



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
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Health Emergency and Disaster Risk Management (Health-EDRM)

What is Health-EDRM?

Emergencies and disasters often result in significant impacts on people's health, including loss of many lives and serious disruptions of the functioning of communities. Every new threat reveals the challenges of managing health risks and effects of emergencies and disasters. Deaths, injuries, diseases, disabilities, psychosocial problems and other health impacts can be avoided or reduced by emergency risk management measures involving health and other sectors. Health-EDRM refers to the systematic analysis and management of health risks, posed by emergencies and disasters, through a combination of hazards and vulnerability reduction to prevent and mitigate risks, preparedness, response and recovery measures.

The traditional focus of the health sector has been on the response to emergencies. The ongoing challenge is to broaden the focus of Health-EDRM from that of response and recovery to a more proactive approach which emphasizes prevention and mitigation and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems based on primary health care at the community level can reduce underlying vulnerability, protect health facilities and services and scale-up the response to meet the wide-ranging health needs in emergencies and disasters.

Why is there a need for Health-EDRM?

Natural, biological, technological and societal hazards put the health of vulnerable populations at risk and bear the potential to cause significant harm to public health. Examples of these hazards are as follows:

- * Natural: landslides, tsunami, floods or droughts
- * Biological: epidemic disease, pests infestations
- * Technological: Chemical substances, radiological agents, transport crashes.
- * Societal: conflicts, stampedes, acts of terrorism

Emergencies, disasters and other crises may cause ill health directly or through the disruption of health systems, facilities and services, leaving many, without access to health care in times of emergency. They also face difficulties with basic needs such as water, food and safe shelter, which are essential for health.

The incidence of emergencies arising from natural hazards has been increasing and the impact of climate change will increase the risk for millions of individuals, their homes, their communities, and infrastructure that supports them. Hazards due to biological emergencies have assumed an increasing importance: major outbreaks related to new and re-emerging infectious diseases such as SARS, influenza (H1N1 and H5N1). Technological Hazards are also increasing and societal hazards including conflicts, continue to affect millions of people.

International consensus views emergencies as barriers to progress on the health-related Sustainable Development Goals (SDGs), as they

Reducing vulnerability to disasters and emergencies: a public health priority

Health risks can be understood in terms of hazards and people's vulnerability to that hazard. Human vulnerability to emergencies is a complex mix of issues that includes social, economic, health and cultural factors. In many situations it is not the hazard itself that necessarily leads to an emergency, but the vulnerability and inability of the population to anticipate, cope with, respond to and recover from its effects. The burden of emergencies falls disproportionately on vulnerable populations, namely the poor, ethnic minorities, old people, and people with disabilities. Worldwide, the loss of life from climate related emergencies is far higher among the less-developed nations than it is in developed nations. High risk populations must be prioritized in targeted efforts to mitigate human vulnerability. Various risk factors for human vulnerability to emergency and disaster-related morbidity and mortality include the following.

- Low socioeconomic status
- Lack of home ownership
- Age more than 65 years
- Age less than 5 years
- Female
- Chronic illness
- Disability
- Social isolation or exclusion

In the context of emergency risk management, public health programmes build capacities and resilience of individuals and communities to risks, to reduce the impact, cope with and to recover from the effects of adversity. They address issues related to health disparities that arise between the general population and the most vulnerable groups.

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often set back hard-earned development gains in health and other sectors.

Health care systems provide core capacities for Health-EDRM. Countries with well-developed systems are often much more resilient and better prepared for disasters. Primary health care (PHC) focuses on basic services to improve health status, which in turn builds community resilience and provides the foundation for responding to emergencies. Policies and strategies focusing on PHC can contribute to decreasing vulnerability and prepare households, communities and health systems for emergencies.

Development of capacities for Health-EDRM

The health sector requires capacities and relationships with other sectors spanning across the spectrum of emergency risk management measures at the community, sub-national, national and international levels. Health risks can be mitigated by decreasing exposures and the human susceptibility to the hazard, and building resilience of individuals, communities and the country to protect health, and respond and recover effectively from a hazard. An all-hazards Health-EDRM program could be expected to have capacities derived from the health system building blocks, emergency management principles and practices, and IHR (2005) including national, sub-national and local levels. These capacities include:

1. Policies, strategies, and legislation

A national policy on Health-EDRM should outline the roles and responsibilities of all public, private and civil society stakeholders, for Health-EDRM including those responsible for initiatives such as IHR (2005), surveillance and early warning, emergency preparedness, and safe hospitals. Multi-sectoral EDRM policies and legislation should refer to the protection of people's health and the minimization of health consequences as specific aims.

