into their 60s and beyond. The consequences for health, health systems, their workforces and budgets are profound”

Dr. Margret Chan, Director-General, World Health Organization.
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The picture from low- and middle-income countries is even less clear [1].

The issue the current generation faces is - how do we ensure active and healthy ageing? And attain a Good Quality of Life. The WHO policy framework on active ageing (defined as the process of optimizing opportunities for health, participation and security in order to enhance QoL as people age) identifies six determinants (economic, behavioural, personal, social, health and social services and physical environment) and four components necessary for health policy response (1. Prevent and reduce the burden of excess disabilities, chronic disease and premature mortality, 2. Reduce risk factors associated with major diseases and increase factors that protect health throughout the life course, 3. Develop a continuum of affordable, accessible, high-quality and age-friendly health and social services that address the needs and rights of people as they age and 4. Provide training and education to caregivers). Healthy ageing (defined as the process of developing and maintaining the functional ability that enables well-being in older age) is determined by Intrinsic capacity (composite of all the physical and mental capabilities of an individual) and Environment (comprises of all the factors in the extrinsic world that form the context of an individual’s life).

Although, there are outstanding exceptions, significant threats to quality of care come from outdated ideas and ways of working, which often focus on keeping older people alive rather than on supporting dignified living and maintaining intrinsic capacity. Within this paradigm, older people are often regarded as passive recipients of care, and services may be built around the needs of the service providers rather than the needs and preferences of the older person [2]. Fragmentation and the inflexibility of responsibilities for care within healthcare systems can further exacerbate these problems. The role of comprehensive or holistic healthcare becomes important in this context. The older person should be viewed and problems identified and addressed from the older persons perspective. The patients’ individual organ systems should not be the priority of the healthcare system.

Figure: Dimensional Comprehensive Care Model

Elderly care in health systems where the consumer has the right to choose the service provider further complicates delivery of quality health care. In developing countries the patient education levels are low and the patients mind set is curing of disease rather than maintaining health. Therefore, in such health systems all levels of healthcare personnel should mandatorily have some level of knowledge, skills and attitudes to deal with elderly patients. Furthermore, provision of the recommended comprehensive healthcare to elderly is a multi disciplinary and multi stake holder approach. Ensuring active and healthy ageing and good quality of life for the elderly should not be viewed as the sole responsibility of healthcare professionals. Even within the medical profession a coordinated approach is needed to deliver optimum care to the elderly through the maze of the numerous medical specialties. The concept of ‘shared care’ should be the foundation within the medical profession to deliver comprehensive, effective and cost effective elderly care.

In delivering such shared care there are a few selected topics I wish to bring to the attention of the reader to reiterate the need for elderly care now more than ever.

Multimorbidity

Although multimorbidity refers to the presence of two or more chronic conditions, there is no standard definition or consensus on which conditions should be considered [2].

It leads to interaction among conditions; between one condition and the treatment recommendations for another condition; and among the medications prescribed for different conditions. As a result, the impact of multimorbidity on functioning, quality of life and risk of mortality may be significantly greater than the sum of the individual effects that might be expected from these conditions [3]. Predictably, it is also associated with higher rates of healthcare utilization and higher costs [3]. Aging with multimorbidity: a systematic review of the literature done in 2011 in seven high income countries concluded that more than half of all older people are affected with multimorbidity, with the prevalence increasing sharply in very old age.

Despite the large number of older people experiencing multimorbidity, most health systems are not equipped to provide the comprehensive care needed to manage these complex health states [2].

Continue on page 14
INTRODUCING TOKYO SUPERLIGHT

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Frailty

The definition remains contested. The majority of the proposed definitions agree that there is a decrease in functional reserve which confers extreme vulnerability to stressors. The net result is an increased risk of a wide range of adverse health outcomes.

Frailty is a reversible state and its early identification and intervention will lead to improved quality of life for the patient. It should not be confused with disability, care dependence and co-morbidity.

As frailty comprises complex decrements occurring in several systems, one key clinical approach is the use of comprehensive assessment of the patient rather than individual organ system based assessment. The assessment and person-tailored interventions that derive from them have been shown to prevent many major negative health related outcomes, including shortened survival times and care dependence [5].

