SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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NEWS

PRESIDENT'S MESSAGE

Dear Members,

The month of October unfolded with mixed feelings. The continuing problems afflicting our profession with the sustained student boycott and missing of valuable learning and career development opportunities come foremost to our minds. What is worrying is the general lethargy of all stakeholders – on taking the easy path of placing the blame on someone else. The damage caused to a generation of future medics by lost time to graduation and training as interns and postgraduates is immeasurable. Sadly the current chaos does seem to drag on – along a windy path that has some less cloudy days of potential solutions; and then a total withdrawal of any probability of restarting student work that is so often coupled with flash strikes by doctors, protest marches, traffic jams and sensational media headlines. The response of the wider public is one of severe disappointment and helplessness. The longstanding trust laid on our profession by the general public; a rare privilege that we have freely enjoyed is severely eroded and very likely to become non-existent. The Sri Lanka Medical Association has not ignored this cancerous malady. The Council has discussed, deliberated with stakeholders and gone to many lengths in trying to bring back some order and possibly a semblance of professionalism to our day-to-day practice and health outcomes of the people. On student boycott and unrest, we have concluded that many a student has become a helpless pawn in the hands of those with a hidden agenda. However, the missing factor is that those staging protests and boycotts are not helping themselves or the general public; the latter who have looked upon our medical students as the very pillars of the wonderful foundation laid by our forefathers to ensure the sustenance of good health among all Sri Lankans, see an ugly side to attitude and behaviour among a few, while the silent majority are being considered to be of a similar milieu. No doubt our medical students, academics and doctors have major concerns about private medical education, the risk of the best of our state school teachers being lured to private medical education, the need for better academic standards with monitoring and a sense of greater social equity with any form of private education. Nevertheless, the paradox of poor quality overseas medical education being sought in many parts of Asia by plane loads of Sri Lankan students, and the expensive private "tuition classes" conducted by our own medics locally for these foreign qualified graduates awaiting formal evaluation for licensing to practice as doctors baffles me. My sincere plea to all rational members of our profession is to join hands and try to find a pragmatic, apolitical and lasting solution to the problems at hand. The need of the hour is to steer back to work and ensure the much-needed attitudinal and behavioural change for our vast majority of highly talented and capable future members. Dignity and decorum in all discussions and deliberations must be uppermost in our agenda.

The month of October commemorates many international health related days. The range includes world Children and Elders days, Palliative and Hospice care, Osteoporosis, Breast Cancer awareness, World Heart Day and beating Obesity being some of these. The SLMA joined hands with relevant stakeholders and tried to awaken the medical community to focus on these issues throughout the year, protect the vulnerable, be aware of the risks and problems related to each issue and help Sri Lanka overcome many of the health related issues. I am also happy and proud to inform you that the SLMA has been a formal partner along with the College of General Practitioners in helping the Ministry of Health in planning and formulating a strong and sustainable primary care service with quality assurance along with professional and public enhancement being addressed. The strong commitment of the Secretary of Health and the DGHS and his team of senior officials are very commendable. I look forward to the state sector health facilities at grass root level to flourish and become the jewel in the crown of Sri Lanka's health sector. The re-orientation of our own profession to view primary care service as a very important, holistic and life course commitment of specialization rather than an unmonitored and a downgraded "general practice" that any quack can conduct in any remote setting of Sri Lanka is of prime importance. It is our bounden duty to win the confidence of our public to seek primary care as their first port of call and receive holistic and appropriate health care referral, minimize out of pocket expenditure and achieve lasting health gains for their families and communities.

The SLMA, while formulating a sound mix of topics for discussion at the Foundation Sessions, in the 4th week of October, along with the delivery of high quality orations that have been awarded on a competitive basis; has ventured further in interacting with the Ministry of Finance and Planning. Following our expressing concern on the state insurance scheme introduced for school children, we were invited to the Prime Minister's office for a wider discussion. Our concerns are that given the existence of the free state sponsored Health Service the justification for an insurance scheme for school-going children is unclear. State coverage of premiums for an age group that generally requires very little curative care, rather than targeting children with critical and chronic illness and disability, who are unable to access timely care in the public health sector, appears mismatched. Additionally the major health issues afflicting the school-going population such as malnutrition, obesity, unhealthy eating patterns, insufficient physical activity, exam stress and broader mental health concerns will not be addressed by this insurance scheme. The solutions to these problems lie in health promotion rather than the provision of curative care.

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PRESIDENT'S MESSAGE...

Another concern is that the health insurance scheme now implemented, needs to have a strong regulatory framework in place. We also request the authorities to better regulate the existing private healthcare and insurance industries. The SLMA will continue to discuss with the authorities to strengthen primary care, by developing a strong primary care system, encompassing preventive and curative services that will be beneficial to all Sri Lankans, including school-going children. Additionally two expert committees of the SLMA have formulated excellent proposals that were formally submitted before the deadline for discussion in the budget appropriation bill for 2018 and released to the media for public attention. I am hopeful that the rational requests made (and published in this newsletter) on the required fiscal measures for tobacco, alcohol and sugar sweetened beverages will help protect our population and particularly the future generation with major health gains.

I cannot conclude without highlighting the excellent regional CPD programmes arranged by our own Council representatives for the Provinces; the 5th of which was in Jaffna in late September 2017. I express my sincere gratitude to Dr Ajini Arasaratnam for the wonderful programme, arrangements and local participation she arranged with dedicated care and commitment. World Dementia day was commemorated with the release of important reading material for the public and patients. Dr Achala Jayatilleke also launched the Sinhala version of the book written by Dr Arasaratnam in 2016 regarding Stroke. The multi disciplinary focus on rehabilitation was well illustrated. The quality of the lecture topics and their content was of very high quality. The month of November will be studded with 4 further regional meetings in Wathupitiwela, Negombo, Avissawella and Matara. Please look out for the dates and programmes and participate as best as you can. I must mention that a wonderful evening on Friday 8th December 2017 has been formulated for the traditional Medical Dance at the Cinnamon Grand by our two energetic social secretaries Dr Pramilla Senanayake and Dr Christo Fernando. Their total commitment and meticulous planning predicts a wonderful evening of music song and dance. Please keep the date free and participate along with your family and friends. The SLMA is also planning a dance-training schedule for its members that will no doubt improve our own physical, social and psychological health!

Yours truly,

Chandrika Wijeyaratne

President SLMA

SLMA FOUNDATION SESSIONS 2017

Dr Achala Balasuriya
Honorary Treasurer, SLMA

The Sri Lanka Medical Association (SLMA) held its Foundation Sessions at the N D W Lionel Memorial Auditorium from 26th to 28th October 2017. This event of historical value which originated in 1997 during the tenure of Dr Ramachandran as the President of SLMA, has been held each year since and is one of the main academic activities of the SLMA. The concept of establishing the Foundation Sessions was to fill the gap between academic activities occurring between Annual Sessions from one year to the next.

The 20th Foundation Sessions were rich in content variety as well as being a vibrant educational activity with the participation of more than 100 registrants from various specialities in the medical field. SLMA, being the apex medical body in the country has over 5000 members, and most importantly the membership is open to all members of the medical profession.

The Chief Guest for the Inauguration Ceremony was Dr Iyanthi Abeyewickreme, Immediate Past President of the SLMA, and the Guest of Honour was Mr Ravi Algama, Senior Counsel of the Supreme Court.

One of the main highlights at this event was the E M Wijerama Endowment Lecture delivered by Professor Gita Fernando, a Past President of the SLMA, An Emeritus Professor of Pharmacology at the University of Sri Jayewardenepura, and currently the Chairperson of the Medicinal Drugs Committee of the SLMA. The lecture was entitled “Role of a Clinical Pharmacologist in the Healthcare System - Yesterday, Today, Tomorrow”, which highlighted the need for a Clinical Pharmacologist in hospital practice and the lack of such an appointment in the Ministry of Health in Sri Lanka.

Awards were presented to winners of Free Papers, Research Grants and also to media personnel for their contributions to medical reporting.

In keeping with the 130th Annual Academic Sessions of the SLMA, the theme of the scientific programme of the Foundation Sessions was also on “Patient Engagement and Professional Enhancement”.

On the first day (26th of October), a very important workshop on Occupational Health and Safety was conducted by Dr Champika Amarasinghe from the Ministry of Labour and NIOSH.

The second day of the sessions was on “Clinical pearls for managing common ailments” in which, presentations were made on rheumatology, gastroenterology, nephrology and haematology. Each session was covered by experts in the field based on clinical case scenarios.

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SLMA FOUNDATION SESSIONS...

The Rheumatology case based discussion was conducted by Consultant Rheumatologists, Drs Duminda Munidasa, Monika de Silva and Jayathri Jagoda; the Gastroentorology discussion was led by Drs Anuradha Dassanyake, Sanjeewa Samaranayake and Nilesh Fernandopulle; the Nephrology discussion was conducted by Drs Mathu Selvarajah and Pramil Rajakrishna; and the Haematology discussion by Drs Chandana Wickramaratne and Visakha Ratnamalala.

