WEEKLY EPIDEMIOLOGICAL REPORT

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Bridge the Implementation or Action Gap– Part IV

Guidelines on the adaptation of interventions typically share the following steps:

* identifying differences between the population for which the policy or intervention was initially designed and the new target population;
* identifying which component(s) of a policy or intervention need to be adapted;
* making modifications to the policy or intervention;
* piloting the modified policy or intervention.

The Method for Program Adaptation through Community Engagement (M-PACE) outlines a way of systematically adapting interventions to a new setting. This involves convening an adaptation steering committee (including experts who can advise on whether an element of a policy or intervention can be changed without reducing effectiveness) and then exposing a limited group of participants to the unadapted intervention.

This is followed by collecting participant and instructor feedback after each implementation session (if appropriate), or conducting a pilot through individual interviews and then conducting focus groups with participants and instructors at the end of the intervention (or pilot).

When adapting a policy or intervention it is important to know that certain elements are essential for desired outcome(s). These elements are known as evidence-based kernels and can be likened to a drug's active ingredients, without which its effects would be lost . Therefore, as far as possible, these kernels should not be modified. However, methodically determining the kernels of a policy or intervention is not typically feasible – it requires the same intervention to be implemented multiple times, with the presumed kernel being changed each time the intervention is re-implemented while other variables are kept constant.

Social validity: How acceptable is the policy or intervention in your local context?

Despite a policy or intervention being highly effective at achieving a desired outcome, its implementers and/or consumers may consider it inappropriate for a particular setting. In order for a policy or intervention to achieve intended outcomes in the practice setting, it must be both effective and socially valid. A programme is said to have social validity when it addresses problems considered relevant by consumers, it does so in a manner that consumers can enjoy or at least tolerate, and it produces outcomes that are considered valuable .

A social validity assessment can provide information regarding how well specific elements of a policy or intervention are liked or disliked. Most current approaches define three elements of a policy or intervention that can be assessed for their social validity. These are:

(i) the social significance of the goals of policy or intervention,

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(ii) the social appropriateness and acceptability of the policy or intervention's procedures and
(iii) the social importance of the effects or the outcomes produced by policy or interventions.

Most methods for assessing social validity ask parties other than policy-makers or researchers about their opinions on policies and interventions and use questionnaires/rating scales and focus groups or interviews .

Evaluating the implementation of a policy or intervention

Typically, evaluation efforts have focused on assessing how effective NCD policies and interventions are at achieving health improvement at the individual or population level. Assessing the effectiveness of a policy or intervention, however, is not sufficient. Planning and focused efforts to evaluate the implementation of NCD policies and interventions must also be in place. Thus, the evaluation should look at the implementation of policies and interventions as well as their effectiveness.

The steps involved in planning an evaluation of the implementation process are analogous to those for planning an evaluation of effectiveness. Evaluation of the implementation process must be addressed early in a programme's planning process.

* 1.Clarify what is to be evaluated.
* 2. Engage stakeholders.
* 3. Determine your evaluation questions.
* 4. Develop an evaluation framework.
* 5. Determine appropriate methods of measurement and procedures.
* 6. Develop an evaluation plan.
* 7. Collect data.
* 8. Process data and analyze results.
* 9. Interpret and disseminate results.
* 10. Apply evaluation findings

What research questions should the implementation evaluation be asking?

Key questions should be designed in order to assess implementation research or to report on implementation research.
What specific policy or intervention was put into place by the implementers in order to address the NCD issue being tackled?

* To what extent was the policy or intervention implemented as intended?
* To what extent was the policy or intervention adopted by implementers?
* What are the factors that can influence how well a policy or intervention is implemented?
* To what extent did these factors influence how well a policy or intervention is implemented?
* What is the association between the health outcomes (i.e. effectiveness) of a policy or intervention and how well is this implemented?
* Was the implementation approach that was used cost effective?

What are implementation outcomes?

In implementation research studies, implementation outcomes describe the intentional actions to deliver a policy or an intervention ; they are distinct from, but related to, health outcomes. Implementation outcome variables include: acceptability, reach, adoption, fidelity, implementation cost and sustainability.

What is the reach of the policy or intervention?

Reach is defined as the absolute number, proportion and representativeness of a study sample . Population impact is a function of how well a policy or intervention is implemented, its effectiveness at the individual level and its reach.

For example, the population impact of a smoking cessation programme depends both on how many smokers are reached and tried to stop smoking, and what the average success rate is. Research indicates that in this example the reach of the programme has much greater impact, since the success rate seems to vary less.

Reach is a combination of both the number of people reached by a policy or intervention and how representative they are of the target population.

The representativeness is important, as generalization of an intervention into real-world settings is likely to have better impact if sample representativeness – and therefore reach – is good. Comparisons for representativeness should be based on basic demographic characteristics and, when possible, on primary outcomes.

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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to be continued ...

