



# SLMA News

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## EDITORIAL

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Sri Lanka has achieved exceptionally good health indices for a developing country. This is especially true of infant and maternal mortality rates, compared to countries with similar income levels (e.g. per-capita income levels) or health expenditure (e.g. per-capita health expenditures). Although our average health status has showed these remarkable gains, there are several areas that need further attention. One issue that is particularly worrying is the widening gap (or inequalities) in health status among groups of populations. An example is the infant mortality rates (IMR) in different groups. The Demographic and Health Survey of 2003 illustrates this point vividly and shows unacceptable inequalities in IMR. Since we are not born equal, there is a proportion of this variation that is unavoidable. However, one cannot turn a blind eye to some of the inequalities that are avoidable or preventable. These are known as *Health Inequities*. Most inequities in health are unfair because they are preventable and we have the knowledge, skills and technology to prevent them.

The past 10-20 years has seen a rapid expansion in the literature on health inequalities (HI) or health disparities, and the social gradient of health. Investigations on the pathways that result in the social gradient (the higher the social position the better the health) and inequalities have led to understanding of the social causes of health. Studies have shown that social inequalities play a key role in generating health inequalities. Countries such as the UK have advanced further and regularly report data on health outcomes in relation to social groups, income groups and social status. This enables policymakers to review progress regarding HI and to evaluate interventions effectively.

An important global level initiative was the establishment of the Commission on Social Determinants of Health (SDH) by the WHO in 2005. This was chaired by Professor Sir Michael Marmot, Professor of Epidemiology and Public Health at University College London (UCL), UK and had a distinguished panel of commissioners that included Nobel Prize winners (such as Economist Amartya Sen) and world leaders in health and social development. Their Report released in August 2008 highlights and collates a large volume of literature on how 'social determinants' influence health outcome and what can be done about them.

### **Why are health inequities relevant to Sri Lanka?**

First and foremost, health inequities should be narrowed because they indicate the existence of preventable deaths and morbidity. For the medical profession, tackling inequities is a matter of the fundamental value of saving lives and suffering. For the wider society, it's a matter of social justice.

Second, inequalities in Sri Lanka may explain why our health indices (e.g. MMR and IMR) have begun to stagnate in the recent past (i.e. groups that perform poorly 'pull-down' the national average). If we improve the worst-off, there is a likelihood that the indices will continue to improve.

Finally there are several global, regional and local initiatives by the WHO and other organizations that focus specifically on health inequities and social determinants. This gives Sri Lanka an opportunity to tap into a vast knowledge base, technical expertise and financial support in order to achieve better equity in health. There is emerging research evidence that social factors or determinants are responsible for a large component of health inequalities.

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These inequalities across social groups (e.g. occupational groups, income groups, social status) are ‘real’ and cannot be explained by the physical environment, behavioural patterns or genes. Though well-distributed and effective health services are vital to the well-being of populations, on their own they cannot overcome health inequalities. To achieve these objectives, we need to work with other sectors. Sri Lanka has a tradition of acting on social determinants (e.g. adult franchise, welfare policies such as free education and food subsidies) and on equity issues (e.g. the network of health facilities even in remote locations is evidence of this). This means we need to redirect some of our attention to areas outside the health sector (i.e. ‘inter-sectoral’ action).

Sri Lanka was closely linked to the work of the Commission. Our representatives met with the Commission in September 2005 when a delegation attended the South East Asian Region Meeting of the WHO. Sri Lanka then became a Country partner with the Commission on SDH and developed academic links with UCL. The Ministry of Health established a Working Group with representation from several sectors and became the Focal Point. In November 2006, the Working Group held a Stakeholder Workshop with the College of Community Physicians. Sri Lanka had a Mission from WHO in February 2007, to discuss areas of collaboration between Sri Lanka and the Commission and activities and technical support needs for Sri Lanka to implement upstream interventions to tackle social determinants of health inequities. Subsequently, a consultation on SDH was held in Sri Lanka from October 2-4, 2007 with participants from nine countries in the Region. In November 2008, Sri Lanka sent a team to the UK to attend the international conference on ‘Closing the Gap in a Generation’ that drew the experiences from other countries in implementing the recommendations of the Commission on SDH. The next activity was the Regional Consultation (SEARO) held in February 2009 in Colombo, which was attended by Prof. Sir Michael Marmot and several high ranking officials and ministers from the region.

