WEEKLY EPIDEMIOLOGICAL REPORT

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Bridge the Implementation or Action Gap– Part III

Different databases work in different ways, so you may need to adapt your search strategy to each database that you use. This process is often referred to as 'tailoring' your search. You may also decide to develop separate search strategies for different aspects of your research.

Note that implementers do not always have access to all databases or to the evidence identified through the databases. This underpins the importance of establishing an intersectoral collaborative team from the outset; ideally, this team will include academic researchers who will typically have access to most online databases and sources of evidence.

When searching for relevant evidence there is a trade-off between sensitivity and specificity; specificity decreases as sensitivity increases. Searches that are highly sensitive will identify all or most of the relevant literature, however they will also likely identify literature that is not relevant. Searches that are highly specific will exclude all or most of the literature that is not relevant, however they may also exclude some of the literature that is relevant. The more sensitive the search, the more time needs to be spent sifting out irrelevant studies. Given that implementers are often time-constrained or resource-limited, some sensitivity may have to be sacrificed in the knowledge that some potentially relevant evidence may be missed.

Stage 4: Searching for relevant evidence (applying the search strategy)

This stage involves searching for all relevant evidence using the selection criteria identified and the predetermined search strategy for a specific database(s). The search will aim to identify as much of the literature that meets the inclusion criteria as possible.

If time and resources allow, it is a good idea to have more than one person performing the same search independently, and then comparing the evidence identified to make sure that findings are consistent and there is no bias in the way that searches are made and evidence is selected.

When searching for research evidence, it is important to ensure you consider which study design will best answer your research question. For example, a systematic review of randomized control trials is ideal if you wish to determine the best type of intervention to prevent or manage a condition. However, if you are wishing to know how common the problem is, then local and current random sample surveys (or censuses) would be more appropriate. The Oxford Centre of Evidence Based Medicine (OCEBM) provides a hierarchy of evidence depending on the research question.

Stage 5: Assessing the quality of evidence found

The quality of evidence is likely to vary considerably. Therefore, you must decide on explicit criteria for appraising studies in order to separate those of higher quality from those of lower quality.

Three main dimensions considered when appraising the quality and relevance of studies are:

* the methodological quality of the study;
* the relevance of that research design to the objectives;
* the relevance of the study focus to addressing the objectives.

Checklists such as the Jadad scale (also known as the Oxford quality scoring system) are commonly used for assessing the methodological quality of trails .

WHO uses the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach to assess the quality of a body of evidence.

Contents **Page**

WHO uses this approach as it represents internationally agreed standards for making transparent recommendations. Detailed information on GRADE is available through the WHO Guidelines Review Committee (GRC) secretariat and on the following websites:

* GRADE working group: www.gradeworkinggroup.org
* GRADE online training modules: http://cebgrade.mcmaster.ca
* GRADE profile software: http://www.cochrane.org

Stage 6: Assembling and analyzing the most complete data set feasible

After assessing the evidence, you will have to collate and analyze all your assessments to determine if there are sufficient grounds to implement the policy or intervention that you are interested in. This is likely to be the stage that implementers, particularly policy officials, are most interested in. You should therefore ensure that output from the knowledge synthesis is presented in a clear format that meets their needs (for example, by drawing out policy implications).

Stage 7: Making an informed decision based on a structured report of the research

Only when all available evidence have been collated and assessed, and evidence for the effectiveness has been ranked, is it possible to select a policy or intervention for adaptation to and implementation in your local context.

Systematic reviews and other approaches to knowledge synthesis

The guidance provided above is sufficient to identify and assess evidence relevant to the effectiveness of policies and interventions for an outcome of interest within a relatively short period of time and with limited resources. A more rigorous approach to identifying, assessing and synthesizing evidence from numerous sources is to carry out a systematic review.

Systematic reviews bring the same level of rigour to reviewing research evidence as should have been used in producing that research evidence in the first place. Using the systematic review approach, however, is time and resource consuming and is not usually possible in the circumstances where most programme implementers are seeking to implement a new policy or intervention (or to implement an existing policy or intervention in a new setting).