2. Planning and coordination

Health-EDRM, including specific integration of IHR (2005), should be addressed within the National Health Plan, informed by the risk and capacity assessments. Relevant health considerations should also be fully integrated into multi-sectoral plans, such as national disaster risk reduction plans, preparedness and response plans, recovery plans and incident management systems. Response plans need to be regularly tested. Health-EDRM coordination mechanisms and/or dedicated units should be established to ensure appropriate coordination across the health sector and with other sectors at each level. They should also have procedures to issue requests to receive and coordinate international health partners during large-scale emergencies exceeding national capacities.

3. Human Resources

Dedicated and skilled personnel to manage Health-EDRM programs and implement activities are required at national, sub-national and local levels. Key human resource management considerations include planning for staffing requirements (including surge capacity for emergency response), education and training for competency development, and occupational health and safety.

4. Financing

Adequate financial allocations are required from governments, including the Ministry of Health and other sources for developing capacities and implementing programs and activities. Financial mechanisms should also include funding for response and recovery.

5. Information management

Information management capacities will need to be strengthened to support risk/needs assessments, disease surveillance and other early warning systems, monitoring and evaluation, and public communications. It is important that information

collection, analysis and dissemination be harmonized across relevant sectors and mechanisms put in place to ensure that "the right information gets to the right people at the right time".

6. Risk Communications

Communicating effectively, including risk communication, is critical to emergency management, especially when relating to other sectors, government authorities, the media, and the general public. The real-time exchange of information, advice and opinions are vital so that everyone at risk is able to take informed decisions to mitigate the effects of the threat (hazard) such as a disease outbreak and take protective and preventive action.

7. Monitoring and evaluation

Processes to monitor progress towards meeting Health-EDRM objectives and core capacities should be integrated into existing health sector monitoring systems. Standardized indicators to monitor risks, capacities and program implementation are necessary.

8. Health infrastructure and logistics

Making hospitals, health facilities and related infrastructure safe and prepared for emergencies protects the lives of their occupants, enables effective health response and recovery, and protects public and private investments. Supporting logistics will include stockpiling and prepositioning of medicines and supplies, effective supply chains, and reliable transportation and telecommunications.

9. Health and related services

Public health, pre-hospital and facility-based clinical services must be well prepared to respond effectively in the event of an emergency with health consequences. They should have the capacity to scale up service delivery to meet increased health needs and to take specific measures related to certain hazards (e.g. isolation of infectious cases). Representatives from these various disciplines should contribute to risk/capacity assessments, planning, implementation, and monitoring and evaluation.

10. Community Capacities for Health-EDRM

For example, many lives can be saved in the first hours after an emergency through effective local response, before external help arrives. The local population will play the lead role in recovery and reconstruction efforts. Participation of communities in risk assessments can reduce risks prior to an emergency occurring. Civil society can contribute to community-level surveillance, household preparedness, local stockpiling, first aid training, and emergency response. Other sectors may be responsible for managing critical infrastructure (e.g. water supply, electricity, transport and telecommunications) and contribute to civic activities.

References

Health Emergency and Disaster Risk Management - Overview Fact Sheets, WHO (2017)

