The overall completeness of special surveillance investigation forms sent by MOH offices in Gampaha district during 2008 was found to be good (more than 80%). It varied from 79.4% (for Tetanus) to 100% (for Rubella). The overall legibility of some special surveillance investigations was not satisfactory (around 60%). Legibility of disease specific surveillance investigations varied from 51.2% (for Chickenpox) to 94.6% (for Pertussis). Based on study findings, it is recommended that the MOOH should try to improve these dimensions by training their PHII on special surveillance by using in-service training days. Before sending these forms to the Epidemiology Unit, MOH and SPHI should scrutinize forms completed by PHII and incomplete and illegible forms should be sent back to the relevant PHI for returning with suggested modifications. Regional Epidemiologist should also monitor special surveillance activities every quarter with a view to introducing relevant corrective measures in MOH areas.

Completeness of data items related to laboratory data (66%), vaccination status (69%) and risk factors (48%) in special surveillance investigation forms of Encephalitis was substandard. Legibility of items related to laboratory data in both special surveillance investigation forms of Meningitis (13%) and Encephalitis (54%) were also found to be poor. Therefore, it is apt that a system should be developed to improve the quality of writing diagnosis cards by the House Officers (HO). Support should be sought from consultants and heads of the institutions to at least check randomly diagnosis cards written by HOs for quality. Wherever possible, RE should discuss the matter with heads of institutions in the hospitals in the district with a view to improving the quality of the diagnosis cards. Public Health Inspectors should be trained on eliciting information on vaccination and risk factors using multiple methods (Child Health Development Record, school health records, vaccination cards etc.)

The number of days taken for special surveillance investigation forms to reach EU from the date of confirmation of the disease by PHII is satisfactory (median 17 days). Sending blank special surveillance investigation forms of the relevant disease along with the notification card when it is sent for routine investigations will further reduce the median number of days required for investigation forms to reach the Epidemiology Unit in the district.

Special surveillance investigation forms of some diseases (Human Rabies and Pertussis) have taken an unacceptable long time (more than six weeks) to reach the Epidemiology Unit from the date of confirmation of the diagnosis. Regional Epidemiologist should immediately investigate reasons for this undue delay and with the support of the RDHS, measures should be taken to prevent similar situations in the future. It is suggested that MOH should review the surveillance status every month while RE should review quarterly the same. Feedbacks on the status of the special surveillance investigations discussed at the RE review should be disseminated to all MOOH by the RE after the conclusion of the quarterly RE review at the Epidemiology Unit.

There was a significant variation in time taken for the special surveillance investiga-

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4. **Summary of selected notifiable diseases reported (06th – 12th February 2010)**  
   Page 4
tion forms to reach the Epidemiology Unit from within the district. This ranged from only two weeks in MOH areas Katana to more than two months in MOH areas Attangalla, Kelaniya and Ja Ela, and more than six months in Ragama. It demonstrates the fact that the RE should conduct review programme on quarterly basis on all surveillance activities in all MOH areas. The wide variety of reasons for observed variations should be identified and necessary actions should be taken through the RDHS and the relevant MOH to improve timeliness in MOH areas within the district. The study highlighted that only few PHII (13%) had undergone training on special surveillance investigation. Therefore, organization of training programmes locally by the MOOH and the RE on special surveillance investigations. It is recommended that the RE should send a quarterly feedback on special surveillance carried out by the PHII in the district based on each quarterly review of RE conducted by the Epidemiology Unit. Since the national level feedbacks of the Epidemiology Unit in the Quarterly Epidemiological Bulletin focuses on district aggregation of data, it may not be useful for MOOH.

According to a majority of PHII, the non revision of petrol allowance (75%, 42/56) was seen as a factor affecting the special surveillance investigations. It is suggested that the district team should conduct a survey to determine the validity of this finding and based on the results, a concept paper should be developed for presentation to the line ministry of health and provincial ministry of health for consideration if it will be proven as a matter for consideration.