A faster approach is that of rapid evidence assessment, which uses targeted literature searches to produce a report in a relatively short period of time. This is less rigorous than a full systematic review, but more so than an ad hoc search. It is well aligned with the approach described.

Adapting and piloting the policy or intervention

The interplay between a policy or intervention and its local context can impact both its implementation and its effectiveness . For example, differences in culture, language, age and socioeconomic status of the target population can – and often do – influence successful implementation of a policy or intervention
either positively or negatively . This means that a policy or intervention may need some adaptation.

Adapting a policy or intervention to the context in which it will be delivered is a delicate balancing act: on the one hand adaptation is crucial to ensure relevance to the local context, improve feasibility, increase local pertinence and adoption, encourage fidelity, foster sustainability and maximize effectiveness; on the other hand, one has to be careful not to modify the policy or intervention so much that fidelity to some of the core components of the policy or intervention is lost and effectiveness is threatened.

Source: A guide to implementation research in the prevention and control of non-communicable diseases. Geneva: World Health Organization; 2016. Licence: CC BY-NC-SA 3.0 IGO.

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Table 1 : Water Quality Surveillance
Number of microbiological water samples June 2018

District	MOH areas	No: Expected *	No: Received
Colombo	15	90	**85**
Gampaha	15	90	**NR**
Kalutara	12	72	**NR**
Kalutara NIHS	2	12	**4**
Kandy	23	138	**72**
Matale	13	78	**22**
Nuwara Eliya	13	78	**10**
Galle	20	120	**46**
Matara	17	102	**5**
Hambantota	12	72	**46**
Jaffna	12	72	**132**
Kilinochchi	4	24	**37**
Manner	5	30	**NR**
Vavuniya	4	24	**35**
Mullatvu	5	30	**NR**
Batticaloa	14	84	**74**
Ampara	7	42	**73**
Trincomalee	11	66	**NR**
Kurunegala	29	174	**40**
Puttalam	13	78	**56**
Anuradhapura	19	114	**81**
Polonnaruwa	7	42	**53**
Badulla	16	96	**141**
Moneragala	11	66	**64**
Rathnapura	18	108	**57**
Kegalle	11	66	**10**
Kalmunai	13	78	**83**

* No of samples expected (6 / MOH area / Month)
NR = Return not received

to be continued ...