#### **Role of the SLMA**

In the background of this situation, the SLMA has chosen the theme “Achieving Equity in Health: the Sri Lankan Experience” for its Annual Academic Sessions scheduled from 31 May – 2 June 2010. We have the honour of having Prof. Sir Michael Marmot as the chief guest. He will participate in the theme pre-congress workshop on Equity in Health, grace the inauguration of the sessions (on 31 May) and deliver a plenary lecture on 1 June. The SLMA has also established a Sub-committee to work on issues relating to health inequities and social determinants of health.

We believe that the SLMA has a key role to play in furthering work to narrow health inequities. Our role could include

- advocacy and raising awareness of the medical profession and general public on issues relating to health equity
- giving leadership to the medical profession on these issues
- encouraging research in these areas, promoting capacity building and translation of knowledge into practice
- networking with local, regional and global partners to take forward the agenda of narrowing health inequities

**Saroj Jayasinghe**  
**Narada Warnasuriya**

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### **SPECIAL ANNOUNCEMENT: CHANGE OF DATES OF ANNUAL SCIENTIFIC SESSIONS**

The 123<sup>rd</sup> Annual Scientific Sessions will be held from 31<sup>st</sup> May to 2<sup>nd</sup> June 2010 Cinnamon Grand, Colombo. The Theme Pre-Congress symposium and inauguration of the sessions will take place on 31<sup>st</sup> May at the same venue. A draft program is published on page 4. Please note that due to unavoidable circumstances the scientific sessions which was scheduled to from 1<sup>st</sup> to 4<sup>th</sup> June 2010 has been advanced to 31<sup>st</sup> May 2010.

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**123<sup>rd</sup> Annual Scientific Sessions – 31<sup>st</sup> May to 2<sup>nd</sup> June 2010 (Post Congress 4<sup>th</sup> June 2010)**