The Sir Nicholas Attygalle Oration was delivered by Dr Kapila Jayaratne, Consultant Community Physician, on the topic entitled "Changing the story of pregnant mothers: A broad based approach".

The final day (28th October) of the sessions had an interesting symposium on "Palliative and End of Life Care" conducted successfully by Professor Thashi Chang, Dr Manoj Edirisooriya and Dr Clifford Perera. The concept of good death, ethical considerations and essence of palliative care were discussed.

The formal launching of the Palliative and End of Life Care Manual and Website was carried out by the Palliative Care Task Force of the SLMA under the guidance of Professor Chandrika Wijeyaratne, President of the SLMA, while the Director General of Health Services was the Guest of Honour. Mr Ranjan Gomez of the Holy Trinity Foundation that generously contributed to the SLMA's effort to implement palliative care services in the country was also in attendance.

The final session of the day was on palliative care of respiratory, neurological and cardiac disease and this symposium was conducted by Dr Ravini Karunathilake, Consultant Respiratory Physician, Dr Gamini Pathirana, Consultant Neurologist and Dr Chinthaka Hathhalwatte, Consultant Cardiologist.








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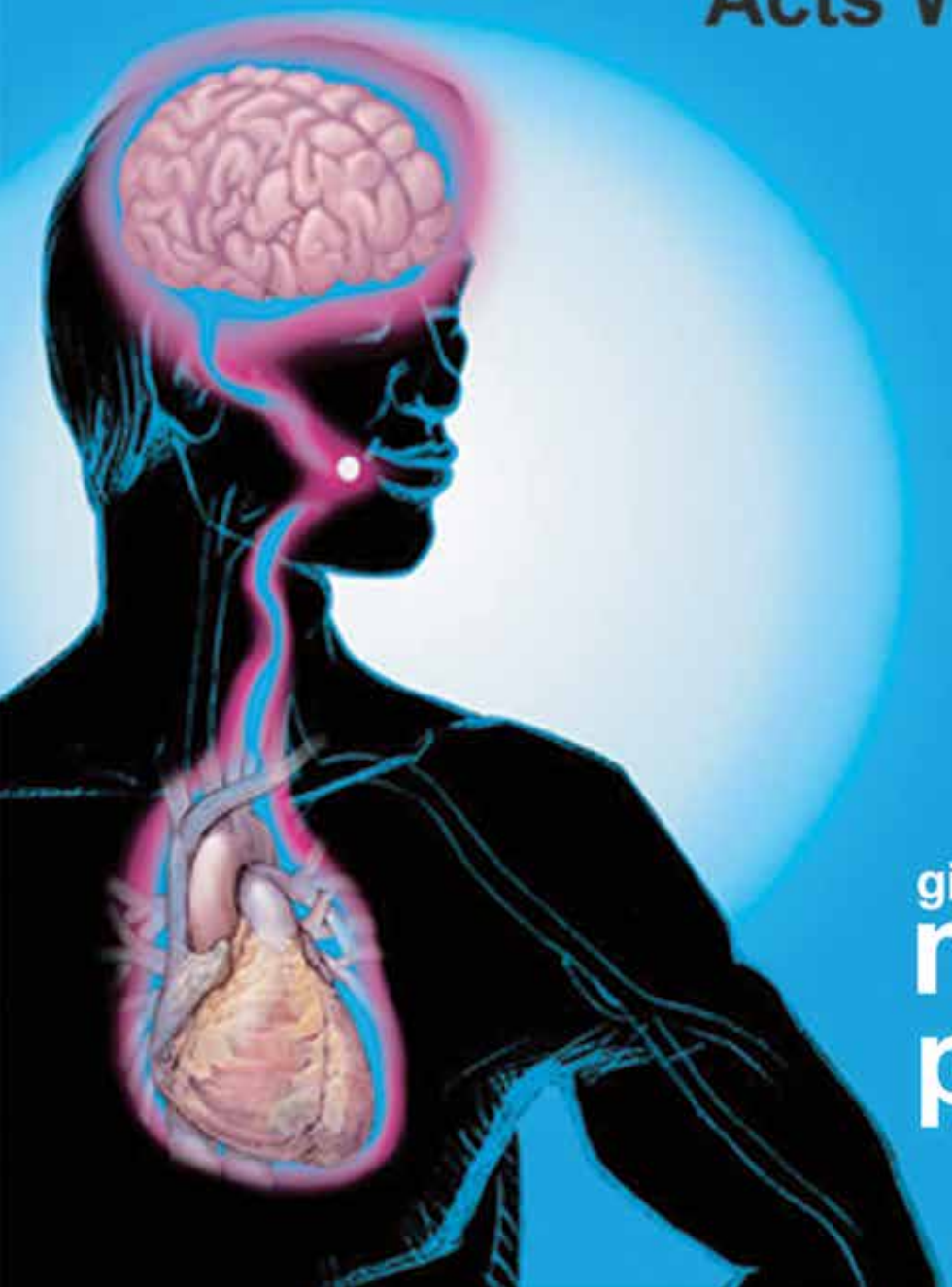

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PRIZES AND AWARDS 2017

FOR RESEARCH PAPERS PRESENTED AT THE 130TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS 2017

1. E M Wijerama Award – PP 081

PP 081

Title: FACTORS ASSOCIATED WITH THE DECISION ON KIDNEY TRANSPLANTATION AMONG ADVANCED CHRONIC KIDNEY DISEASE PATIENTS ATTENDING THE DISTRICT GENERAL HOSPITAL POLONNARUWA

Sandaruwanie PKS[1], De Silva Weliange AASH[2]

[1]ET and R Unit, Ministry of Health, Sri Lanka; [2]Department of Community Medicine, Faculty of Medicine, University of Colombo, Sri Lanka

2. S E Seneviratna Award – OP 053

OP 053

Title: EVALUATION OF PHARMACODYNAMIC PROPERTIES AND SAFETY OF CINNAMOMUM ZEYLANICUM (CEYLON CINNAMON) IN HEALTHY ADULTS: A PHASE I CLINICAL TRIAL

Ranasinghe P[1], Ramanayake V[1], Jayawardena R[2], Pigera S[1], Wathurapatha WS[1], Premakumara GAS[3], Katulanda P[4], Constantine GR[4], Galappaththy P[1]

[1]Department of Pharmacology, Faculty of Medicine, University of Colombo, Sri Lanka; [2]Department of Physiology, Faculty of Medicine, University of Colombo, Sri Lanka; [3]Industrial Technology Institute, Colombo, Sri Lanka; [4]Department of Clinical Medicine, Faculty of Medicine, University of Colombo, Sri Lanka

3. H K T Fernando Award – PP 046

PP 046

Title: HEIGHT MEASUREMENT TECHNIQUE IN OSTEOPOROSIS PATIENTS

Kottahachchi DC[1], Gao F[2], Sztal-Mazer S[2], Topliss DJ[2]

[1]Faculty of Medicine, University of Kelaniya, Sri Lanka; [2]The Alfred Diabetes and Endocrinology Department, Melbourne, Australia

4. Sir Nicholas Attygalle Award – PP 044

PP 044

Title: DETERMINANTS OF BALANCE CONFIDENCE (BC) AND STANDING BALANCE PERFORMANCE (SBP) IN STROKE SURVIVORS WITH HEMIPLEGIA

Sandaruwan MHH[1], Fernando ADA[2]

[1]BSc Physiotherapy Degree Programme, Faculty of Medicine, University of Colombo, Sri Lanka; [2]Department of Physiology, Faculty of Medicine, University of Colombo, Sri Lanka

5. Wilson Peiris Award – PP 037

PP 037

Title: ATTITUDES ON DIABETIC NEPHROPATHY IN PARENTS OF ADOLESCENTS WITH TYPE 1 DIABETES AND INCREASED URINARY ALBUMIN EXCRETION: A QUALITATIVE STUDY

Wijewickrama ES[1], Liyanage UA[1], Samaranayake D[1], Mythily S[1], De Abrew K[1], Wijesuriya M[2]

[1]Faculty of Medicine, University of Colombo, Sri Lanka; [2]National Diabetes Center, Rajagiriya, Sri Lanka

6. Daphne Attygalle Award for the best paper in Cancer – PP 083 & PP 129

PP 083

Title: IMPLEMENTATION OF MULTI-GENE PANEL TESTING FOR HEREDITARY CANCER PREDISPOSITION IN SRI LANKA: INITIAL EXPERIENCES

Sirisena UND[1], Neththikumara N[1], Wetthasinghe K[1], Herath L[1], Dissanayake VHW[1]

[1]Human Genetics Unit, Faculty of Medicine, University of Colombo, Sri Lanka

PP 129

Title:

DETECTION OF HUMAN PAPILLOMAVIRUS IN PATIENTS WITH ORAL AND OROPHARYNGEAL CARCINOMAS

Samaraweera B[1], Abeynayake JI[1]

[1]Department of Virology, Medical Research Institute, Colombo, Sri Lanka

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PRIZES AND AWARDS...

