WEEKLY EPIDEMIOLOGICAL REPORT

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Aging Population

Aging population

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates.

This population ageing can be seen as a success story for public health policies and for socioeconomic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security.

Active ageing

Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups.

Active ageing allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, while providing them with adequate protection, security and care when they need.

The word “active” refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work, ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age.

“Health” refers to physical, mental and social well being as expressed in the WHO definition of health. Maintaining autonomy and independence for the older people is a key goal in the policy framework for active ageing.

Ageing takes place within the context of friends, work associates, neighbours and family members. This is why interdependence as well as intergenerational solidarity is important tenets of active ageing.

Emergencies and Older People

Emergency situations are increasing worldwide and older people remain one of the most seriously affected groups. Yet, the needs and contributions of older people are generally overlooked by humanitarian organizations in terms of policy and practice.

There are specific health and social factors that can, separately or in combination, affect older persons and impact on them during an emergency situation. These include: physical health, oral health and dentition, mental health, functional status and disability, lifestyle habits, nutrition, family and social relations, economic situation, and gender considerations. Consideration of these issues within the context of later life can help ensure that older people at risk can be identified before, during and following an emergency situation. For example, impairments that in normal circumstances do not interfere with daily functioning, can quickly become handicaps that overwhelm the person’s capacity to cope in an emergency situation. For example, an older person with arthritic knees, diminished vision and poor hearing can rapidly become incapable of getting food or receiving messages to flee from danger.

For WHO, older people are not simply a vulnerable population group, rather they are in general very resilient and their knowledge of their community, experience with past emergencies as well as positions of respect within families and communities, makes them valuable resources that should be drawn upon.

Awareness of the needs and contributions of older persons among those developing policies and guidelines and providing care can contribute to more effective interventions, including equitable access to essential health and social services to older people during all phases of an emergency.

Primary Health Care

As stated earlier increased longevity is not only a triumph for society but a huge challenge for health systems which need to be prepared to address the needs of older people at the community level. It is paramount that health care workers are well versed in the diagnosis and management of the so called**"four giants" of geriatrics** (memory loss, urinary incontinence, depression and falls/immobility) as well as the chronic diseases that are common in later life and that can often be prevented or delayed. However, prevention requires reaching the individual before the disease takes hold.

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Most preventative health care and early disease screening takes place in Primary Health Care (PHC) centres within health systems. These centres play a critical role in the health of older people worldwide at the local level.

WHO has developed a set of age-friendly primary health care principles that are part of the Perth Framework for Age Friendly Community Based Primary Health Care and were finalized during a meeting on age care which took place in Perth, Australia, 2002. These principles, including those which are cross cutting, gender, culture and human right, were used to develop the age friendly standards and to determine what makes primary health care services "age-friendly." The standards development process included 44 focus group discussions in five countries in order to:

Document the views of older people as well as health care providers on whether primary health care services are accessible, appropriate and affordable for older persons. Identify some of the most common barriers to primary health care for older adults in the areas of information; education; training; management; and the physical environment. Establish a set of general principles to be observed when making primary health care more age-friendly.

WHO Age-Friendly Environments Programme

The Age-friendly Environments Programme is an international effort by WHO to address the environmental and social factors that contribute to active and healthy ageing in societies. Rationale of this programme is,

- In 2000, the global population of people aged 60 and over was 600 million; by 2025 there will be 1.2 billion and, by 2050, almost 2 billion.
- The proportion of the global population aged 60 will double from 11% in 2006 to 22% by 2050.
- Older people play a crucial role in communities - in paid or volunteering work, transmitting experience and knowledge, or helping their families with caring responsibilities. These contributions can only be ensured if older persons enjoy good health and if societies address their needs.
- Making cities age-friendly is one of the most effective policy approaches for responding to demographic ageing.
- In 2008, for the first time in history, the majority of the world's population lived in cities and by 2030; approximately 3 out of every 5 people will live in an urban area.

Since cities have the economic and social resources to undertake the necessary changes to become more age-friendly and are in the position to lead the way for smaller communities, most of WHO's initial work in this area has focussed on the urban environment. Cities wishing to become more age-friendly can take part of the WHO Global Network of Age-friendly Cities. A age friendly city is defined as an Age-friendly City is an inclusive and accessible urban environment that promotes active ageing.