Monday 31 <sup>st</sup> May 2010	Tuesday 1 <sup>st</sup> June 2010				Wednesday 2 <sup>nd</sup> June 2010				3 <sup>rd</sup> June	Friday 4 <sup>th</sup> June 2010
	Time	Hall A	Hall B	Hall C	Time	Hall A	Hall B	Hall C		
<b>Pre Congress Workshop</b>  9.00 am – 1.00 pm  Achieving equity in health, the Sri Lankan experience	8.00 am – 8.30 am	Registration			8.00 am – 8.30 am	Registration				<b>Post Congress Workshops</b>  <b>Workshop I</b> 9.00am 4.00pm Satellite Meeting on Genetic Diagnostics <i>(Faculty of Medicine, University of Colombo)</i>  <b>Workshop II</b> (9.00am – 4.00pm) Sexual and Reproductive Health <i>(SLMA Auditorium)</i>  <b>Workshop III</b> (9.00am – 4.00pm) Hands on training session on Rehabilitation (LRH)
	08.30 am – 10.00 am	<b>Symposium 1</b> Congenital Heart Disease	<b>Symposium 2</b> Dermatology	<b>Symposium 3</b> Mental Health	8.30 am – 9.00 am	<b>Guest Lecture 7</b> Dr. Lucy Dorrel HIV	<b>Guest Lecture 8</b> Dr. Vinya Ariyaratne A Holistic Approach to the Care of IDPs	<b>Guest Lecture 9</b> Prof. Mohan de Silva The Story of Surgery - from a Gruesome Past to a Fascinating Future		
	10.00 am – 10.45 am	<b>Plenary 1 : Fair Society Healthy Lives</b> Prof. Sir Michael Marmot			9.00 am – 10.00 am	Free paper session 7 Tropical Medicine	Free paper session 8 Community Medicine (2)	Free paper session 9 Surgery		
	10.45 am – 11.00 am	<b>Tea &amp; Poster Viewing</b>			10.00 am – 10.45 am	<b>Interactive session 1</b> Neurology	<b>Preliminary Session</b> Local and Global Experiences in Disability Dr. Padmani Mendis Prof. Maria Crotty	<b>Interactive session 2</b> Common Issues in Surgery		
	11.00 am – 11.30 am	<b>Guest Lecture 1</b> Dr. Zulfiqar Bhutta (Mainstreaming Nutrition : Going Beyond Survival)	<b>Guest Lecture 2</b> Dr. Kamilia Tai (Undernutrition and Frailty in Older Adults)	<b>Guest Lecture 3</b> Prof. Saroj Jayasinghe (From Society to Molecules: How Social Factors Lead to Disease)						
	11.30 am – 12.30 pm	Free paper session 1 Cardiology	Free paper session 2 Medicine	Free paper session 3 Community Medicine (1)	10.45 am – 11.00 am	<b>Tea &amp; Poster Viewing</b>				
	12.30 pm – 1.00 pm	<b>Guest Lecture 4</b> Dr. David Osrin (Community Interventions to Improve Neonatal Survival)	<b>Guest Lecture 5</b> Dr Jonathan Levi (Advances in Insulin Management of Type 2 Diabetes)	<b>Guest Lecture 6</b> Clinical Ethics	11.00 am – 12.30 pm	<b>Symposium 7</b> Erectile Dysfunction	<b>Symposium 8</b> Enabling the Disabled	<b>Symposium 9</b> Healthcare in Humanitarian Crisis		
	1.00-1.45 pm	<b>Lunch &amp; Poster Viewing</b>			1.00-1.45 pm	<b>Lunch &amp; Poster Viewing</b>				
6.00 pm  Inauguration  SLMA Oration	1.45 pm – 2.45 pm	Free paper session 4 Paediatrics	Free paper session 5 Miscellaneous (1)	Free paper session 6 Miscellaneous (2)	1.45 pm – 2.45 pm	Free paper session 10 Obstetrics and Gynaecology	Free paper session 11 Miscellaneous (3)	Free paper session 12 Miscellaneous (4)		
					2.45 pm – 4.15 pm	<b>Symposium 10</b> Diabetes and Cardiovascular Risk in Sri Lanka: Where have we gone wrong ?	<b>Symposium 11</b> Session by SLMC	<b>Symposium 12</b> New challenges in ICU		
	2.45 pm – 4.15 pm	<b>Symposium 4</b> Nutrition for Development	<b>Symposium 5</b> New frontiers of e-learning in Medicine	<b>Symposium 6</b> GPs Role from Advocacy to Social Responsibility	4.15 pm – 5.30 pm	SC Paul Oration				
	4.15 pm	<b>Tea</b>			5.30 pm	<b>Tea</b>				
	7.30 pm	Doctors Concert			7.30 pm	Conference Dinner				

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## Drug and food company sponsorship and medical professionals

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**Original article from:** Jayawardana P. Sponsorship, public private partnership and medical professionals. Journal of College of Community Physicians of Sri Lanka 2008; 13 (2): 39-43.

### Introduction

We as doctors have a moral obligation to the patients as well as to the society to equip ourselves with the latest advancements of medicine and this is pursued through continuing medical education (CME). In the modern version of the Hippocratic oath, this is expressed as “I will continue with diligence to keep abreast of advances in medicine”<sup>1</sup>. The corporate sector has stepped into the scene and extends a hand to facilitate achievement of this goal by creating a conducive environment. Reviewing the literature, it is obvious that we as a profession are caught in between the dilemma of the need to promote continuing professional development utilizing the generosity extended by the industry and on the other, on avoiding conflict of interest.