Table 1: Selected notifiable diseases reported by Medical Officers of Health 07th – 13th July 2018 (28th 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	431	5464	1	50	0	5	0	32	1	26	5	116	0	6	0	3	0	0	14	426	1	29	0	2	**61**	**100**
paha	212	2877	2	39	0	5	1	14	0	14	3	134	0	4	0	10	0	0	7	452	2	27	0	22	**66**	**100**
Kalutara	123	1931	1	44	0	3	1	6	6	43	17	340	0	5	0	7	0	0	22	373	4	53	0	9	**52**	**100**
Kandy	119	2039	6	53	0	4	0	3	0	9	3	37	0	67	0	15	0	0	10	202	0	18	1	15	**60**	**100**
Matale	27	612	3	12	0	1	0	2	0	31	5	59	0	2	3	6	0	0	0	21	2	11	5	69	**59**	**100**
NuwaraEliya	4	107	0	36	0	3	0	9	0	47	0	19	5	96	0	19	0	0	9	147	0	23	0	0	**31**	**100**
Galle	36	647	3	31	1	8	0	0	0	3	13	257	1	21	0	2	0	1	10	193	3	36	0	5	**14**	**100**
Hambantota	33	570	0	11	0	4	0	2	0	4	2	34	3	30	0	2	0	1	1	170	1	4	17	427	**73**	**100**
Matara	53	560	2	27	0	5	0	4	1	22	10	144	2	25	1	7	0	0	7	180	2	8	24	244	**54**	**100**
Jaffna	77	1952	4	101	0	2	0	33	0	209	0	8	0	237	0	1	0	2	1	193	0	9	0	3	**37**	**93**
Kilinochchi	8	201	0	20	0	1	5	13	0	2	1	3	2	13	0	0	0	1	0	28	0	2	0	1	**51**	**100**
Mannar	17	69	0	17	0	0	1	3	0	2	0	1	0	0	0	0	0	0	0	27	1	2	0	2	**37**	**100**
Vavuniya	26	354	0	14	0	3	2	32	0	11	0	26	0	7	0	0	0	1	0	38	0	3	1	5	**58**	**100**
Mullaitivu	1	60	0	5	0	0	0	8	0	10	0	8	0	3	0	0	0	0	0	6	0	1	0	1	**21**	**100**
Batticaloa	74	3910	2	102	0	5	1	4	3	23	3	36	0	1	0	2	0	2	1	90	0	12	0	0	**65**	**100**
Ampara	17	162	4	39	0	3	0	1	1	5	0	32	0	0	1	5	0	1	5	141	0	14	0	1	**66**	**100**
Trincomalee	57	765	1	35	0	1	0	4	0	13	1	39	0	17	0	1	0	0	1	146	1	7	0	18	**27**	**100**
Kurunegala	71	1554	9	91	0	8	0	10	0	3	11	99	0	13	0	12	0	1	16	330	4	62	18	185	**67**	**100**
Puttalam	34	1286	7	31	1	6	0	4	0	4	5	31	3	11	0	2	0	0	4	92	6	55	0	1	**71**	**100**
Anuradhapura	45	590	2	30	0	6	1	3	0	38	5	93	1	16	2	6	0	1	9	273	1	27	14	231	**43**	**95**
Polonnaruwa	12	204	1	17	0	2	0	0	0	12	3	83	0	0	0	3	0	1	6	152	3	15	7	137	**60**	**88**
Badulla	20	301	3	75	0	5	0	6	0	10	6	101	2	42	0	19	0	0	10	301	4	71	0	5	**46**	**100**
Monaragala	19	598	0	47	0	2	0	1	0	2	2	202	2	81	2	17	0	0	3	102	4	58	1	24	**66**	**100**
Ratnapura	109	1445	8	112	2	30	0	17	0	4	30	373	0	22	0	13	0	2	5	198	4	72	0	140	**45**	**100**
Kegalle	55	848	4	41	0	7	0	5	2	73	10	138	0	51	0	10	0	0	4	222	0	29	2	8	**65**	**100**
Kalmune	35	1390	1	26	1	2	0	1	1	28	0	4	0	0	0	1	0	0	2	124	1	8	0	1	**50**	**100**
SRILANKA	**1715**	**30496**	**64**	**1106**	**5**	**121**	**12**	**217**	**15**	**648**	**13**	**2417**	**21**	**770**	**9**	**163**	**0**	**14**	**147**	**4627**	**44**	**656**	**90**	**1556**	**53**	**99**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 13th July , 2018 Total number of reporting units 353 Number of reporting units data provided for the current week: 351 C**-Completeness

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

Table 2: Vaccine-Preventable Diseases & AFP

07th – 13th July 2018 (28th 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*	01	00	00	00	00	00	00	00	00	01	01	36	41	- 12.1 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	01	00	01	00	00	03	01	00	03	09	06	199	196	1.5 %
Measles	00	01	00	00	00	00	00	00	00	01	02	73	134	- 45.5 %
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	01	00	00	00	00	00	00	01	02	14	10	40 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	01	00	00	00	01	00	18	21	- 14.2 %
Whooping Cough	00	00	00	00	00	00	00	00	02	02	00	32	09	255.5 %
Tuberculosis	129	24	04	08	00	00	11	05	05	186	170	4457	4429	0.6 %

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

Influenza Surveillance in Sentinel Hospitals - ILI & SARI							
Month	Human				Animal		
	No Total	No Positive	Infl A	Infl B	Pooled samples	Serum Samples	Positives
July	107	40	29	11	1225	693	0
Source: Medical Research Institute & Veterinary Research Institute							

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