Ten Facts on aging and life course

- Ageing is a global phenomenon. The world's elderly population people 60 years of age and older - is the fastest growing age group. By 2050 about 80% of the elderly will be living in developing countries. Population ageing is occurring in parallel with rapid urbanization: in 2007 more than half of the world's population live in cities. By 2030 that figure is expected to rise to more than 60%.
- Population ageing is a triumph of modern society. It reflects improving global health, but also raises special challenges for the 21st century in both developing and developed countries. In 2005, life expectancy in countries like Japan and France was already more than 80 years. Life expectancy is also rising in developing countries: a child born today in Chile, Costa Rica, Jamaica, Lebanon, Sri Lanka or Thailand can expect to live for more than 70 years.
- Vast health inequalities persist, as is clear from differences in life expectancy at birth. For example, while Japan has the highest life expectancy in the world at 82.2 years, in several countries in Africa the figure is as much as 40 years lower.
- Within countries, health inequalities are also significant. For example, in the United States of America higher socioeconomic groups can expect to live up to 20 years longer than those from lower socioeconomic groups.
- By 2050, close to 80% of all deaths are expected to occur in people older than 60. Health expenditure increases with age and is concentrated in the last year of life - but the older a person dies, the less costs are concentrated in that period. Postponing the age of death through healthy ageing combined with appropriate end-of-life policies could lead to major health care savings.
- Healthy older people also represent a resource for their families, communities and economies. Investing in health throughout life produces dividends for societies everywhere. It is rarely too late to change risky behaviours to promote health: for example, the risk of premature death decreases by 50% if someone gives up smoking between 60 and 75 years of age.
- Effective, community-level primary health care for older people is crucial to promote health, prevent disease and manage chronic illnesses in dependent and frail patients. In general, training for health professionals includes little if any instruction about care for the elderly. However, they will increasingly spend time caring for this section of the population. WHO maintains that all health providers should be trained on ageing issues, regardless of their specialism.
- Disasters and emergencies severely impact the most vulnerable, including older people. As examples: the highest percentage of fatalities in Indonesia caused by the 2004 Indian Ocean tsunami was in people 60 years of age and older, and the majority of the 2003 heat wave victims in Europe were people 70 years of age and older. Policies to protect older persons during emergencies are urgently required.
- In older age, the risk of falls increases and consequences of injuries are far more serious. This leads to significant health, human and economic costs. In Australia, the average health system cost per one fall-related injury for people 65 years of age and older was US$ 3611 in 2001-2002.
- Elder abuse is on the increase as the population ages and social dynamics change. WHO estimates that between 4% and 6% of older persons worldwide have suffered from a form of elder abuse - either physical, psychological, emotional, financial or due to neglect. Elder abuse is an infringement of human rights.

