WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health, Nutrition & Indigenous Medicine

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Vol. 49 No. 31 30th– 05th Aug 2022

WEER SRI LANKA 2022

Can we eliminate Tuberculosis? Part II

This is the last article of series of two articles.

According to the WHO estimates, 14,000 cases should be notified each year. It is slightly decreased towards this number after 2000. Is this estimation correct? If so, we lack nearly 5000 cases each year and 6000 in 2020. Is there that amount of undetected or missed cases in our community? Or has the WHO overestimated it? If it is, the decline in the number of TB cases is justified by the following factors.

- The constant decline of smear-positive TB cases.
- TB cases at the young age groups are drastically declined and age distribution has deviated to the old age groups.
- Routine notification data are tallied between national and sub-national levels.

We have partly achieved the objectives of the national TB strategic plan 2015-2020. Now we have adhered to the newest strategy 2010-2025 to achieve universal access to TB diagnosis and treatment by 2025 and get on track to achieve the End TB targets by 2035. Is it possible even with the economic crisis and Covid pandemic we are facing to?

If yes, how?

INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION is composed of 2 objectives according to the NTP 2021-2025. The first one is “To find and successfully treat, on average, between 2021 and 2025, 10,000 cases of drug-sensitive TB annually, including 600 children”

Steps that should be taken for active case detection.

- Increasing the awareness of Tuberculosis among patients and health care workers.

“Cough more than two weeks” is the cardinal feature we look in to suspect TB in one. That information should be gone to both the community and HCWs. Then people will actively approach by seeking health care assistance when they have a cough for more than 2 weeks. Doctors and nurses will enthusiastically look for people compatible with TB in OPD and inward settings and refer them for further investigations of TB.

- Contact tracing of pulmonary TB patients, to find latent TB and active TB cases.
- Launching TB detection campaigns targeting high-risk groups.
- Screening of HIV patients

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- Use advanced and extensive diagnosis methods – TB culture, WRD Gene X-perts, Histology

Steps that should be taken for successful treatment outcome.

- DOT strategy (direct observation of therapy) – treatment adherence is crucial to cure TB and avoid the emergence of drug resistance. Patients take their pills in front of the DOT provider. Hence make sure the best possible outcome for the patient through integrity.
- Retrieval mechanism for defaulters – Look for defaulters actively and recruit them back for DOT.
- Support patients to cope with drug side effects.
- By the above means, we can interrupt the chain of transmission.

Other steps to prevent TB

- **Infection control - standard precautions, administrative controls, environment control, infrastructure for effective infection control, personnel protective equipment**
- **BCG vaccination**
- **Chemo prophylaxis**
-

Budget for national TB strategic plan 2021-2025

The total cost of this plan is US$ 29.81million. This amount will be divided unequally among the different objectives of the plan. 60.2% of this is allocated for intensified case detection and prompt treatment. The next highest allocation is for the 6th objective. That is to improve the efficiency and effectiveness of this management and organization of TB control activities. And, to expend on the salary of NTP staff and training sessions. US$ 14.7 million of the total cost will be supplied by the government of Sri Lanka and US$5.685 million will be supplied by the Global fund. The budget gap of 7.543 is supposed to be picked up by other donors like the World Bank, WHO, and SAARC.

Currently, Sri Lanka is facing the worst economic crisis ever met in recent decades. Therefore, such a big allocation for the TB program could not be realistic. In that case, we may have to find more foreign funds. In Sri Lanka, health facility is available free of charge and most TB cases are detected through the government health sector. DOT provision, sputum microscopy, and all other management of TB patients are conducted through district chest clinics and other regional focal points established by the government. Anyhow, we should continue the strategy to reduce the TB –related burden. Using this amount of budget for TB control is justifiable rather than spending them for treating a large amount of TB patients. Then we can move to a new low-cost strategic plan in 2025 after achieving targeted milestones. So, this is still possible if we can get more funds.

Other challenges ahead in the path of TB elimination are,

- Drug addiction
- Poverty
- Overpopulation in TB hotspots
- Lack of awareness in health care workers and the community
- Defaulting of treatments by patients
- Diabetes mellitus
- HIV and MDR TB are not the issues with a big gravity in Sri Lanka.

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 23rd– 29th Jul 2022 (30th Week)