The pharmaceutical and food industry (especially milk food companies) interacts with doctors in two ways with reference to professional development. One is at the individual level and the other at the organizational level through different professional bodies.

Free drug samples, meals, free travel and lodging for educational events, financial incentives to participate in clinical trials, honoraria for delivering lectures, other gift items including expensive text books, note pads, pens etc and lavish leisure trips are some of the benefits received at individual level. Sponsorship of annual scientific meetings on CME and special projects and funding of research are the organizational activities supported by them<sup>2</sup>.

Definitions available on sponsorship are diverse. A more generally applicable one describes sponsorship as a “business relationship between a provider of funds, resources or services and an individual, event or organization which offers in return, rights and association that may be used for commercial advantage in return for the sponsorship investment”<sup>3</sup>. Therefore, it is no secret that the corporate sector involvement with the medical profession is with the ultimate aim of influencing the prescription behaviour<sup>3</sup>.

It is not only the cash incentives and offer of other services and gifts but food, friendship and flattery are also said to be powerful tools specially when combined, in changing a persons behaviour<sup>2,4,5</sup>. The companies have excelled in establishing good public relations and it has been observed that mere personal contact with industry officials itself could be seductive<sup>6</sup>.

### Influence on individuals

Doctors in favour of maintaining links with the drug companies are said to be of strong belief that they are immune and invulnerable to promotional influences<sup>2,6,7</sup>. Also described is the phenomenon of “self serving bias” where individuals fail to identify themselves as biased when such offers and services are to their benefit”<sup>2</sup>. They attribute such resistance to the type of training they receive where patients’ interest take priority above other concerns. In addition, they feel that patients benefit from such relationships through a two pronged process. One is through advancement of knowledge of the prescribing doctor which has a direct bearing on improving patient care and the other through offer of free drug samples<sup>2</sup>. The latter is considered to have many advantages such as ability to help indigent patients and availability of drugs to commence therapy immediately<sup>8</sup>. However, there are counter arguments put forward, and as quoted, “any type of gift or gesture can create a feeling of indebtedness on the recipient, which in turn creates a sense of obligation to reciprocate consciously or unconsciously”<sup>2</sup>.

The reason behind the concerns expressed is the resultant influence of the company largess on the prescribing habits that compromise fidelity to the patients, prescribing pattern of generics and thus the quality and cost of healthcare and the credibility of the medical profession. Those in favour of rational

use of drugs are said to be convinced that the links between doctors and the drug companies are partly responsible for the soaring costs of drugs and undermining of control of costs<sup>4</sup>.

There is a wealth of research published in relation to the influence of industry sponsorship on the prescription behaviour of doctors. In a study conducted on family physicians in the USA, a significant association between the number of free samples distributed and the prescriptions written for those medications, than the clinic settings which do not dispense free samples<sup>8</sup> had been observed. In a review of 29 papers, Wazana<sup>9</sup> reports that attending sponsored continuing medical educational events and accepting funding for travel and or lodging for such conferences were associated with higher prescription rates for medications of the sponsoring company and non rational prescribing patterns.

Sponsorship and the escalation of cost of drugs form a vicious cycle in that, in order to ensure sale of the individual product, the industry needs the help of the doctors to prescribe their products. To influence the behaviour of doctors in to prescribing their brand the industry needs to conduct educational sessions on the available drugs, which is done through myriad forms of interactions as described above. In order to meet with the marketing costs incurred thus, the industry needs to raise the drug prices. According to Kalantri<sup>10</sup>, attending a sponsored banquet could mean adding significantly to the drug prices.