7. Sir Frank Gunasekera Award for the best paper in Community Medicine – OP 042

OP 042

Title: AN ISLANDWIDE HOSPITAL BASED EPIDEMIOLOGICAL SURVEY OF HAEMOGLOBINOPATHIES AND AN ASSESSMENT OF STANDARDS OF CARE IN 23 CENTRES

Premawardhana AP[1], Mudiyanse RM[2], Jifri MN[3], Nelumdeniya UBP[4], Silva DPSI[5], Nizri AHM[5], Rajiyah MOF[1], de Silva TUN[6], Pushpakumara KRC[7], Dissanayake DMR[8], Jansz M[9], Rifaya MI[10], Navarathne NMUSB[11], Arambepola WWMM[12], Thirukumaran V[13], Vaidyanatha USDeS[14] , Mendis D[14], Weerasekara KP[14], De Silva NN[14], Meththananda DSG[1], Oliveri NF[15], Weatherall DJ[16]

[1]Faculty of Medicine, University of Kelaniya, Sri Lanka; [2]Faculty of Medicine, University of Peradeniya, Sri Lanka; [3]District General Hospital, Matale, Sri Lanka; [4]Provincial General Hospital, Badulla, Sri Lanka; [5]Hemal's Adolescent and Adult Thalassaemia Care Centre, North Colombo Teaching Hospital, Sri Lanka; [6]Teaching Hospital, Anuradhapura, Sri Lanka; [7]District General Hospital, Polonnaruwa, Sri Lanka; [8]General Hospital, Chilaw, Sri Lanka; [9]General Hospital, Vavuniya, Sri Lanka; [10]District General Hospital, Ampara, Sri Lanka; [11]District General Hospital, Monaragala, Sri Lanka; [12]Teaching Hospital, Kandy, Sri Lanka; [13]Teaching Hospital, Batticaloa, Sri Lanka; [14]Lady Ridgeway Hospital, Colombo, Sri Lanka; [15]University of Toronto, Canada; [16]University of Oxford, UK

8. Kumaradasa Rajasuriya Award for the best paper in Tropical Medicine – PP 002

PP 002

Title: PLASMODIUM VIVAX RELAPSES: A CHALLENGE TO THE PREVENTION OF REINTRODUCTION OF MALARIA

Dharmawardena P[1], Premaratne R[2], Fernando SD[3]

[1]Anti Malaria Campaign, Sri Lanka; [2]Ministry of Health, Sri Lanka; [3]Department of Parasitology, Faculty of Medicine, University of Colombo, Sri Lanka

9. Special Prize in Cardiology – PP 093

PP 093

Title: CHARACTERISTICS OF YOUNG PATIENTS WITH ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION; A SINGLE CENTRE EXPERIENCE

Bandara HGWAPL[1], Kogulan T[1], Jegavanthan A[1], Jayasekara NMTC[1], Kodithuwakku NW[1], Siribaddana MAH[1], Dolapihilla SNB[1], Jayawikcreme SR[1], Sirisena TS[1], Weerakoon WMG[1]

[1]Teaching Hospital, Kandy, Sri Lanka

10. S Ramachandran Award for the best Scientific Communication in Nephrology – OP 069

OP 069

Title: A RANDOMIZED (DOUBLE BLIND) CONTROL TRIAL OF CORTICOSTEROIDS AND DOXYCYCLINE IN PATIENTS PRESENTING WITH ACUTE INTERSTITIAL NEPHRITIS FROM CHRONIC KIDNEY DISEASE OF UNCERTAIN AETIOLOGY ENDEMIC REGIONS

Badurdeen MZ[1], Nanayakkara N[4], Wazil AWM[2], Ratnatunga NVI[2], Abeysekara DTJ[1], Rajakrishna P[4], Thinnarachchi J[4], Kumarasiril PVR[3], Welagedera DMSDKD[4], Rajapaksha RMNN[4], Alwis APD[4]

[1]Centre for Education Research and Training on Kidney Diseases (CERTKiD), Faculty of Medicine, University of Peradeniya, Sri Lanka, [2]Department of Pathology, Faculty of Medicine, University of Peradeniya, Sri Lanka; [3]Department of Community Medicine, Faculty of Medicine, University of Peradeniya, Sri Lanka; [4]Renal Transplant and Dialysis Unit, Teaching Hospital, Kandy, Sri Lanka

11. SLACPT Award for the best presentation in Pharmacology – OP 054

OP 054

Title: PHARMACOKINETICS OF ZINC IN PRE-DIABETES AFTER ORAL ZINC ADMINISTRATION

Ranasinghe P[1], Ramanayake V[1], Galappaththy P[1], Jayawardena R[2], Wathurapatha WS[1], Katulanda P[3], Constantine GR[4]

[1]Department of Pharmacology, Faculty of Medicine, University of Colombo, Sri Lanka; [2]Department of Physiology, Faculty of Medicine, University of Colombo, Sri Lanka; [3]Department of Clinical Medicine, Faculty of Medicine, University of Colombo, Sri Lanka

12. SLMA Prize for the best Poster – PP 004 & PP 084

PP 004

Title: DIAGNOSTIC CHALLENGES AND CASE MANAGEMENT OF THE FIRST IMPORTED CASE OF PLASMODIUM KNOWLESI REPORTED IN SRI LANKA

Ranaweera D[1], Danansuriya M[1], Pahalagedera K[2], Gunesekera KTDeA[1], Dharmawardena P[1], Hapuarachchi HC[3], Herath HDB[1], Fernando SD[4]

[1]Anti Malaria Campaign, Sri Lanka; [2]Regional Malaria Office Kandy, Anti Malaria Campaign, Sri Lanka; [3]Environmental Health Institute, National Environmental Agency, Singapore; [4]Department of Parasitology, Faculty of Medicine, University of Colombo, Sri Lanka

PP 084

Title: THE RELATIONSHIP BETWEEN THE LEVEL OF MOTOR FUNCTIONS AND BALANCE IN POST-STROKE PATIENTS

Sandeepani HMV[1], Dissanayake WDN[2]

[1]Department of Allied Health Sciences, Faculty of Medicine, University of Colombo, Sri Lanka; [2]Department of Physiology, Faculty of Medicine, University of Colombo, Sri Lanka

Research Grants

1. SLMA-Glaxo Welcome Research Grant – Awarded to Dr. W M D G Bandara for the project titled 'Evaluation of antimicrobial potential of silver nano preparations synthesized from Sri Lankan medicinal plants

2. SLMA Research Grant – not awarded

3. Dr. Thistle Jayawardena SLMA Research Grant for Intensive and Critical Care – not awarded

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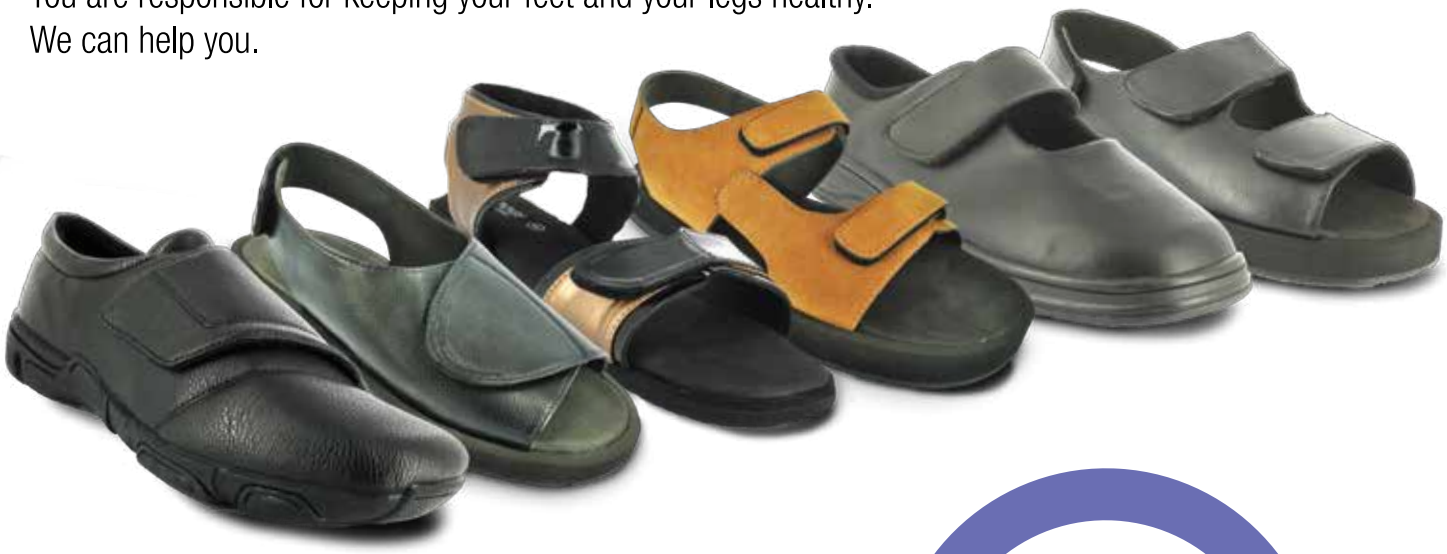

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LETTER 01

14th October 2017
Hon. Minister of Finance and Media
Ministry of Finance and Planning
Colombo 1

Dear Sir,

Re: Taxation on Sweetened Beverages

The Sri Lanka Medical Association wishes to make a strong recommendation on the above subject in concurrence with major stakeholders, viz. NCD Alliance of Sri Lanka, Diabetes Association of Sri Lanka and Sri Lanka Medical Nutrition Association.