RDHS	Dengue Fever		Dysentery		Encephaliti		Enteric Fever		Food Poi-		Leptospirosis		Typhus		Viral Hep-		Human		Chickenpox		Meningitis		Leishmania-		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	38	8215	0	4	0	3	0	0	0	5	2	112	0	0	0	3	0	0	2	19	0	7	0	2	**14**	**97**
Gampaha	17	4803	0	5	0	1	0	0	0	12	4	95	0	0	0	8	0	3	1	28	1	26	0	28	**5**	**76**
Kalutara	17	2560	1	12	0	1	0	1	0	6	17	235	0	3	0	2	0	2	7	46	0	17	0	2	**3**	**100**
Kandy	23	2904	3	15	0	0	0	2	1	5	8	103	2	25	0	8	0	0	5	42	1	6	1	17	**12**	**100**
Matale	36	669	0	2	0	0	0	0	0	0	1	73	0	3	0	2	0	0	2	15	0	1	4	203	**17**	**100**
NuwaraEliya	9	152	1	15	0	0	0	2	0	1	0	49	0	12	0	4	0	0	0	26	1	3	0	0	**23**	**98**
Galle	15	2582	0	7	0	0	0	0	0	0	7	272	1	13	0	2	0	0	1	47	0	13	0	0	**11**	**100**
Hambantota	76	972	0	24	0	0	0	0	0	2	5	148	4	30	0	4	0	0	0	19	0	6	15	304	**16**	**97**
Matara	59	1063	1	12	1	2	0	0	0	0	4	164	0	8	0	1	0	0	0	25	0	6	0	176	**28**	**100**
Jaffna	46	2324	4	41	0	2	1	57	0	27	0	19	0	408	0	6	0	4	1	73	1	10	0	0	**64**	**88**
Kilinochchi	1	93	0	6	0	0	0	1	0	21	0	11	0	9	0	0	0	0	0	4	0	1	0	2	**31**	**98**
Mannar	1	174	1	2	0	0	0	0	0	0	0	18	0	3	0	2	0	0	1	6	0	15	0	0	**19**	**81**
Vavuniya	0	66	1	3	0	1	0	2	0	0	1	15	0	1	0	0	0	0	2	14	0	0	0	4	**2**	**99**
Mullaitivu	1	47	0	4	0	0	0	2	0	3	0	23	0	5	0	0	0	0	0	6	0	1	0	1	**21**	**94**
Batticaloa	8	966	0	44	0	7	0	0	0	20	0	29	0	0	0	1	0	1	0	15	0	25	0	1	**36**	**100**
Ampara	4	123	1	10	0	1	0	0	0	17	0	76	0	1	0	1	0	0	0	35	0	16	0	12	**9**	**96**
Trincomalee	1	973	0	22	0	0	0	1	0	2	0	20	0	3	0	4	0	0	0	32	0	6	0	1	**17**	**85**
Kurunegala	61	1869	1	14	0	1	0	0	0	4	5	98	2	20	0	0	0	1	2	40	0	22	14	316	**9**	**97**
Puttalam	36	1378	0	3	0	0	0	0	0	0	0	19	0	7	0	0	0	0	1	8	0	21	0	4	**15**	**91**
Anuradhapur	25	290	0	8	0	2	0	1	0	5	0	122	0	19	0	2	0	1	1	37	1	29	8	259	**8**	**89**
Polonnaruwa	7	101	0	5	0	0	0	0	0	1	5	90	0	0	0	3	0	0	1	10	0	3	14	281	**15**	**96**
Badulla	36	732	1	14	0	1	0	1	0	5	11	139	2	33	3	91	0	0	0	38	0	11	1	16	**14**	**100**
Monaragala	11	308	0	6	0	1	0	4	0	2	2	213	0	20	3	37	0	0	0	37	2	34	1	89	**11**	**100**
Ratnapura	13	1941	1	30	0	6	0	3	0	26	27	636	2	18	0	17	0	0	2	52	4	42	17	140	**12**	**95**
Kegalle	11	1698	1	12	0	5	0	1	0	5	4	337	1	15	0	4	0	0	1	62	0	34	0	15	**8**	**99**
Kalmune	28	704	0	24	0	0	0	1	0	6	0	16	0	1	0	1	0	0	1	36	5	28	0	0	**29**	**100**
SRILANKA	**18**	**37707**	**17**	**344**	**1**	**34**	**1**	**79**	**1**	**175**	**10**	**3132**	**14**	**657**	**6**	**20**	**0**	**12**	**31**	**772**	**16**	**383**	**75**	**1873**	**17**	**94**

Source: Weekly Returns of Communicable Diseases (esurvillance.epid.gov.lk). T=Timeliness refers to returns received on or before 29th July , 2022 Total number of reporting units 361 Number of reporting units data provided for the current week: 314 **C****-Completeness

Table 2: Vaccine-Preventable Diseases & AFP

23rd– 29th Jul 2022 (30th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2022	Number of cases during same week in 2021	Total number of cases to date in 2022	Total number of cases to date in 2021	Difference between the number of cases to date in 2022 & 2021
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	01	00	00	00	00	01	03	45	31	45.1 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	00	00	00	00	00	00	00	01	01	02	44	52	- 15.3 %
Measles	00	00	00	00	00	00	00	00	00	00	00	14	09	55.5 %
Rubella	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
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	05	02	150 %
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	01	00	0 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Tuberculosis	00	00	00	03	110	12	07	10	00	142	88	3396	3173	7.0 %

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

Covid-19 Prevention & Control

For everyone's health & safety, maintain physical distance, often wash hands, wear a face mask and stay home.

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**

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