Table 1: Selected notifiable diseases reported by Medical Officers of Health 14th – 20th July 2018 (29th 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	380	5844	0	50	0	5	0	32	1	27	2	118	0	6	0	3	0	0	12	438	2	31	0	2	**61**	**100**
paha	225	3102	6	45	1	6	1	15	0	14	3	137	0	4	0	10	0	0	6	458	2	29	1	23	**66**	**100**
Kalutara	85	2016	2	46	0	3	0	6	1	44	13	353	0	5	0	7	0	0	16	389	2	55	0	9	**51**	**100**
Kandy	151	2190	3	56	0	4	0	3	0	9	2	39	1	68	0	15	0	0	5	207	4	22	0	15	**60**	**100**
Matale	37	649	0	12	0	1	2	4	0	31	1	60	0	2	0	6	0	0	1	22	0	11	4	73	**60**	**100**
NuwaraEliya	10	117	0	36	0	3	0	9	0	47	1	20	0	96	0	19	0	0	11	158	1	24	0	0	**31**	**100**
Galle	23	670	2	33	1	9	0	0	0	3	7	264	5	26	0	2	0	1	8	201	4	40	0	5	**16**	**100**
Hambantota	17	587	0	11	0	4	0	2	0	4	0	34	4	34	0	2	0	1	2	172	1	5	8	435	**72**	**100**
Matara	35	595	0	27	0	5	0	4	0	22	7	151	1	26	0	7	0	0	3	183	0	8	10	254	**53**	**100**
Jaffna	85	2037	2	103	1	3	0	33	2	211	0	8	6	243	0	1	0	2	6	199	0	9	0	3	**37**	**93**
Kilinochchi	9	210	1	21	0	1	2	15	0	2	0	3	0	13	0	0	0	1	0	28	0	2	0	1	**51**	**100**
Mannar	34	103	0	17	0	0	0	3	0	2	0	1	0	0	0	0	0	0	0	27	0	2	1	3	**39**	**100**
Vavuniya	22	376	1	15	0	3	1	33	0	11	2	28	0	7	0	0	0	1	0	38	0	3	1	6	**58**	**100**
Mullaitivu	4	64	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	77	3987	1	103	0	5	0	4	0	23	0	36	0	1	0	2	0	2	3	93	2	14	0	0	**66**	**100**
Ampara	8	170	2	41	0	3	0	1	0	5	0	32	0	0	0	5	0	1	5	146	1	15	0	1	**67**	**100**
Trincomalee	43	808	0	35	0	1	0	4	0	13	1	40	0	17	0	1	0	0	2	148	0	7	0	18	**26**	**100**
Kurunegala	60	1614	0	91	1	9	1	11	0	3	3	102	0	13	1	13	0	1	7	337	3	65	7	192	**66**	**100**
Puttalam	27	1313	0	31	0	6	0	4	0	4	0	31	0	11	0	2	0	0	5	97	2	57	0	1	**70**	**100**
Anuradhapura	29	619	1	31	1	7	0	3	0	38	5	98	0	16	1	7	0	1	11	284	2	29	6	237	**43**	**95**
Polonnaruwa	5	209	1	18	0	2	0	0	0	12	2	85	0	0	0	3	0	1	4	156	0	15	2	139	**60**	**88**
Badulla	21	322	2	77	0	5	0	6	0	10	4	105	1	43	1	20	0	0	2	303	1	72	1	6	**45**	**100**
Monaragala	16	614	1	48	0	2	0	1	0	2	5	207	1	82	1	18	0	0	4	106	2	60	1	25	**66**	**100**
Ratnapura	67	1512	1	113	1	31	0	17	0	4	26	399	0	22	0	13	0	2	5	203	4	76	3	143	**46**	**100**
Kegalle	53	901	0	41	0	7	0	5	0	73	5	143	1	52	0	10	0	0	7	229	1	30	0	8	**66**	**100**
Kalmune	28	1418	3	29	1	3	1	2	1	29	0	4	0	0	0	1	0	0	6	130	0	8	0	1	**51**	**100**
SRILANKA	**1551**	**32047**	**29**	**1135**	**7**	**128**	**8**	**225**	**5**	**653**	**89**	**2506**	**20**	**790**	**4**	**167**	**0**	**14**	**131**	**4758**	**34**	**690**	**45**	**1601**	**53**	**99**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 20th 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

14th - 20th July 2018 (29th 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	01	00	00	01	00	37	41	- 9.7 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	01	00	01	00	01	00	00	00	00	03	07	202	203	- 0.4 %
Measles	02	00	00	00	00	00	02	00	00	04	02	77	141	- 45.3 %
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	01	00	00	00	00	00	00	00	00	01	01	15	11	36.3 %
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	18	21	- 14.2 %
Whooping Cough	00	01	00	01	00	00	00	00	00	02	00	34	09	277.7 %
Tuberculosis	146	31	18	04	30	28	11	14	13	296	234	4753	4663	1.9 %

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 July 2018,

05

All are Imported!!!

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ON STATE SERVICE

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