WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
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Global "END TB strategy" and targets for tuberculosis control – I I I

Component 2.2- Engagement of communities, civil society organizations, and all public and private care providers

2.2.1 Engage communities and civil society

A robust response to end the tuberculosis epidemic will require the establishment of partnerships across the health and social sectors and between the health sector and communities.

Civil society organizations have specific capacities and tuberculosis programmes can benefit from harnessing them. Their competencies include reaching out to vulnerable groups, mobilizing communities, channeling information, helping to create demand for care, framing effective delivery models and addressing determinants of the tuberculosis epidemic.

2.2.2 Scale up public–private mix approaches and promote International Standards for Tuberculosis Care

National tuberculosis programmes will have to scale up country-specific public–private mix approaches already working well in many countries. To this effect, close collaboration with health professionals' associations will be essential. The International Standards for Tuberculosis Care, other tools and guidelines developed by WHO as well as modern information and communication technology platforms can be used effectively for this purpose.

Component 2.3- Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control

2.3.1 Move with urgency to universal health coverage

Universal health coverage, defined as, "the situation where all people are able to use the quality health services that they need and do not suffer financial hardship paying for them" is fundamental for effective tuberculosis care and prevention.

2.3.2 Strengthen regulatory frameworks.

National policy and regulatory frameworks for health care financing and access, quality-assured use of medicines and diagnostics, quality-assured health services, infection control, vital registration and disease surveillance systems are powerful levers that are essential for effective tuberculosis care and prevention.

2.3.3 Enforce mandatory notification of tuberculosis cases.

Many tuberculosis cases are not notified, especially those managed by private care providers that are not linked to national tuberculosis programmes. Under - notification of cases hampers disease surveillance, contact investigation, outbreak management, and infection control.

2.3.4 Undertake comprehensive infection control measures

Appropriate regulation is required to ensure effective infection control in health care services and other settings where the risk of disease transmission is high.

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Component 2.4- Social protection, poverty alleviation and actions on other determinants of TB

2.4.1 Relieve the economic burden related with tuberculosis

A large proportion of people with tuberculosis face a catastrophic economic burden related to the direct and indirect costs of illness and health care. Adverse social consequences may include stigmatization and social isolation, interruption of studies, loss of employment, or divorce. The negative consequences often extend to the family of the persons ill with tuberculosis.

Even when tuberculosis diagnosis and treatment are offered free of charge, social protection measures are needed to alleviate the burden of income loss and non-medical costs of seeking and staying in care.

2.4.2 Expand coverage of social protection.

Social protection should cover the needs associated with tuberculosis such as schemes for compensating the financial burden associated with illness, such as sickness insurance, disability pension, social welfare payments, other cash transfers, vouchers or food packages.

2.4.3 Address poverty and related risk factors.

Crowded and poorly ventilated living and working environments often associated with poverty constitute direct risk factors for tuberculosis transmission. Under-nutrition is an important risk factor for developing active disease. Poverty is also associated with poor general health knowledge and a lack of empowerment to act on health knowledge, which leads to risk of exposure to several tuberculosis risk factors. Poverty alleviation reduces the risk of tuberculosis transmission and the risk of progression from infection to disease.

Pillar –3

Intensified research and innovation

Component –3.1 Discovery, development and rapid uptake of new tools, interventions and strategies

3.1.1 Develop a point-of-care rapid diagnostic test for tuberculosis

An accurate and rapid point-of-care test that is usable in field conditions is still missing and needs to be developed.

3.1.2 Develop new drugs and regimens for the treatment of all forms of tuberculosis.

The pipeline of new drugs has expanded substantially over the last decade . In order for further progress to be made, investments are required in both research and capacity building to implement trials in accordance with international standards.

Component 3.2 Research to optimize implementation and impact; and promote innovations

3.2.1 Invest in applied research

Investments in fundamental research need to be complemented with those for applied research that supports rapid adoption, adaptation, and implementation of evidence-based policies. Research is also needed to identify and address bottlenecks to implementation of existing and new policies, and to provide evidence from the perspective of patients as well as from health systems.

3.2.2 Use research to inform and improve implementation.

Most innovations cannot be translated into effective local action without careful planning and adaptation, and partnership with stakeholders.

3.2.3 Create a research-enabling environment.

Fostering better and more relevant operational, health system and social science research will help implementation and contribute to the development of national and global policies .

A broad-based, concerted effort is needed to develop research capacity, allocate appropriate resources, and encourage stakeholders to work together. An enabling environment for performing programme based research and translating results into policy and practice is necessary to achieving the full potential of tuberculosis programmes.

“Tuberculosis kills five thousand people every day. The social and economic impacts are devastating, including poverty, stigma and discrimination”. We are all committed to support the robust roll-out of the strategy to end TB.