Background

Obesity is a global epidemic and a major risk factor linked to the growing burden of non-communicable diseases (NCDs) including heart disease, type 2 diabetes and some forms of cancers. NCDs are the leading causes of premature mortality and morbidity globally and nationally. In Sri Lanka 70% of the deaths occur due to chronic NCDs with nearly 1/5th of this being premature.

The prevalence of overweight and obesity has doubled among schoolchildren over the last 10 years; while one third of adult females and one fourth of adult males are overweight in the country. As a result the prevalence of diabetes has increased by approximately 300% over the last 2 decades, which has added an enormous burden to the health sector with increasing treatment costs related to diabetes related complications.

The Ministry of Health developed a National Chronic NCD policy (2010) and a multi sectoral NCD Strategic Plan for the Prevention and Control of NCDs 2017 - 2025. These strategies set an ambitious target of halting a further rise in obesity and diabetes prevalence and aim for 0% by 2025.

Evidence for action

Given the rising trends in obesity and diabetes, the Expert Committee on Non-communicable diseases of the SLMA has examined the factors that contribute to these epidemics

- Given the persistent trend of a rise in overweight and obesity, the related illnesses, disability, and death will have an increasingly adverse impact on the Sri Lankan population. Even a small increase in weight among individuals of normal weight has major implications for metabolic dysfunction, diabetes, heart disease, and cancer risk.
- Sugar Sweetened Beverages (SSB) contain sugar that is added during processing, manufacturing, packaging, or preparation. At present, one third of schoolchildren are consuming these unhealthy beverages in Sri Lanka.
- High sugar consumption mainly through processed and ultra-processed food products is one of the major risk factors for obesity and co-morbidities such as diabetes. Hence, the sugar concentration as well as the quantity of sugar in the container must be taken into account. Large size containers obviously contain heavy amounts of sugar; with no guarantee how much people consume once brought to the home.
- Some beverages contain non-sugar sweeteners (NSS), which have not been proven as being totally healthy. There is emerging evidence to conclude that NSS do contribute to ill-health.
- Ending Childhood Obesity by implementing an 'effective tax on sugar-sweetened beverages' is a key recommendation issued by the World Health Organization.
- Available evidence suggests that a 20 per cent increase of the price of SSBs is required to have a significant impact on purchasing, consumption, and ultimately a reduction of obesity and a population-wide health gain.
- Globally, fiscal measures such as taxes are increasingly recognized as effective complementary tools to address obesity at population level. In this context, countries such as Denmark, Finland, France, Hungary, Ireland, Mexico, Mauritius, Norway and Thailand have levied taxes on SSBs, while other countries such the United Kingdom, and Australia have recently announced their intention to introduce such taxes.

Scope of the Tax on Beverages

Many beverages contain added caloric sweeteners such as sucrose, high-fructose corn syrup (HFCS), or fruit-juice concentrates, which include but are not limited to: fruit, vegetable or mixed juices, water based flavored drinks including 'sport and energy drinks', coffee, coffee substitute, tea and herbal drinks, chocolate or malt based drinks, cereal grain and tree nut based beverages, milk or dairy based drinks.

Proposed Taxation for Sweetened Beverages:

The most accurate proxy for harm caused by sweetened beverages is its added sugar content. The advantage of this approach is that it is better targeted and the tax is in direct proportion to the level of added sugar in beverages. However, other caloric sweeteners in beverages are also to be considered for taxation procedure.

Recommendation

We strongly recommend imposing taxation on sweetened beverages as a part of a comprehensive package of interventions throughout the life-course to control chronic NCDs in Sri Lanka. Some guidelines to impose taxation on sweetened beverages are mentioned below for your kind consideration.

1. Ten percent Tax to be imposed on all beverages with the total sugar concentration more than 6g/100ml
2. Further, tax to be added if the total sugar content exceeds 18g and to be increased in dose dependent manner as total sugar increases irrespective of the container size.
3. Other caloric sweeteners in beverages are also to be considered for this taxation procedure.

We pledge our best support to the government of Sri Lanka in taking effective measures to stem the tide of chronic NCDs and thereby increase national productivity, and ensure optimal health in our future generations.

Yours sincerely,

Professor Chandrika N Wijeyaratne
President, Sri Lanka Medical Association

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Hon. Minister of Finance and Media
Ministry of Finance and Planning
The Secretariat
Colombo 1

Dear Sir,

Re: The Tax on Alcohol and Tobacco Products and the availability of Alcohol Products

The Expert Committee on Tobacco, Alcohol and Illicit Drugs of the Sri Lanka Medical Association (SLMA) recommends that the taxation and price of tobacco and alcohol products should be increased this year to further reduce the affordability of these products.

One important consideration that is usually overlooked is that the majority of the adult population in Sri Lanka does not use tobacco or alcohol. Over 85% of adults do not smoke and over 80% of adults do not consume alcohol, according to the statistics of the Ministry of Health. A study by the National Authority on Tobacco and Alcohol (NATA), SLMA and the World Health Organization (WHO) showed that the annual economic cost of tobacco and alcohol use was at least Rupees 209 billion in Sri Lanka. Therefore, in this case, a minority habit causes extensive economic and social harm to the entire population of the country. The only beneficiaries of this situation are the industries that produce and market these products.

The Expert Committee recommends that the price of such products should increase in view of the following reasons:

- Making alcohol and tobacco more affordable and available will lead to more young people taking up alcohol and tobacco and lead to more problems in society, an increase in health care bills and much suffering for individuals and their families.
- Scientific research has shown that the overall consumption or the per-capita consumption (consumption per person) comes down with price increases. As per capita consumption is proportionate to the extent of alcohol and tobacco related problems in a society, a reduction in alcohol and tobacco related problems will be seen with reduced consumption.
- Econometric Studies also show that the tax increase will increase the government revenue at the same time. Agencies such as the World Health Organization strongly recommend increasing taxation to reduce harm and increase government revenue for both alcohol and tobacco. Both the tobacco and alcohol industries use the bogeys of "smuggling" and "increase" of illicit products and substitute products to mislead policy makers. There is no basis or sound evidence for these arguments, which are used by the industry lobby.
- There is also very strong evidence that increasing the price of cigarettes and alcohol will also prevent young persons including school children taking up cigarettes and alcohol.
- Both tobacco and alcohol are direct causes of poverty and ill health. It has been shown that the poor are the biggest beneficiaries of increasing the prices of these substances as they reduce their own consumption when the prices are increased. Therefore it is a pro-poor policy, not otherwise. The illicit trade should be dealt with by appropriate law enforcement and not by trying to compete by price.

It has also been recently announced in Parliament that the Ministry of Tourism is seeking the relaxation of laws restricting the availability of alcohol products, to make such products easily available for "tourists".

There is no evidence anywhere in the world that tourists visit specific countries to consume alcohol. Even if it was the case, Sri Lanka should surely not aspire to be one of them. The "tourist industry" is another bogey by the industry, which seems to have misled several policy makers. The effect of increasing availability of alcohol will simply increase the use of alcohol by Sri Lankans, not tourists.

There is ample evidence that increasing the availability of alcohol will not only increase its use, but also escalate social problems, such as domestic other forms of violence and road traffic accidents. The effects mentioned on the tourism industry seem irrelevant when it comes to the strata of tourists who in fact bring in foreign currency. These tourists will anyhow stay in star class hotels and do have access to alcoholic beverages.

Hence, we strongly recommend increasing the tax on alcohol and tobacco products, taking into account inflation and affordability. The SLMA also requests the Government of Sri Lanka not to initiate any steps towards relaxing the licensing and other laws which will enable alcohol to be available and accessible easily.