This article was prepared by Dr. Nandika Nagodawithana based on his MSc (Community Medicine) dissertation. Author wishes to thank Dr. Ranjan Wijesinghe, Consultant Epidemiologist for his guidance during the designing and conducting of the study, data analysis and report writing.

| Categorization of responsibility of investigation of special surveillance of communicable diseases |
| (Adopted from circular no. EPID/50/XVI/2008) |
| **Person responsible** | **Diseases** |
| Medical Officer of Health | - Encephalitis  
- Meningitis  
- Human Rabies  
- Poliomyelitis / Acute Flaccid Paralysis  
- Cholera (with Epidemiology Unit) |
| Medical Officer of Health / Public Health Inspector | - Diphtheria  
- Pertussis  
- Tetanus and Neo Natal Tetanus  
- Measles  
- Rubella and Congenital Rubella Syndrome  
- Viral Hepatitis  
- Mumps  
- Chickenpox  
- Leptospirosis (field investigation)  
- Dengue and Dengue Hemorrhagic Fever  
- Leptospirosis (hospital investigation) |

It was mentioned by PHII that the non availability of feedbacks from Epidemiology Unit (48%) regarding special surveillance investigations was a factor affecting special surveillance investigations. It is recommended that the RE should send a quarterly feedback on special surveillance carried out by the PHII in the district based on each quarterly review of RE conducted by the Epidemiology Unit. Since the national level feed backs of the Epidemiology Unit in the Quarterly Epidemiological Bulletin focuses on district aggregation of data, it may not be useful for MOOH.
### Table 1: Vaccine-preventable Diseases & AFP

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of cases by Province</th>
<th>Number of cases during current week in 2010</th>
<th>Number of cases during same week in 2009</th>
<th>Total number of cases to date in 2010</th>
<th>Total number of cases to date in 2009</th>
<th>Difference between the number of cases to date in 2010 &amp; 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Flaccid Paralysis</td>
<td></td>
<td>02</td>
<td>01</td>
<td>00</td>
<td>00</td>
<td>02</td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td>00</td>
<td>01</td>
<td>00</td>
<td>00</td>
<td>01</td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Whooping Cough</td>
<td></td>
<td>01</td>
<td>00</td>
<td>00</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td>119</td>
<td>17</td>
<td>23</td>
<td>01</td>
<td>10</td>
</tr>
</tbody>
</table>

#### Key to Table 1 & 2

**Provinces:**
- W: Western
- C: Central
- S: Southern
- N: North
- E: East
- NE: North Central
- NW: North Western
- U: Uva
- Sab: Sabaragamuwa

**DPDHS Divisions:**
- CB: Colombo
- GM: Gampaha
- KL: Kalutara
- KD: Kandy
- ML: Matale
- NE: Nuwara Eliya
- GL: Galle
- HB: Hambantota
- MT: Matara
- AP: Ampara
- TR: Trincomalee
- KM: Kalmunai
- KN: Killinochchi
- MN: Mannar
- VA: Vavuniya
- MO: Moneragala
- BD: Badulla
- RP: Ratnapura
- KG: Kegalle

**Data Sources:**
- Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008.

### Table 2: Newly Introduced Notifiable Disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of cases by Province</th>
<th>Number of cases during current week in 2010</th>
<th>Number of cases during same week in 2009</th>
<th>Total number of cases to date in 2010</th>
<th>Total number of cases to date in 2009</th>
<th>Difference between the number of cases to date in 2010 &amp; 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td></td>
<td>97</td>
<td>139</td>
<td>407</td>
<td>872</td>
<td>- 53.3 %</td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td>22</td>
<td>09</td>
<td>235</td>
<td>121</td>
<td>+ 94.2 %</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td>13</td>
<td>22</td>
<td>100</td>
<td>215</td>
<td>- 53.5 %</td>
</tr>
<tr>
<td>Leishmaniasis</td>
<td></td>
<td>05</td>
<td>12</td>
<td>46</td>
<td>45</td>
<td>+ 0.2 %</td>
</tr>
</tbody>
</table>