We need to be conscious of the fact that it is the patient who is at the mercy of the doctor, who pays for it, which is not by choice ironically, but due to lack of a choice when it comes to his/her, health. Falling ill and the need to seek medical help cannot by any means be compared to purchasing of an item that one may fancy where one has the choice of reconsidering if it is not with in the means of his/her pocket. Sadly, this choice is not available when it comes to illness. Why cannot the industry reduce the profit margin which anyway is spent on doctors and give the patient the full benefit of it by reducing the cost of drugs?

### **CME**

Controversies also surround the corporate involvement in conducting medical meetings. However, there is no doubt that it has the advantage of the ability to invite speakers from outside the local area and from abroad (which may help elevate the conference standards to international levels), as the travelling costs of such speakers are borne by the sponsors. This may not be feasible in the absence of availability of such funds.

The main issue with regard to above is lack of transparency on the involvement of the sponsors in the selection of speakers. However, the drug companies and the educational providers who obtain sponsorship counter argue that the organizers of these conferences have the independence to decide on the speakers and the names suggested are scrutinized by the relevant organizing committees<sup>11</sup>.

Apart from above, the dependence exerted on the individual doctor on company sponsorship is also said to be immense. A deputy editor of the Journal of American Medical Association (JAMA) Drummand Rennie, who is also a researcher attached to University of California in San Francisco is quoted to have stated "I do not blame the marketers for behaving like marketers. What they do is make people feel entitled – so it's not a bribe; it's their due. And you end up with a situation where doctors won't walk fifty yards at a big medical meeting without being transported in a drug company bus"<sup>4</sup>. This reflects the extent of the entanglement between doctors and sponsorship and the future plight, in the absence of regulations imposed.

The issues related to sponsorship by milk food companies have a different side to the story. We as doctors are well aware of the benefits of breast feeding not just during the first six months, but which extends beyond, the least up to two years of age. When the Ministry of Health Guidelines on Infant and Young Child Feeding promotes breast feeding, we doctors who are entrusted with the task of implementing these guidelines accept sponsorship from milk food companies which deliver exactly the opposite message by promoting formula feeds from the age of one year. Do we forget that we are

playing with the health and well being of our future generations despite the available scientific evidence in support of breast feeding? Aren't we adopting double standards?

### **Preventive measures**

Several professional organizations including the American Medical Association and various interest groups in the USA had made an attempt to address the above concerns by revising the existing codes of conduct. However, it has been observed that apart from direct receipt of cash payments which is illegal and amounts to bribery, other forms of interactions are more or less endorsed by these professional bodies<sup>2,4</sup>. This stand reflects the belief that at least some of these relationships are "ethical, often beneficial and certainly unavoidable"<sup>2</sup>. However Mildred Cho, a biomedical ethicist at the Stanford University disagrees with the above proposition that "private financial interests of physicians or research institutions enhance the interests of the patients"<sup>4</sup>. The Editorial in the British Medical Journal by Abbasi and Smith<sup>12</sup> had been critical of formulating codes of practice which they refer to as "mere window dressing" and call for distancing from the industry.

Some believe that in accepting corporate funding, the best approach would be to weigh the risks and benefits on a case by case basis<sup>7</sup>. Capozzi and colleageus<sup>13</sup> who hold a more moderate view, is of the opinion that the product of interest should be independently evaluated through all possible means and assistance of the industry be sought only if further exploration is warranted, and when that information could only be obtained through industry. This seems quite a rational proposition.

In India, there is a call for doctors to pay their own conference fees, citing examples of such conferences held related to clinical fields, which will help to maintain academic independence and uphold the integrity of the profession<sup>10</sup>.

In the United Kingdom the relationship between the pharmaceutical industry and the doctors are governed by a code of practice which highlights that the level of hospitality provided at meetings to be "appropriate and not out of proportion to the occasion and costs must not exceed that level which the recipients would normally adopt when paying for themselves"<sup>14</sup>.