Generic interventions such as increasing physical activity have been shown to be effective in more severe cases and improving nutritional status may also be beneficial, but evidence is limited [6].

Ageism

The world is changing rapidly in many dimensions. The past 50 years has seen massive demographic shifts from rural to urban living. Now for the first time, the majority of the world’s population lives in cities [7]. Older parents living with their children are becoming less common. In India, which is considered a country with strong family ties, only 20% of households include people living in joint or extended families. In many parts of the world, the traditional position of being respected as an older person within a family and society may be weakening or at least transforming. These among many other socio-economic factors have led to the traditional ‘looking up to elder’s concept’ changing rapidly within a generation.

Ageism is the stereotyping of and discrimination against individuals or groups based on their age [2]. Ageism can take many forms, including prejudicial attitudes, discriminatory practices or institutional policies and practices that perpetuate stereotypes.

Negative ageist attitudes are widely held across societies and not confined to one social or ethnic group. Research suggests that ageism may now be even more pervasive than sexism and racism. This has serious consequences both for older people and society. It is a major barrier to developing good policies as it steers policy options in limited directions [2].

Ageism is also prevalent within the healthcare system. These include negative attitudes towards the elderly, engaging in patronizing behavior, failing to consult older people about their preferences for care and discouraging/restricting access to otherwise-indicated medical interventions. These attitudes are further reinforced during medical education. Medical students (at least in Sri Lanka) are rarely trained to handle the multiple and complex health issues and priorities of the elderly or to even attempt to understand their priorities.

An extreme form of ageism in the healthcare sector is rationing of health care based on the notion that health services are a limited resource and must be allocated to achieve the greatest good for the greatest number of people. The basis for this restriction is that, chronological age is an ethical, objective and cost effective criterion for allocating health care because older people have already enjoyed life and have less future life to enjoy [8].

Nutrition

Malnutrition in older people often goes undiagnosed. It interacts with underlying age related changes often taking the form of reduced muscle mass (sarcopenia), reduced bone mass (osteoporosis) and increases the risk of frailty. Malnutrition has been associated with diminished cognitive function, diminished ability to care for oneself and higher risk of becoming care dependent.

Ageing is accompanied by physiological changes, sensory impairment, poor oral health, psychological changes, environmental changes and financial inadequacy all combined leading to a negative impact on the overall nutritional status of the elderly.

Although energy need decreases with age the need for most nutrients remains relatively unchanged. Hence adequate nutrition to cover major and minor nutrients is a must in the maintenance of overall good health and quality of life of the elderly.

In identifying malnutrition in the elderly for research and for daily practice the questionnaire based approach is suitable, effective and efficient.
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Contd. from page 14

Care of the elderly...

In this regard in Sri Lanka we have available to us a validated Sinhala Translation of the widely used Mini Nutritional Assessment (MNA®) tool. More widespread use of this tool both in research and daily practice in Sri Lanka would no doubt help us better understand and offer higher quality of nutritional care and support to our patients.

New Expectations

As a society we must escape from the ‘Life Cycle’ approach to life. It is high time that we emerge from the inevitable categorization of fixed stages in life particularly with regards to the elderly. The idea that learning is something that should occur only during the early stages of life reflects outdated employment patterns in which people are trained for a role and work at it for life [9]. One consequence of this rigid categorization of the life cycle approach is that the extra years that accrue from longevity are often considered as simply extending the period of retirement. However, as of now and more so in the future, these extra years are going to be enjoyed in better overall health and productivity in whatever work the elderly person is going to be in. But, current policies do not take these factors into account and contribute towards the poor overall QoL of elderly persons.

In anticipation of better health outcomes based on longevity perhaps policy makers should consider formulating policy to cover at least a few of the following eventualities;

a. In anticipation of living longer people should be allowed to raise families and have children first and then start a career say at age 40 years.

b. Choose to retire at 35 years for a while and rejoin the work force at say age 60 years.

c. Allow access to educational institutes for those above age 60 years to either pursue their original field of study or undertake a new field of study.

Thus, if policy permits, the combination of greater longevity and good health can allow endless variations of the traditional categories at the upper spectrum of the Life Cycle approach to life.