Source: WHO

Table 1: Selected notifiable diseases reported by Medical Officers of Health 29th – 04th Nov 2016 (45th Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmaniasis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	84	14003	4	157	0	12	1	54	3	63	5	264	0	7	0	42	0	0	8	401	2	54	0	0	75	94
Gampaha	25	5864	3	144	0	14	1	27	0	87	0	298	0	16	1	46	0	1	0	363	0	43	0	7	33	100
Kalutara	23	3013	0	97	0	10	0	33	0	34	1	396	0	8	0	27	0	1	2	260	1	89	0	0	57	93
Kandy	42	3692	1	147	0	17	1	22	1	36	0	112	2	91	0	47	0	0	5	221	1	41	0	9	91	96
Matale	7	964	1	61	0	1	0	14	0	4	1	85	0	20	2	20	0	1	0	34	0	55	0	18	54	77
NuwaraEliya	2	380	2	97	0	3	0	54	0	36	1	60	3	75	0	38	0	0	1	126	2	41	0	0	77	85
Galle	74	2194	0	130	0	8	0	9	0	10	8	277	2	108	0	9	0	0	6	265	0	35	0	3	70	95
Hambantota	2	702	0	74	0	1	0	5	0	61	2	97	0	62	0	98	0	0	3	213	0	15	0	313	75	92
Matara	24	1131	0	110	0	15	0	8	0	39	5	173	1	52	0	41	0	0	1	168	1	24	1	182	94	100
Jaffna	25	1917	11	316	0	9	0	80	4	66	1	18	1	601	0	9	0	0	1	161	0	58	0	1	92	92
Kilinochchi	0	75	0	38	0	1	0	36	0	75	0	13	0	25	0	2	0	0	0	10	0	10	0	0	50	100
Mannar	2	139	1	42	0	4	0	23	1	10	1	11	0	42	0	0	0	0	0	7	0	4	0	0	80	100
Vavuniya	2	232	0	14	0	5	1	93	0	34	0	15	0	11	0	6	0	0	1	29	0	10	0	6	100	100
Mullaitivu	2	165	0	27	0	5	0	19	0	41	0	24	0	6	0	2	0	1	0	23	0	11	0	6	80	80
Batticaloa	1	469	6	295	0	4	0	47	0	98	0	46	0	6	0	13	0	1	1	98	0	14	0	1	43	93
Ampara	0	227	0	49	0	2	0	1	0	21	0	26	0	0	0	10	0	0	1	153	0	5	0	8	14	71
Trincomalee	2	365	2	54	0	2	0	12	0	25	0	32	0	24	0	33	0	2	2	146	2	15	2	13	58	67
Kurunegala	20	2200	6	289	0	11	0	4	0	19	2	146	0	41	0	30	0	3	8	353	1	56	0	96	72	97
Puttalam	1	940	1	86	0	5	0	7	0	2	4	50	0	61	0	3	0	2	1	88	1	58	0	4	50	71
Anuradhapura	0	641	0	96	0	3	0	10	0	33	0	259	0	25	0	16	0	1	3	242	1	45	0	232	32	74
Polonnaruwa	4	413	0	39	0	4	0	12	0	15	1	88	0	4	0	4	0	0	2	134	1	19	0	116	71	86
Badulla	16	946	5	120	0	13	0	13	0	28	0	123	3	110	0	116	0	0	2	232	3	191	0	3	71	94
Monaragala	10	389	0	120	0	1	1	5	0	11	1	162	1	119	1	142	0	2	3	80	0	24	2	38	82	82
Ratnapura	20	2685	2	331	0	31	0	26	0	25	10	537	0	37	2	191	0	0	3	221	2	147	0	1	67	83
Kegalle	19	1324	1	75	0	19	0	32	0	57	0	167	0	30	1	31	0	0	2	306	1	53	0	2	82	91
Kalmune	9	495	0	92	0	3	0	5	0	53	0	21	0	0	0	5	0	4	1	99	0	27	0	0	54	100
SRILANKA	416	45565	46	3100	0	203	5	651	9	983	43	3500	13	1581	7	981	0	19	57	4433	19	1144	5	1059	66	89

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 04th November, 2016 Total number of reporting units 339 Number of reporting units data provided for the current week: 308 C**-Completeness

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

Table 2: Vaccine-Preventable Diseases & AFP

29th – 04th Nov 2016 (45th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2016	Number of cases during same week in 2015	Total number of cases to date in 2016	Total number of cases to date in 2015	Difference between the number of cases to date in 2016 & 2015
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	02	59	63	-6.3%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	01	00	01	00	00	01	01	01	05	01	346	334	+3.5%
Measles	00	00	00	00	00	00	00	00	00	00	15	356	2426	-85.3%
Rubella	00	00	00	00	0	00	00	00	00	00	00	09	08	+12.5%
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Tetanus	01	00	00	00	00	00	00	00	00	01	01	10	16	-37.5%
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Japanese Encephalitis	01	00	00	00	00	00	00	00	00	01	00	18	10	+80%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	61	92	+34.1%
Tuberculosis	42	25	02	11	17	07	12	04	04	124	163	7979	8502	-6.1%

Key to Table 1 & 2

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

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

Data Sources:

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

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

CRS** =Congenital Rubella Syndrome

AFP and all clinically confirmed Vaccine Preventable Diseases except Tuberculosis and Mumps should be investigated by the MOH

Number of Malaria Cases Up to End of October 2016,

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All are Imported!!!

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

ON STATE SERVICE

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