Professor Chandrika Wijeyaratne
President
Sri Lanka Medical Association

SASSM

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DR DESMOND FERNANDO MEMORIAL LECTURE 2016

Delivered by Dr Ruvaiz Haniffa, MBBS DFM MSc PgDip MD FCGP MRCGP, at the Regional Meeting of the Sri Lanka Medical Association held in conjunction with the Kalutara Clinical Society on Saturday 17th December 2016 at Hotel Blue Waters Kalutara

Bothalage Desmond James Stanley Fernando was born on 26th November 1930 to Mr. James Fernando and Mrs Mercia Fernando as the eldest in a family of three. He had his early education at St. Thomas Preparatory School Kollupitiya and Royal College Colombo and completed his secondary education at St Thomas College Mount Lavinia, with academic excellence. He entered the Faculty of Medicine, University of Colombo in 1948 on a university scholarship and passed out with MBBS in 1954. Upon passing out he married Ms Sumana Hemalatha De Silva the same year and went on to have two children - Ms Sreeni Manohari Dalpatadu, Attorney-At-Law and Professor Devaka Fernando, Professor of Endocrine and Metabolic Health at the Post-Graduate University of Hallam, Sheffield, United Kingdom.

Dr B D J S Fernando, a visionary in the field of General Practice in Sri Lanka, was a multifaceted medical luminary who has been described by a contemporary of his as “a lovable man, who achieved a lot, and whenever he was asked, helped fellowman in great measure”. He was a clinician, inventor, author, medical educationist, medical administrator, health ambassador and above all a true servant of the Sri Lankan medical profession.

The Clinician

He was in government service until 1958 – serving as DMO Elpitiya and DMO Minnuwangoda. He left government service to set up his own General Practice clinic in Ratmalana in 1958. During the mid-late 1960’s until 1976, Dr. Fernando worked in the USA and the UK where he had the opportunity to meet with the pioneers in Paediatrics and Family Medicine - the latter discipline was which he played such a big role in establishing as a clinical discipline in Sri Lanka in the early and mid-1980’s. On returning to Sri Lanka in 1976 he resumed his practice which he continued till 2010 until his retirement from active practice.

The Inventor

Together with his colleague Dr. P T De Silva he developed a phonocardiograph which was produced locally. He developed a rubber band haemorrhoid ligator forceps and a cryosurgery gun for which he holds international patents. He designed and popularized the use of a locally produced Monofilament.

The Medical Author

He had fourteen single author articles published in prestigious medical journals. He contributed to every issue of the Sri Lankan Family Physician with inspiring and unique papers since its first issue in 1979. He also published six research papers and presented papers and participated in over thirty international conferences. He contributed chapters to the SLMA Guidelines on vaccines 1st to 4th Editions.

The 5th edition of the SLMA Guidelines on Vaccines published in 2014 and the Sri Lankan Family Physician Vol 31(1) published in 2014 were dedicated to his memory.

The Medical Educationist

As a founder member of the Board of Study in Family Medicine at the Post-Graduate Institute of Medicine (PGIM) of the University of Colombo

Dr. Desmond Fernando
MBBS, FCGP, FAAFP
Family Physician
1930 -2012

in 1979 he was associated with planning and the implementation of the academic activities of the College of General Practitioners of Sri Lanka and (CGPSL) Independent Medical Practitioners Association of Sri Lanka for 3 decades. He functioned as the course coordinator, examiner and chief examiner of the Diploma in Family Medicine and MD (Family Medicine) exams at the PGIM. He helped the CGPSL and the PGIM to organize the training sessions for its members in achieving the arduous task of making teachers out of family doctors with the help of his overseas contacts in Family Medicine. He played the lead role in inculcating the culture of clinical teaching among General Practitioners in Sri Lanka by creating and institutionalizing the Faculty of Teachers (FoT) of the CGPSL.

The Medical Administrator

He was the President of the College of General Practitioners of Sri Lanka

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HEALTH AND DIPLOMACY...

from 1993 to 1996 and served as the Vice President of the Independent Medical Practitioners Association of Sri Lanka. He held membership in many important Health Ministry Committees including - Drug Evaluation Sub Committee (DESC) and Advisory Committee on Communicable Diseases (ACCD). He has served as Honorary Advisor to the Minister of Health on Private Sector Health Services and played a lead role in conducting the DFM (and subsequently the MD Family Medicine) exam in Chennai, India (from 1999 until 2000). These to date remain the only Post Graduate Medical Examinations to be conducted by the PGIM overseas.

The Health Ambassador

He was a pioneering member of WONCA (the World Organization of Family Doctors) from Sri Lanka and served on its Council. He led the largest Sri Lankan delegation of Family Physicians overseas to the Family Doctors Conference in Lahore, Pakistan in 1994. He used these attributes, among other issues, to make family medicine a recognized and respected academic discipline in Sri Lanka and the rest of the world, especially the Asia Pacific Region.

I did not have the privilege of personally meeting or knowing Dr Desmond Fernando, but as a proud product of his vision to establish family medicine as a separate clinical discipline in Sri Lanka I am indeed honoured and humbled as a Family Physician to have been selected to deliver the 2nd Desmond Fernando Memorial Lecture today. I dedicate this lecture to the memory of this pioneering Family Physician.

HEALTH AND DIPLOMACY

Introduction

As stated in the World Health Organization (WHO) Constitution (among other principles) 'The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states.' In today's multipolar world, power and influence are exercised by many different groups of states and non-state actors through many different channels at many different settings using many different mechanisms and techniques.

In this scenario, the measurement of the traditional 'Balance of Power' is no longer confined to military power alone (Hard Power). Soft and 'Smart' Power are playing a larger role in determining the 'Balance of Power' in regional settings in particular and global settings in general.

Health is an issue that crosses many of these boundaries of power because the inputs in to maintaining 'good health' and the outcomes of 'bad' health' are fundamentally universal and is only affected by the social determinants of health. These social determinants cause inequality in health status between and within countries which requires constant negotiation to make right. Negotiation is the operational word in Edmund Burke's classical definition of the term 'diplomacy' in 1796. Hence, the negotiation of health matters at intentional level requires an intimate knowledge of both health and diplomacy and the wider theoretical basis upon which diplomacy depends-International Relations.

Due to the trans-border nature of health issues today (Table 1) the solution to them require a multi sectoral approach. The fundamental question to be asked in dealing with these issue is Are these health issues needing foreign and trade policy solution or are these foreign and trade policy issues requiring a health intervention? Furthermore, Does the Sri Lankan foreign, trade and health sectors have the capacity to deal with these issues either in isolation or collectively?

As discussed by Kickbusch and Kokeny in their paper Global Health Diplomacy: five years on [1] the following four elements have contributed to the ascent of global health diplomacy.

- Foreign affairs ministries are becoming more involved in health because of its relevance for soft power, security policy, trade agreements and environmental and development policy
- The venues of health diplomacy are changing; many new actors outside the WHO have (health) diplomats
- Globalization; new donor-recipient relationships, new types of health alliances and rise of cooperation between low and middle-income countries have heightened the need for health diplomacy
- Need for competent health diplomats.

What is Health Diplomacy

There is no accepted definition for the term as yet. An analysis of the many definitions been used today identifies the global nature of the issue, multi stakeholder/actor involvement, communication, interaction, negotiation, cooperation, and help and politics and decision making as the core themes of these definitions. (Table 2)

Table 1: Examples of the trans-border nature of health issues

International scenario	*Sri Lankan scenario*
• Eradication of small pox from the world in 1930	Eradication of Malaria – constant danger of resurgence due to high prevalence in the SAARC region
• Marching toward eradication of polio from the global	TB – danger of increase in incidence and Prevalence due to influx of foreign labour
• International Health Regulation (IHR) 2008	Kidney transplantation of foreign citizens in Sri Lanka
• Framework Convention on Tobacco Control (FCTC) 2012	Health impacts of economic and technological cooperation agreements with other countries
• Influenza Preparedness Framework 2010	
• Trade Aspects of Intellectual Property Rights (TRIPS) 1990	

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HEALTH AND DIPLOMACY...

Global health diplomacy has been practiced from ancient times as evident in the - Exchange of physicians between Royal Courts as gesture of good will, declaring cease fires during war and conflict for health reasons (evacuation of dead, tend to injured), Informing the spread of Contagious Diseases in territories and restrict access to the territory, Use of health as means to spread religious and other ideology (Christian Missionary work in Africa)- This even lead to colonization and imperialism ! The modern evolution of the concept of global health is thought to have begun with the formation of the League of Nations and the office Office d'Hygiène Public (OIHP) in 1851. (Table 3)

- 'Multi-level, multi-actor negotiation process that shape and manage the global policy environment for health.' – Kickbusch et al 2007
- 'A system of organization, communication and negotiation process that shape the global policy environment in the sphere of health and its determinants.' – Kickbusch et al 2013
- 'Chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems and securing right to health for vulnerable populations' – Health Diplomat 2007

Table 2: Selected definitions for Global Health Diplomacy

Table 3: Phases of development of the concept of Health Diplomacy.