Conclusion

The societal response to population ageing will require a transformation of health systems that move away from disease-based curative models and towards the provision of old-person-centered and integrated care models. It will require delivery of comprehensive long term institutionalized care or even home based care where the health team will be required to make home visits to care for the elderly. Using ICT in healthcare or eHealth will be a critical tool for transforming health systems and services to deliver person-centered and integrated care that is appropriate to older people.

These transformations though hypothetical now are sure to manifest in some form or the other in the not too distant future purely based on the laws of demand and supply of healthcare. It will no doubt require a coordinated response from many other sectors and will require policy guidance from the government. Although these actions will inevitably require resources, they are likely to be sound investments in society’s future: our future. The generation of evidence needed for planning to be able to achieve these outcomes needs to occur now. Therefore, we need to focus on the care of the elderly now more than ever.

References


Excerpts of the symposium organized by the SLMA Expert Committee on Communicable Diseases to mark World Rabies Day held on 30th September 2015 from 11.30am – 01.00 pm, at the Auditorium of the Sri Lanka Medical Association.

Policy decision on cessation of stray dog elimination - has it affected the rabies control activities in Sri Lanka?

Dr. Ramasamy Balasubramaniam 1,2, Professor AR Wickeremasinghe1, Dr. KTTA Kasturiratne, 1 Dr. Kamal Jayasinghe 3

1Department of Public Health, Faculty of Medicine, University of Kelaniya; 2Medical Research Institute, Ministry of Healthcare and Nutrition, Colombo 8; 3Medical Supplies Division, Ministry of Healthcare and Nutrition, Colombo 8

Rabies control activities in Sri Lanka focus on 3 key preventive strategies:

1. Control of dog population, mainly by sterilization and environmental modification. Now the preferred term for control of dog population is dog population management
2. Vaccinations of dogs
3. Post Exposure Prophylaxis (PEP) for people who have been exposed to rabies virus especially through animal bites, and scratching

Let us briefly look at the history of dog population management in Sri Lanka. Based on ethical and scientific principles stray dog elimination which had been in practice since 1975, was completely halted in 2007. Since then, animal birth control methods such as surgical sterilization and chemical methods took the precedence and the government allocated funds for these programmes in support of this shift in rabies control activities. However, outcomes of this policy shift had not been formally reviewed.

At least we know that this policy shift has not affected the incidence of human rabies as it continues to decline at the same pace unhindered by the policy shift (Table 1).

<table>
<thead>
<tr>
<th>Year</th>
<th>Human rabies deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>96</td>
</tr>
<tr>
<td>2005</td>
<td>55</td>
</tr>
<tr>
<td>2006</td>
<td>73</td>
</tr>
<tr>
<td>2007</td>
<td>56</td>
</tr>
<tr>
<td>2008</td>
<td>51</td>
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<td>2009</td>
<td>58</td>
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<tr>
<td>2010</td>
<td>49</td>
</tr>
<tr>
<td>2011</td>
<td>41</td>
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<tr>
<td>2012</td>
<td>38</td>
</tr>
<tr>
<td>2013</td>
<td>28</td>
</tr>
<tr>
<td>2014</td>
<td>19</td>
</tr>
</tbody>
</table>

In the absence of reliable data on any other direct indicators, let us look at the trends in two proxy indicators, namely (1) incidence of animal rabies diagnosed at the Department of Rabies Diagnosis and Research at the Medical Research Institute and (2) supply of rabies post exposure prophylaxis immunologicals by the Medical Supplies Division. The thought behind our selection was if the new strategies are not efficient to replace stray dog elimination, then there would be an increase in these two indicators after the policy shift. These two indicators also fulfilled our other requirements namely: (1) objectivity (2) availability (3) accuracy (4) extractable within the time frame and (5) ability to reflect the trend. However, being proxy indicators, any change in these indicators will not be confirmatory and would require more corroborative evidence.

We analysed ten year data (2002-2011). The number of suspected (brain specimen received at the MRI) and confirmed cases (brain specimen positive for rabies virus) of animal and dog rabies at the MRI showed an increase soon after the policy shift. However, it was short lasting, and the numbers started to decrease in 2010. This epidemiological laboratory surveillance data also confirmed that dogs were the predominant host and transmitter of rabies to humans in Sri Lanka followed by cats. The annual national supply of rabies PEP immunologicals did not show any definite pattern after the policy shift. Even before the policy shift, the annual supplies were fluctuating. However, there was no significant increase in these proxy indicators after 2007. This observation, together with the continued reduction in the incidence of human rabies deaths (Table 1) support that the policy decision on cessation of stray dog elimination has not significantly affected the rabies control activities in Sri Lanka.