I am certain, most of us feel that obtaining corporate sponsorship is the norm as it is what we experience on a day to day basis and do not feel the need to ponder over the ethicality and its implications. I hope through this write up I have been able to create awareness on the concerns expressed and numerous ongoing debates that are existent over this controversial issue. May you be able to make a rational decision of your own as to the suitability for the members of a noble profession such as ours to dine and wine utilizing profits made by pharmaceutical companies through the sale of drugs prescribed by us, in order to save the patients who are at our mercy, from death and disability.

### **Pushpa Jayawardana**

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### **Acknowledgements**

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*The Subcommittee on Women's Health - Sri Lanka Medical Association*

## **Seminar on "Addressing health issues and providing health care in Sri Lanka: are we gender sensitive?"**

**8<sup>th</sup> March 2010**

**1. Is there gender equity in provision of Healthcare ?**

*Dr. Vathsala Jayasuriya*

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Faculty of Medical Sciences, University of Sri Jayewardenepura*

Gender analysis is a way of understanding, that can be applied to all health issues, to recognize the ways in which gender roles, resources and perceptions impact upon women's and men's health. The objective of this presentation was to explore the role of gender in health needs and care provision in Sri Lanka based on an analysis of published sex-disaggregated data and a community based survey of women's health in the Western province.

While it is seen that the mortality gap between males and females are increasing in favour of the females, it is necessary to explore in detail the relative burden from different causes of death. While women continue to bear the reproductive health burden, more men die from ischaemic heart disease, diseases of the digestive system and suicide. We need to examine whether there are gendered roles and perceptions that contribute to the mortality burden as the physical and physiological differences alone do not provide an adequate explanation. Traditional gender norms that subordinate women and place a higher value for male and masculine attributes are prevalent even within the Western province of Sri Lanka. These value systems increase women's contraceptive burden, limit her access to healthcare and reduce her economic and social freedom.

Within the organization of Healthcare, majority of the healthcare workers are females (70%), however her decision making power is limited and the upper echelon of the healthcare administration is dominated by males. While almost 80% of health administrators, 90% of obstetricians and 80% of surgeons are males, females tend to self select into specialties such as anaesthesiology, community medicine, laboratory medicine and dermatology. We need to examine the gendered hierarchy in the healthcare system and its impact on management strategies, work scheduling and welfare of the workforce.

There is a dearth of knowledge with regards to gender issues in healthcare need and provision in Sri Lanka. Gender analysis should form an integral part of health services review, reform and planning in order to achieve equitable health status for both men and women.

**2. Gender disaggregation of diabetes and its correlates**

**Dr. Prasad Katulanda**

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**Introduction**

Women play a vital role in the Sri Lankan society. The Sri Lankan woman is considered to be the nucleus of the Sri Lankan family. Her role has evolved from the basic functions of bearing children and keeping the integrity of a family, to generating an income in many families. Women are seen in almost all the professions in Sri Lanka which produced the first woman Prime Minister in the world. Therefore, maintaining good health among women is vital to the Sri Lankan society. During the reproductive age, the maternal medical conditions have direct effect on the health of the child. Thus women's health has a direct bearing on the health of future generations.

Sri Lanka has undergone a rapid socio-demographic transition during the past few decades. This has led to adoption of more sedentary lifestyles, urbanization, internal migration and change of food habits. These changes have led to an epidemiological transition, with the infectious diseases which killed most people in the past becoming less prevalent compared to the non communicable diseases (NCDs). Ischaemic heart disease (IHD) is the NCD that kills most people in Sri Lanka and throughout the world. In addition, cerebrovascular diseases and diabetes are considered to be other important NCDs.