Phase I (1850s-1950s) *Institutional Foundations of Global Health*	"Golden age" –discovery of x rays, stethoscope, germ theory First International Conference on Sanitation 1851. Formation of League of Nations and Office d'Hygiène Public (OIHP). Private Philanthropy (Rockefeller Institute of Medical Research) , League of Nations Health Organization(1920) and WHO (1948)
Phase II (1970s-1990s) *Eradication and emergence of disease and rise of neoliberalism*	Eradication of Smallpox (1980). Alma Ata declaration (1978) Emergence of HIV/AIDS and the global response. Neoliberal reforms of health system (E.g. Privatization of the NHS in the UK)
Phase III (2000s) *Partnerships, Goals, Innovations and Pandemic Flu*	Public-private partnership at international level for health financing (GAVI, UNITAID and GFATM). MDGs. G8 and G20 communiqués on health, international celebrity involvement. Global security concerns due to H5N1 (2003) and H1N1 (2009). Concern over focused on "narrow" number of health issues resulting certain health situations to be ignored (War and health, Environment and health .....)

Basics for practice of Health Diplomacy

Due to the fact of current health issues being cross border in nature, multi stakeholder involvement and requiring an intra and inter disciplinary approach in addressing the issues, the model of 'traditional diplomacy' is incapable of fully addressing the issues to the satisfaction and benefit of all stake holders in an equitable manner. Hence a new approach was needed. This 'new diplomacy' describes shifts in foreign policy that challenge how diplomatic practice is carried out [2]. A core element in this shift as discussed by Lee and Smith, is the shift from highly trained officials within foreign ministries, to a border range of other actors who may not have formal training in the art and practice of international relations and diplomacy. These actors may include states, non-state actors, non-governmental organizations, multinational business entities, philanthropic organizations, political/ religious/ideological organizations or individuals.

'New diplomacy' is increasingly being shaped by non-state actors particularly with regards to health and diplomacy. These non-state actors have the financial clout at international level or grass root following at local level to influence health inputs and outcomes. E.g. Global Fund to fight AIDS, TB and Malaria (GFATM) – This fund receives aid from the Bill and Melinda Gates Foundation, GAVI (Global Alliance for Vaccine and Immunization)- Funded by vaccine producers plus specific initiatives funded by Gate Foundation, Global Polio Eradication Initiative - Rotary International.

In a more negative sense, these non-state entities may even influence and frankly be the cause of outbreaks of infectious disease. E.g.- In 2003 the people of Kano state,

Northern Nigeria began refusing WHO supported Polio vaccination based on rumors, echoed by local political and religious leaders that the campaign represented a Western conspiracy to sterilize the Muslim population (Similar situation is happening now in tribal areas of Pakistan and Afghanistan)

Issues such as war and health (inter and intra state conflicts, fragile states), human displacement and health, environmental health, antimicrobial resistance and the treat of bio terrorism are accentuating the need for 'new diplomacy' to have 'health diplomacy' as at least one of its pillars. This is sine qua non in the context of attainment of peace and security throughout the world.

The practice of health diplomacy within the frame work of the concept of 'new' diplomacy can be summarized in to three major areas

- Core diplomacy or Traditional diplomacy - Formal negotiation between states.
- Bilateral treaties and agreements – Involves high level negotiations between national representatives (health or otherwise). Aims;

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HEALTH AND DIPLOMACY...

- To secure reciprocal healthcare in each other's countries for citizens

- For technical assistance

- Funding for health-related projects

• Multilateral treaties and agreements – Negotiations that come under aegis of multilateral institutions such as the WHO. These institutions lead the effort in shaping agreements and norms with consent and agreement of members. There are about 50 such multi-lateral agreements in the world today. Aims;

-To tackle an identified health issue in a uniform manner taking in to account the epidemiological evidence

- To develop standard operational best practices for health issues

To coordinate global effort in control of health issues

E.g.- Framework Convention on Tobacco Control (FCTC) / International Health Regulations (IHR) – Member states to develop and maintain core capacity to detect, assess, report and respond to public health events and promptly notify WHO of any public health emergency that might affect other nations.

- **Multi stakeholder diplomacy-** International negotiations and interactions in which various states, non-state and multilateral actors work together to address common issues.

- Partnerships between government agencies E.g. – The Family Health Bureau of the Ministry of Health and Ministry of Education programme to improve child nutrition funded by the GOSL

- Global initiatives and International Organizations E.g. Global Fund to fight AIDS, TB and Malaria (GFATM) – This fund receives aid from the Bill and Melinda Gates Foundation, GAVI (Global Alliance for Vaccine and Immunization)- Funded by vaccine producers plus specific initiatives funded by Gate Foundation, Global Polio Eradication Initiative - Rotary International.

- Counterbalancing Conflicts through Health Diplomacy. E.g. eradication of Smallpox during Cold War. Negotiated Ceasefires for health interventions during conflicts (One-day Polio Immunization during Sri Lankan civil war, Guinea Worm Ceasefire in Sudan 1995) – Concept of Health as Bridge for Peace as a strategic element

- **Informal Diplomacy** – Interactions between health and non-health professionals from different sovereign nations, other actors including the public.

- Government Employees – 'Free agents in the field. E.g. US President's Emergency Plan for AIDS relief (PEPFAR) – requires US diplomats to implement and evaluate the plan. US Military personnel involved in health projects for research and humanitarian assistance programmes.

- Private funders and NGOs – Gates Foundation – has disbursed $ 17 billion in medical assistance between 2002-6.

- Research. – Partnerships between individual and/or institutions. Clinical trials funded by pharmaceutical industry to test new medication (drugs, vaccines) –potential for 'health conflicts'

- Humanitarian Assistance and Disaster Response – 'Disaster Diplomacy'

Conclusion

Health is a universal and cross cutting issue. Its effects, at the human level, are universal as well. Social Determinant of Health causes inequality in health status globally. In the modern era, these inequalities are aggravated and accentuated by health and non-health related issues (wars, conflicts, human displacement etc etc). This requires constant dialogue between nation states, non-state actors and myriad of other stakeholders on constant basis.

Though Health Diplomacy currently eludes definitional precision it is a mechanism to discuss/resolve health issues using the principles of International Relations, Foreign Policy and Diplomacy in a globalized world.

Health Diplomacy is becoming an increasingly prominent element in the foreign policy tool kit of state and non-state actors. It requires a delicate combination of technical expertise, legal knowledge and diplomatic skill to be effective to achieve its ultimate goal of improving global health status

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Let's keep Sri Lanka Malaria free

LET'S EMPOWER INTERNS TO SELECT THE SPECIALTIES OF THEIR CHOICE!

Saroj Jayasinghe
Professor of Medicine
University of Colombo

In Sri Lanka, medical graduates select their internship posts based on a complicated nation-wide ranking system that takes into account their performance in clinical assessments and a common MCQ paper. The selection and appointment is firstly to the hospital of their choice, and secondly to the specialty after reporting to the respective hospital. Though this allows higher rankers to secure the specialty of interest, the majority undergo considerable apprehension as they cannot predict which specialties would be available for them at a given hospital. The unfair situation has led to unofficial strategies such as the use of social media to develop a database of self-expressed preferences of graduates. However, these are inefficient and none-binding in nature, and those reporting to the particular hospital have a right to change their previous preferences and fill-up posts that are different to what they initially submitted to the informal database. This situation is very unfortunate because three studies from Sri Lanka (spanning a period of almost 3 decades) and from other countries have demonstrated that, career preferences are made even at the stage of undergraduates (2,3,4,5).

The current system of allocating internship which has gone on for decades is therefore unfair and inefficient. Furthermore it is educationally unsound. Extensive practical training in a specialty of one's choice will offer a distinct educational advantage to any aspiring medical officer. The ability to choose one's specialty at internship is also desirable due to the current requirements to postgraduate training in Sri Lanka. Most postgraduate courses (e.g. MD in General Medicine), mandatorily requires that the prospective candidate should have 6 months of internship in the specialty or undergo 6 months training in an allied specialty (1).

The way forwards is therefore for the Ministry of Health as the principle employer, to develop a formal system that enables the graduates to select at least one six-month period of internship in a specialty of his or her choice. This should be feasible using simple software with the following specifications:

1 A list is made available of names of hospitals, hospital category, their address, and number of vacancies per specialist (or specialty). These are made available through the Ministry of Health's website to give adequate time for prospective intern medical officers to deliberate on their choices.

2 The posts are filled during the day of selection of interns according to the descending order of ranking.

3 The selection is for the specialty of choice for the first or second 6 months of internship within the same hospital. One cannot have the two internship appointments in two different hospitals.