It is recommended that extending the study period, expanding laboratory surveillance, establishing sentinel surveillance sites, keeping private hospitals under surveillance, amalgamating multi-source data, computerized linking of data and regular trend analysis are prerequisites to improve the quantification of human and animal rabies rates in Sri Lanka.

Control of rabies...

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The two research projects were conducted in collaboration with the Medical Research Institute where the necessary technology was available for the Rapid Fluorescent Focus Inhibition Test: RFFIT which is a WHO recommended method to determine rabies virus neutralizing antibody titres. The first preliminary study was on ‘Determination of efficacy and virus neutralizing antibody levels in canines before and after immunization with anti-rabies vaccine in Kotte: 1999-2002’, and included domestic canines (adult dogs with and without previous vaccination history and puppies of vaccinated and unvaccinated female dogs). The second research study on ‘Serological response following anti-rabies immunization in a representative canine population in Kalutara: 2009-2012’ was a comprehensive study involving stray and domesticated canines in eight different groups on predetermined criteria. Based on the findings of the above mentioned research projects the following conclusions and recommendations were made; maternal antibodies were inadequate to protect the puppies until the primary vaccination against rabies which should be done around 6 weeks and the necessity for a booster vaccination in the first year within a suitable interval after the primary vaccination, with annual boosters thereafter. These research projects were funded by the National Science Foundation (Grant No. RG/99/V/01 and RG/2007/HS/03).

Implementation of the revised anti-rabies vaccination protocol and requesting veterinary surgeons and National Rabies Control authorities to adhere to the new schedule will improve immunity against rabies in stray and domestic dogs (herd immunity). Furthermore, adhering to a single schedule prevents immunization of dogs against rabies according to individual schedules which was the practice in the past. When the herd immunity is increased, reintroduction of rabies virus from wild animals will be prevented, disrupting rabies transmission by both the urban and sylvatic cycles. Finally we will be able to achieve our target of a ‘Rabies free Sri Lanka’ in the near future thus reducing the burden it has on the country’s economy.

Members of the Research Team:

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Opportunities and challenges for elimination of rabies in Sri Lanka

Dr. P. A. L. Harischandra
Director, Public Health Veterinary Services, Ministry of Health

Rabies in Sri Lanka is now approaching elimination stage. Mannar, Kegalle, Nuwaraeliya, Hambanthota and Ampara districts have been free of human rabies since 2012.

Government supported dog rabies control programme in Sri Lanka is conducted by the Public Health Veterinary Services through the primary health care network in Sri Lanka. Trained experts provide planning, organizing and implementation of rabies control strategies for dogs. The main strategies comprise of mass Anti Rabies Vaccination and birth control methods for dogs.

Contd. on page 20
Benefits of eChannelling System

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Control of rabies...

Approximately 150,000 female dogs are subjected to ovariohysterectomy annually during birth control measures.

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Multi-sectoral cooperation is already initiated with the animal health sector and the local government.

Activities being implemented include establishment of a national steering committee, dog rabies vaccination in collaboration with the animal health sector, initiation of amendments of rabies ordinance with collaboration from Ministry of Local Government and training of veterinary investigation officers on dRIT.

The main challenges faced were rapid turnover and the dog population structure (27% annual mortality) which affect the sustainability of herd immunity and the pulsed nature of mass vaccination campaigns. Others include, lack of an island-wide rabies surveillance network, lack of stray dog control settings and lack of logistics and resources for island-wide short term (three months) mop up mass vaccination campaigns.

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Split pills can be uneven...

It will not deliver half the dose with the same efficacy...

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Brand of paracetamol

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- Patients may split the tablets unevenly and experience adverse effects from an excessively high dosage or exacerbation of the disease from a dosage that is too low \(^1\)

Recommend correct dose variant for children*

*Recommend to dose children below the age of 12 years by their weight as per the Panadol for children dosage chart


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