#### Key to Table 1 & 2

**Provinces:**
- W: Western
- C: Central
- S: Southern
- N: North
- E: East
- NE: North Central
- NW: North Western
- U: Uva
- Sab: Sabaragamuwa

**DPDHS Divisions:**
- CB: Colombo
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- MT: Matara
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- TR: Trincomalee
- KM: Kalmunai
- KN: Killinochchi
- MN: Mannar
- VA: Vavuniya
- MO: Moneragala
- BD: Badulla
- RP: Ratnapura
- KG: Kegalle

**Data Sources:**
- Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008.

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10th South East Asia Regional Scientific Meeting of the International Epidemiological Association
23rd - 26th May 2010
Colombo, Sri Lanka

Theme

"Epidemiological Methods in Evidence Based Healthcare"

Visit http://www.episea2010.com
### Table 4: Selected notifiable diseases reported by Medical Officers of Health

**06th – 12th January - 2010 (06th Week)**

<table>
<thead>
<tr>
<th>DPDHS Division</th>
<th>Dengue Fever/DHF*</th>
<th>Dysentry</th>
<th>Encephalitis</th>
<th>Enteric Fever</th>
<th>Food Poisoning</th>
<th>Leptospirosis</th>
<th>Typhus Fever</th>
<th>Viral Hepatitis</th>
<th>Human Rabies</th>
<th>Returns Received %</th>
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</thead>
<tbody>
<tr>
<td>Colombo</td>
<td>145</td>
<td>810</td>
<td>2</td>
<td>19</td>
<td>1</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Gampaha</td>
<td>181</td>
<td>878</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>21</td>
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<tr>
<td>Kalutara</td>
<td>34</td>
<td>185</td>
<td>5</td>
<td>26</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Kandy</td>
<td>51</td>
<td>287</td>
<td>6</td>
<td>57</td>
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<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Matale</td>
<td>12</td>
<td>173</td>
<td>6</td>
<td>26</td>
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<td>0</td>
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<td>6</td>
<td>3</td>
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<td>3</td>
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<td>Galle</td>
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<td>75</td>
<td>6</td>
<td>27</td>
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<td>1</td>
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<td>0</td>
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<tr>
<td>Hambant</td>
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<td>98</td>
<td>2</td>
<td>7</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>9</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>16</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vavuniya</td>
<td>24</td>
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<td>1</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>16</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Mullaitivu</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Batticaloa</td>
<td>56</td>
<td>426</td>
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<td>15</td>
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<td>5</td>
<td>6</td>
<td>9</td>
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<tr>
<td>Ampara</td>
<td>5</td>
<td>17</td>
<td>4</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
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<td>Trincomal</td>
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<td>2</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Kurunegya</td>
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<tr>
<td>Puttalam</td>
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<td>324</td>
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<td>2</td>
<td>8</td>
<td>21</td>
<td>0</td>
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<tr>
<td>Anuradha</td>
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<td>442</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Badulla</td>
<td>14</td>
<td>108</td>
<td>8</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Monaraga</td>
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<td>63</td>
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<td>40</td>
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<td>1</td>
<td>14</td>
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<td>1</td>
</tr>
<tr>
<td>Ratnapur</td>
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<td>133</td>
<td>9</td>
<td>44</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
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<td>8</td>
</tr>
<tr>
<td>Kegalle</td>
<td>14</td>
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<td>2</td>
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<td>Kalmunai</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>SRI LANKA</td>
<td>105</td>
<td>6997</td>
<td>68</td>
<td>534</td>
<td>04</td>
<td>27</td>
<td>45</td>
<td>309</td>
<td>12</td>
<td>85</td>
</tr>
</tbody>
</table>

Source: Weekly Returns of Communicable Diseases WRCD.

*Dengue Fever / DHF* refers to Dengue Fever / Dengue Haemorraghic Fever.

**Timely refers to returns received on or before 12th February, 2010 Total number of reporting units =311. Number of reporting units data provided for the current week: 252

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

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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 cephid@slt.net.lk.

ON STATE SERVICE

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