4 Once the first choice of specialty (and the hospital) is made, the programme automatically shows the other recognized posts available in the same hospital for the intern that would be required by the Sri Lanka Medical Council to gain full registration.

5 The intern makes the second selection and confirms choices.

6 The selected choices disappear from the window of the computer interface (i.e. only the posts that are vacant are shown).

7 The intern receives a signed print out immediately after confirming the choices he makes.

8 The next person in the ranking begins the process from step 3 onwards.

There are added advantages of this approach. Empowering interns to select their specialty of choice is certain to make them happier at work. Furthermore, the ability to train in a post relating to the career preference will improve the quality of postgraduate training, as better trained medical officers will enter the training programmes.

Despite all these advantages, it is strange that there is a lack of interest on the part of prospective interns, the Ministry of Health, and the unions to change status quo. The SLMA should take a lead in lobbying for this NOW!

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of which			
saturates	**g**	**0.8**	**0.04**
Carbohydrates (1% TEI)	**g**	**0.3**	**0.015**
of which			
sugars	**g**	**0.3**	**0.015**
lactose	**g**	**<0.3**	**<0.015**
Fibre	**g**	**0**	**0**
Protein (96% TEI)	**g**	**88**	**4.4**
Salt = (Na (g) x 2.5)	**g**	**1.4**	**0.07**
MINERALS			
Sodium	**mg**	**550**	**27**
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LETTER TO THE EDITOR

Editor in Chief SLMA News
Sri Lanka Medical Association
Colombo 7

Dear Sir/Madam

The Time has come to think out of the box to control the Dengue epidemic

Dengue is on the rampage despite much effort to eradicate breeding grounds of the mosquito. A recent stunning observation was a child who was admitted to the cardiac ward at Lady Ridgeway Hospital for Children in Colombo. He was taken up for cardiac surgery after over a month's stay in the ward and unfortunately was diagnosed as having Dengue 2 days following surgery while in the ICU. This clearly indicates that the virus was contracted while in hospital.

How could it happen and could it have been prevented?

Yes, the hospital has loads and loads of dengue patients from all over the country carrying the dengue virus in abundance. Also the hospital is full of mosquitoes and they feed on the infected blood which is easily accessible to them. These infected mosquitoes then bite other children admitted for other illnesses as well as staff members. This results in them contracting dengue once they are in hospital or more often following discharge needing re admission once again but for dengue on this occasion.

Then comes the PHI and action begins. Immediate large scale fogging is then carried out within the hospital which drives out all the infected virus loaded mosquitoes (which are similar to highly destructive missiles) to the neighbourhood thereby infecting all those living around hospitals. This may be one reason why the Western province which has so many large hospitals with dengue patients has the most number of dengue cases.

So what I suggest is that it should be made mandatory that all dengue patients in hospitals should be nursed under the cover of a mosquito net at all times which would greatly help prevent spread of the disease. Also fogging within hospitals should be carefully revisited and pros and cons assessed rather than just fogging which may cause more harm than good.

Eradicating mosquitoes are of paramount importance but seems impossible at present. The next best strategy should be to prevent the mosquitoes getting access to the virus thereby preventing the spread of the disease.

I feel we should change our focus as all our efforts in preventing dengue have failed.

I hope the health authorities could look into this and issue strict guidelines to all health care institutions on use of nets for all patients being treated for dengue fever. It may be cumbersome for the caregivers but worth the effort.

Regards

Dr Shehan Perera
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Lady Ridgeway Hospital for Children
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27th September 2017

DRAFT PROPOSAL ON A NEW APPROACH TO DENGUE PREVENTION

Dr Panduka Wijeyaratne
Chairman
Tropical & Environmental Diseases and Health Associates (Private) Limited - TEDHA

Preamble

The Current Dengue situation in the country is driven by epidemiological, environmental and climatological factors and exacerbated by the proliferation of Aedes aegypti and Aedes albopictus, the key Dengue vectors in the country, particularly the former.

The mosquito vectors are day time biters emphasizing dusk and dawn peaks both indoors and outdoors with a minor peak around noon. The predominant breeding sites are small containers, tyres, gutters, tree holes, leaf axils with less in small unpolluted drains and the like. Breeding has diversified over the years. These features are important to keep in mind in a strategic preventive strategy towards minimizing of vector breeding – the main thrust of sustained Dengue prevention in the absence of an efficacious vaccine. Excellent case management support and efficient countrywide surveillance are imperative. Solid program management is key to effective prevention and for progressive reduction of targets and, participation of principal stakeholders outlined in this document is imperative for sustainable and effective prevention and reduction of targets.

Background

Status of Dengue From 1st Jan – 28th July 2017 is 4 times higher than the average number of cases reported for the same period from 2010 – 2016: (National Dengue Control Unit - NDCU)

- Cases - 110,372
- Deaths – 301
- Vectors - 40% which are container breeders.

Key Considerations in this proposal are:

- Existence of the Presidential Task Force and its scope of work (unavailable for reference to me)
- Current Overall Strategy of the NDCU
- Existing framework (from Tissera et al 2016)
- Source reduction – Vectors and their principal bionomics

- Institutional / Agency Coordination

eg. MOH & Municipalities & other stakeholders

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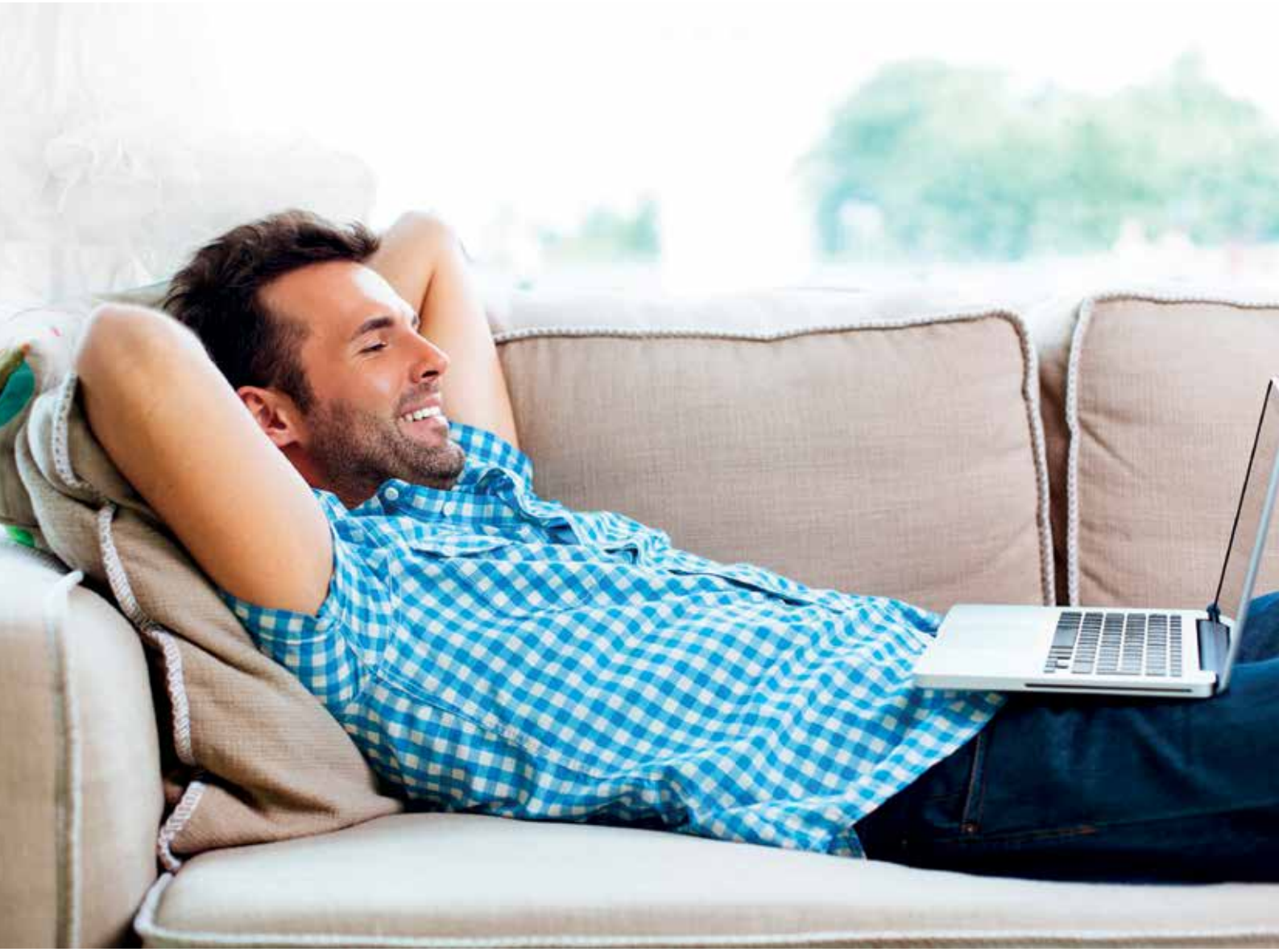

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DRAFT PROPOSAL ON...