Source: WHO. The End TB Strategy. Available at : http://www.who.int

Compiled by Dr. Shilanthi Seneviratne
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Table 1: Selected notifiable diseases reported by Medical Officers of Health 14th – 20th Apr 2018 (16th Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmania-sis		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	98	2542	0	23	0	4	1	18	0	5	9	69	0	5	0	3	0	0	15	282	0	19	0	1	63	100
Gampaha	32	1483	1	17	0	4	0	11	0	10	0	90	0	2	0	4	0	0	20	299	0	13	2	6	74	100
Kalutara	39	1134	0	23	0	2	0	2	2	34	13	165	0	2	0	5	0	0	9	211	4	31	1	3	53	100
Kandy	34	1037	0	21	0	4	0	1	0	6	3	15	4	40	0	10	0	0	7	120	0	8	0	6	62	100
Matale	25	321	0	5	0	1	0	0	0	10	3	17	0	1	0	3	0	0	1	15	0	4	1	39	61	100
NuwaraEliya	4	63	5	11	0	2	0	7	0	2	0	9	8	62	2	12	0	0	10	104	2	16	0	0	28	100
Galle	16	410	0	14	0	5	0	0	0	2	11	165	0	12	0	1	0	1	9	100	0	15	0	4	14	100
Hambantota	18	414	0	6	0	0	0	2	0	4	0	17	0	21	1	1	0	0	2	103	0	2	17	221	73	100
Matara	9	389	0	13	0	4	0	3	0	21	2	70	2	17	0	2	0	0	2	119	0	3	2	132	56	100
Jaffna	22	1227	6	51	0	0	0	20	2	196	1	5	8	204	0	0	0	0	19	135	0	6	0	1	34	93
Kilinochchi	10	114	1	10	0	1	0	8	0	1	1	2	2	7	0	0	0	1	0	22	0	0	0	0	50	100
Mannar	1	25	0	10	0	0	0	2	0	2	0	1	0	0	0	0	0	0	0	16	0	1	0	0	35	100
Vavuniya	5	184	1	5	0	3	1	23	0	7	3	17	0	7	0	0	0	1	3	19	0	1	0	3	55	100
Mullaitivu	1	29	0	2	0	0	0	6	0	9	0	6	0	2	0	0	0	0	1	6	0	0	0	1	10	100
Batticaloa	166	2057	6	66	0	5	0	2	5	14	2	15	0	1	0	2	0	1	2	47	1	9	0	0	63	100
Ampara	0	57	0	14	0	0	0	1	0	2	0	19	0	0	0	3	0	0	4	79	0	4	0	1	70	100
Trincomalee	21	296	0	22	0	0	2	4	0	8	0	18	0	13	0	1	0	0	4	91	0	1	1	10	31	100
Kurunegala	25	1060	10	52	0	5	1	7	0	2	0	37	0	6	0	7	0	1	15	196	0	34	3	76	69	100
Puttalam	13	972	1	16	0	4	0	3	0	4	0	12	0	6	0	1	0	0	2	56	2	31	0	1	74	100
Anuradhapura	11	316	2	18	0	2	0	2	0	6	1	49	0	12	0	4	0	0	8	144	1	10	6	119	44	100
Polonnaruwa	2	100	0	10	0	1	0	0	0	6	0	50	0	0	0	2	0	0	2	76	0	6	4	64	66	100
Badulla	5	169	0	38	2	4	0	5	0	7	1	50	2	23	0	10	0	0	4	219	1	33	0	2	50	100
Monaragala	17	420	2	36	0	2	0	1	0	2	7	118	4	56	0	5	0	0	1	60	3	16	0	16	60	100
Ratnapura	49	648	4	60	2	22	0	8	0	2	12	134	2	17	0	6	0	1	10	124	1	41	0	105	40	100
Kegalle	17	452	1	21	0	5	0	2	2	60	5	39	1	33	0	7	0	0	9	136	0	16	0	3	66	100
Kalmune	30	1047	2	18	0	0	0	1	2	15	0	2	0	0	0	1	0	0	1	67	0	5	0	1	48	100
SRILANKA	**670**	**16966**	**42**	**582**	**4**	**80**	**5**	**139**	**13**	**437**	**74**	**1191**	**33**	**549**	**3**	**90**	**0**	**6**	**160**	**2846**	**15**	**325**	**37**	**815**	**54**	**99**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 20th April , 2018 Total number of reporting units 351 Number of reporting units data provided for the current week: 330 C**-Completeness

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

Table 2: Vaccine-Preventable Diseases & AFP

14th – 20th Apr 2018 (16th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2018	Number of cases during same week in 2017	Total number of cases to date in 2018	Total number of cases to date in 2017	Difference between the number of cases to date in 2018 & 2017
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	01	00	01	00	18	27	- 33.3 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	00	00	00	01	00	00	00	00	01	03	123	103	19.4 %
Measles	00	01	00	00	00	00	00	00	00	02	01	39	101	- 61.3%
Rubella	00	00	00	00	00	00	00	00	00	00	00	04	05	- 20 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	08	07	14.2 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	13	21	- 38.1%
Whooping Cough	00	00	00	00	00	00	00	00	01	01	01	14	05	180 %
Tuberculosis	119	07	14	20	07	25	09	00	29	230	258	2330	2478	- 5.9%

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

NA = Not Available

Number of Malaria Cases Up to End of April 2018,

06

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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