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 17th - 23rd Feb 2018 (08th 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	134	1774	4	11	0	1	3	11	2	4	3	31	0	1	0	1	0	0	0	12	118	2	9	0	1	62	95
Gampaha	89	1115	0	7	0	1	1	7	1	7	10	33	0	1	0	2	0	0	0	35	155	1	6	1	1	73	100
Kalutara	56	745	1	11	0	2	0	0	1	14	6	57	0	1	0	2	0	0	0	8	102	0	19	0	0	54	100
Kandy	49	752	2	11	0	3	0	1	1	2	0	8	0	15	2	4	0	0	8	50	2	6	0	3	59	100	
Matale	17	208	1	3	0	1	0	0	0	5	3	8	0	1	0	1	0	0	0	0	8	0	2	6	11	65	100
NuwaraEliya	4	39	0	2	0	0	0	4	0	2	0	2	3	14	0	4	0	0	8	50	3	8	0	0	24	100	
Galle	3	114	0	3	0	0	0	0	0	1	2	34	1	7	0	0	1	1	3	10	0	1	0	1	36	36	
Hambantota	40	246	0	2	0	0	0	0	0	0	0	9	1	11	0	0	0	0	6	51	0	1	6	122	72	100	
Mataru	32	256	2	6	1	1	1	2	0	13	2	29	4	7	0	1	0	0	7	56	1	1	9	62	56	100	
Jaffna	63	947	3	25	0	0	1	13	3	11	1	3	13	159	0	0	0	0	10	60	0	5	0	0	35	92	
Kilinochchi	6	68	0	5	0	0	1	8	0	0	0	1	0	2	0	0	0	0	1	2	0	0	0	0	41	100	
Mannar	0	14	0	9	0	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	10	0	1	0	25	100	
Vavuniya	7	117	2	2	1	1	1	11	0	6	1	10	0	5	0	0	0	1	1	8	0	1	0	0	59	100	
Mullaitivu	0	12	0	1	0	0	0	1	0	5	0	2	0	1	0	0	0	0	0	0	0	0	0	0	30	58	
Batticaloa	116	1094	5	35	2	4	0	0	6	7	0	6	0	1	0	1	0	1	7	22	0	5	0	0	64	100	
Ampara	2	38	0	6	0	0	0	0	0	0	0	14	0	0	0	3	0	0	7	32	1	3	0	0	59	100	
Trincomalee	21	182	0	12	0	0	0	1	0	1	0	7	0	8	0	0	0	0	4	45	0	0	0	5	36	100	
Kurunegala	95	814	5	26	0	2	2	4	0	2	0	26	1	5	1	2	1	1	15	97	4	18	2	33	70	100	
Puttalam	62	807	0	8	0	2	0	1	0	1	1	8	1	4	0	0	0	0	3	20	4	16	0	0	74	100	
Anuradhapura	39	227	1	12	0	1	0	1	0	0	2	38	1	11	0	0	0	0	13	63	0	4	15	64	44	100	
Polonnaruwa	3	65	3	8	0	1	0	0	0	6	0	39	0	0	0	1	0	0	9	42	1	4	3	35	65	96	
Badulla	6	115	4	31	0	0	0	4	1	5	1	24	0	9	1	4	0	0	7	64	1	17	0	2	53	98	
Monaragala	35	305	4	26	0	2	0	1	0	2	4	72	1	27	0	4	0	0	5	31	2	5	1	7	57	100	
Ratnapura	42	377	4	35	4	16	0	4	0	2	3	49	0	5	1	3	0	1	10	52	2	22	2	69	42	100	
Kegalle	20	302	0	9	0	4	0	1	2	27	0	18	2	15	0	6	0	0	11	57	1	4	0	0	70	100	
Kalmune	28	803	1	6	0	0	0	0	1	13	0	1	0	0	0	1	0	0	1	24	0	2	0	0	48	100	
SRILANKA	969	11536	42	312	8	42	10	77	18	136	39	530	28	310	5	40	2	5	191	1229	25	160	45	416	56	95	

Source: Weekly Returns of Communicable Diseases (WRCD). *T=Timeliness refers to returns received on or before 23rd February, 2018. Total number of reporting units 349. Number of reporting units data provided for the current week: 326. C**=Completeness. A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

17th – 23rd Feb 2018 (08th 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	01	00	01	00	00	02	01	09	17	- 47 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	03	00	01	02	01	01	00	00	00	08	04	43	47	- 8.5 %
Measles	01	01	01	00	00	00	01	00	00	04	05	17	55	- 69.1 %
Rubella	01	00	00	00	00	00	00	00	00	01	00	04	01	300 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus	00	01	00	00	00	00	00	00	00	01	00	05	03	66.7 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	01	00	00	00	00	01	00	10	04	150 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	07	04	75 %
Tuberculosis	78	09	12	14	19	04	14	14	13	177	123	1213	1308	- 7.2 %

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 February 2018,

02

All are Imported!!!

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ON STATE SERVICE

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