- Need for an Effective communication strategy

eg. Key messages, Instruments for message delivery, Static vs dynamic messaging – field testing for impact

- Participation of different entities / key stake holders in interventions
- Surveillance, decision making and feed-back / transparency

Proposed Key Elements for Enhanced Participatory Strategy

- Nation-wide strategy – covering all districts regardless of risk level
- Focused training of stakeholders and regular training updates
- Continuous interventions– not periodic, including cost considerations (likely lower costs)
- Minimally a 5 year strategy with regular reviews & feedback
- 50% - 60% reduction of indices at end of year one to be achieved with subsequent annual progression
- Key Stake Holder participation complementing the existing plan; as follows ;

Key Stakeholders (not in any preferential order)

1. Hotels & Guest houses & related service industry –

"0" star to 5 star hotels are nationally proliferating; numbers of employees and guests make highly significant numbers

2. Defense & Security Establishments in all districts –

numbers and geographic distribute to be determined; Includes, Police, STF, Three Services Army, Navy, Air Force

3. Public & Commercial Transport Sector

-numbers of persons involved are enormous but measurable.

Eg.

Year 2016	
Motor Cars	717,674
Motor Tricycles	1,115,987
Motor Cycles	3,699,630
Buses	104,104
Dual purpose vehicles	391,888
Motor Lorries	349,474
Land Vehicles-Tractors	353,624
Land Vehicles-Trailers	63,088
Total	6,795,469

(From Department of Census & Statistics)

4. Micro, Small & Medium Enterprises (MSMEs) (2013 – 2014)

- Nationwide MSMEs in all districts– 65% of population are in MSMEs

Eg.

Major Economic Sector	SME Groups	Criteria(Number of persons engaged)
Industry & Construction	Micro Small Medium Large	1 -4 5 – 24 25 – 199 200 and above
Trade	Micro Small Medium Large	1 – 3 4 – 14 15 – 34 35 and above
Services	Micro Small Medium Large	1 – 4 5 – 15 16 – 74 75 and above

Eg.

	No. of Establishments				No. of Persons Engaged				
	Total	Ind %	Trade %	Services%	Total	Ind %	Trade %	Services %	Services%
Total	1,019,681 (100%)	25.6	41.1	33.4	3,003,119 (100%)	40.6	25.6	33.8	33.8
Micro	935,736 (100%)	25.3	42	32.7	1,338,064 (100%)	27.1	39.1	33.8	33.8
Small	71,126 (100%)	28.8	31.3	39.9	529,248 (100%)	32.3	24.4	43.4	43.4
Medium	10,405 (100%)	32.0	19.6	48.4	387,859 (100%)	52.5	11.1	36.4	36.4
Large	2,414 (100%)	31.6	36.9	31.5	747,948 (100%)	64.6	93.8	25.7	25.7

(From Department of Census & Statistics)

5. Community and nationwide household strategy

- Total National level household coverage to be targeted
- Total population in the country (2014) – 20,359,439
- Total number of households (2014) - 5,207,740
- Dengue Prevention to be targeted to all households

6. Schools and educational establishments; teachers & children

7. Religious establishments:

Buddhist and Hindu Temples; Mosques and churches; clergy and devotees

8. Construction sites and workers, nationwide (rapidly proliferating).

9. Municipalities & their staff and beneficiaries

Proposed Vector Indices for *Aedes* Surveillance

- House Index (HI)

- Percentage of houses / sites infested with *Aedes* Larvae and or Pupae

- Breteau Index (BI)

- Number of *Aedes* positive containers per 100 houses / sites inspected

Envisaged Process for Achievement

- Rapid situation Analysis for follow-up 2018 - 2023
- Stakeholder Meetings – 9 stakeholder groups and central NDCU
- Setting future targets : 50 – 60 % reduction in year 1 followed by 20% reduction progressively
- Training and re-training of stakeholders and periodic updates
- Continuous rigorous interventions

Contd. on page 24

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Contd. from page 22

DRAFT PROPOSAL ON...

- Web based data reporting from multiple sources; periphery to central level
- Peripheral management of district level stakeholders (role of MOH staff?)
- Colombo based strong management structure

Effective Communications Strategy including feedback

- With Health sector & key decision makers
- With community at large
- With the key stake holders
- For vector breeding control
- For early diagnosis and prompt treatment
- Key messages to be crafted and tested with appropriate instruments
- The right instruments should be designated for the right message
- The role of media
- Impact measurements

Web Based Surveillance

- Existing App (Veta App with Dialog) (other)
- Report suspected or confirmed Dengue cases & Dengue breeding sites
- Receive alerts on reported Dengue cases in the locations that you frequently visit
- Assist NDCU to mobilize the resources effectively and execute preventive measures in the required areas (www.dengue.health.gvt.lk)
- Alert your neighbourhood and take preventive measures against Dengue
- Vector data reporting
- Case data reporting
- Other data
- Analysis, feedback and reporting

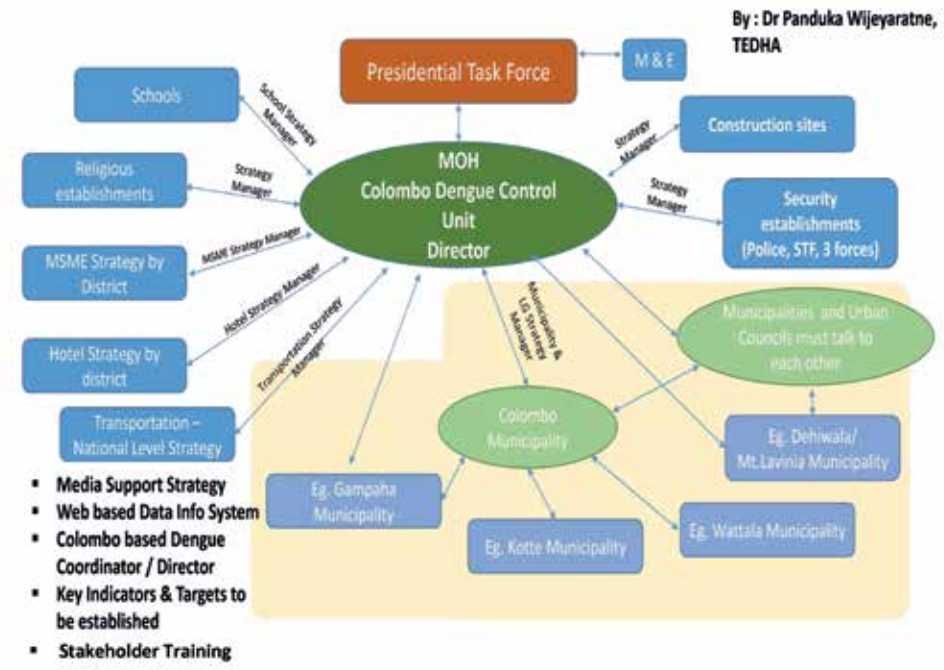
Moving Forward

- Keep it simple, simple, simple
- Enhanced stakeholders in strategy
- Given the multiple stakeholders, establishing Solid Management Structure and right persons to manage is essential
- Monitoring Plan for web based surveillance
- Ensuring feedback and transparency nationwide
- Technical support plan to participating stakeholders in Entomological, web use & other areas
- Initial training followed by periodic on site / Centralized training updates to stakeholders
- Ensure targets are monitored closely and achieved on time
- Incentives for achievements?
- Cost considerations imperative
- Communication Strategy /Maintaining of behavioural change impact – COMBI
- Communication for behavioral impact ; adopting and maintaining those behaviors using behavioral indicators for monitoring the communities – impact.

In Synthesis

- .Strengthening Management structure to include Managers for the proposed different nationwide stakeholders under the overall Dengue Program Manager, eg. one for managing MSMEs another for the complete hotel sector, another for the transportation sector, another for the household sector, another for schools for religious establishments, another for the construction sector and another for the security establishment sector ; solid coordination amongst these and reportable to the Dengue Program Director .
- Imperative to ensure strong coordination and information sharing among the local government / provincial / urban councils / Municipalities and with Central Dengue Program – seemingly weak at the moment
- Sharing of information and constant feedback to the community at large and transparency towards ensuring optimal participation.
- Communications, messages and instruments for delivering messages must be precise and fine-tuned for maximum effectiveness.
- Web based information flow from the periphery / data cloud system for ease of management data at the central level— training required.
- Achieving targets eg. Year 1 - 50% - 60% reduction followed by subsequent annual targets including entomological, environmental and case load data is essential.

Possible Revamped Dengue Strategic Management Structure



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