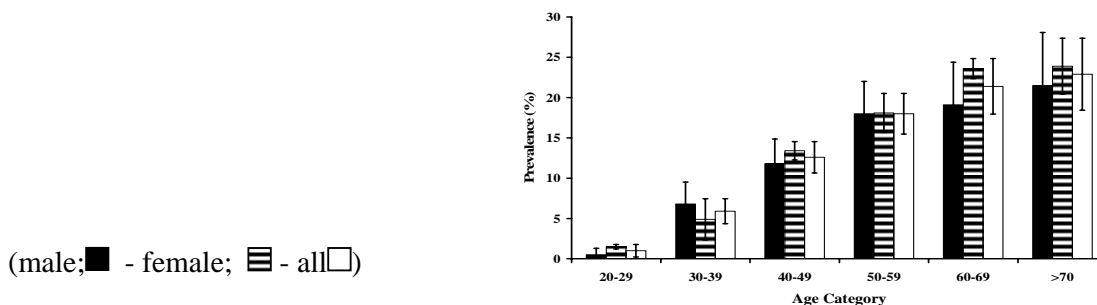
Traditionally, females were considered to have less risk of IHD due to the protective effect of the female sex hormones. This protective effect disappears after menopause. However mortality among those with IHD is higher among women. The differences of the prevalence of heart disease, diabetes and its risk factors between males and females are not well documented in Sri Lanka.

The Sri Lanka Diabetes and Cardiovascular Study has made available nationally representative data on diabetes, ischaemic heart disease and its risk factors in Sri Lanka. This was conducted in the year 2005 in 7 out of the 9 provinces in Sri Lanka. Two provinces were not accessible due to the war and hence omitted from the study. Out of the 5000 adults invited, 4456 participated in the study; 2668 (59.87%) were females. Participants' age ranged from 18 years to 90 years and the mean ( $\pm$  SD) was  $46.13 \pm 15.12$  years.

Prevalence of ischaemic heart disease for females was 11.71% whereas for males it was only 8.86% ( $p < 0.01$ ). Age standardized prevalence of diabetes among Sri Lankans was 10.9% for females and 9.8% among males ( $p < 0.01$ ). The gender difference in diabetes was minimal before the 50-59 year age category. The higher prevalence of diabetes becomes more evident after this age to reach a maximum level during 70-79 year age category.

When the gender specific prevalence of risk factors for ischaemic heart disease in Sri Lanka were considered, lipid abnormalities, physical inactivity, obesity (both generalized obesity and central adiposity) were significantly common among the females.

Figure 1: Prevalence of diabetes according to the age and sex in Sri Lanka (Reproduced from Katulanda *et. al.* Diabet Med 2008; 25: 1062–69)



### **Conclusions and discussion**

According to most of the published studies, IHD and its risk factors are more prevalent among the males. However the results in this study indicate that the trend in Sri Lanka is different. Diabetes is commoner among the women in Sri Lanka when compared to men. This pattern is mainly due to the higher prevalence of diabetes among the post menopausal age group. The most probable reason for the increase in the prevalence of IHD among women is the higher prevalence of risk factors including diabetes and obesity among Sri Lankan women. Awareness among Sri Lankan women on the high risk of IHD and its risk factors needs to be increased along with public health interventions specifically targeting the females to reverse this trend.

### **3. Gender disaggregation of nutritional status and its correlates**

***Dr. Angela De Silva***

*Nutritionist, Senior Lecturer in Physiology, Faculty of Medicine, University of Colombo*

Sri Lanka leads South Asia in some dimensions of gender equality such as health, nutrition and education. Availability of gender-sensitive nutrition indicators is useful for informed decision making and monitoring progress to achievement of further gender equality in nutrition. Gender- focused data on nutrition status helps put in place in responses that are gender specific and targeted towards those in greatest need of assistance.

#### **Nutrition and gender**

Malnutrition can take a variety of forms that contribute to each other, such as protein-energy malnutrition and deficiencies of micronutrients like iodine, iron and vitamin A. Majority of nutrition interventions in Sri Lanka are geared towards women and children, identified as the most vulnerable group at risk for malnutrition and most available nutrition status data is on women and young children. Causative factors for gender inequalities in nutrition is chiefly an outcome of inadequate and/or poor quality of dietary intake, the long-term results of low birth weight and repeated illnesses<sup>1</sup>. Where women are concerned, other issues are involved, including biased allocation of intra household resources, discrimination against women, often by women themselves, ensuing women eating last and least, and sometimes being deprived of prospects that would empower them to care for themselves and their children. Malnourished women who become pregnant often give birth to low birth weight babies, whose ability to contribute to society as adults maybe diminished and this cycle perpetuates itself.

#### **Availability of gender disaggregated nutrition status data; children**

Island wide nutrition status data is available for women and children < 5 years from the Demographic and Health Surveys conducted by the Department of Census and Statistics approximately once every 5-6 years<sup>2</sup>. When nutrition status data of woman and children are compared between DHS surveys done in 1993, 2000 and 2007, the data indicates that a marked improvement of nutrition status in women and children have occurred from 1992 to 2000. The improvement of nutrition status from 2000 to 2007 was not so distinct, with data showing only marginal improvements in child nutrition status<sup>2</sup>.

The current prevalence of underweight among children under five years is 22%, with 18% being stunted and 15% being acutely malnourished/ wasted. The most striking of these prevalence figures are the regional disparities, rather than gender disparities<sup>2</sup>. An interesting point to note from the 2007 DHS survey is that nutritional status of the girl child is marginally better than that of a boy child <5 years<sup>2</sup>. These facts are also corroborated by other surveys done recently such as the Sri Lanka complementary feeding study, the nine district Nutrition and food security survey<sup>3,4</sup>. These surveys also have detailed information on factors which contribute to nutrition status such as observation of correct infant and young child feeding practices, consumption of micronutrient rich food etc. which were found to be similar for male and female children<sup>2,3,4</sup>.

The recent MRI survey indicates that where micronutrient status is concerned too, the girl child is marginally better off, with prevalence of anaemia being higher in boys (27,3 % vs. 21.2 %) <sup>4</sup>. The

causative factors for such high prevalences as well as gender differences need to be identified and addressed. Another interesting finding is the mothers schooling data. The evidence clearly indicates that mothers' schooling has a major impact on the child nutrition where mothers without schooling or only primary level schooling give birth to low birth weight babies and children of such mothers showing the greatest levels of stunting (height for age for age < 2 SD of Z score) <sup>2,4</sup>.

**Gender disaggregated nutrition status data; older children and adults**

Nutrition status data (Body Mass Index and micronutrient status) are available for adolescents and women (aged 15-49 years) from the DHS surveys as well as the Nutrition and Food security Survey <sup>2,4</sup>. The prevalence of thinness among women (BMI < 8.5 kg/m<sup>2</sup>) is high (approximately 20%) <sup>2,4</sup>, while the prevalence of anaemia is also high among pregnant and lactating women <sup>4</sup>. The data also suggests that a high proportion of women (especially those in urban areas) are overweight or obese, indicative of the nutrition transition that is occurring in Sri Lanka.

**What data is missing?**

There are some gaps in country wide nutrition status data among some populations in Sri Lanka. There is a scarcity lack of adequate data on children aged between 5-15 years, both male and female. Where adolescents are concerned, there is no data on male adolescents. Data on adult males are also not available. Even though it can be argued that women's nutrition status is more a priority since a cycle of stunting, low birth weight, and metabolic disorders may be perpetuated by women being malnourished, having some data indicative of male nutrition status is also of importance. The contribution of males to the economic workforce is high. Poor nutrition is well known to cause reduced work productivity, leading to compromised productivity resulting in economic losses to the country. Inadequate nutrition status data of older adults is also a major deficiency since Sri Lanka has one of the most rapidly aging populations in the world. Another deficiency is the dearth of gender disaggregated data on food insecurity. Though food security data is available at household level, there is no information on nutrition status in male or female headed households.

Men, women, and children face different risks in relation to nutrition status during the lifecycle. These differing vulnerabilities are related to both differing requirements and socio cultural factors related to gender. Availability of gender disaggregated data paves the way for targeted interventions to suit each group in achieving improved nutrition status.

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