



# WEEKLY EPIDEMIOLOGICAL REPORT

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## Emergency risk communication - policy and practice

Risk communication refers to the real-time exchange of information between experts of different related fields and the people who are at risk. Risk communication enables people at risk to safeguard their lives and the lives of their loved ones by taking necessary precautions without delay. However the success of risk communication depends on the education level, perceptions, practices and beliefs of the affected community, the attributes of the communicator such as empathic nature and commitment and the ability of the experts to detect when and how to implement risk communication before the rumours and misconceptions make the environment difficult to carry out effective risk communication. Risk communication not only helps the affected communities to save their lives but also other parties such as local programme managers, other stakeholders and donors to streamline their programmes as well, people concerned around the world to get well informed about the risk situation. Furthermore, it ensures political stability of a country and increases the trust people lay on relevant health officials of a country. Hence, risk communication warrants application to each and every emergency. But due to lack of preparation, limited capacity and limited budget it is less well practised worldwide. Pertaining to the diversity of the public health emergencies and humanitarian crises even the practised risk communication strategies are found to have gaps and deficiencies. Because of all above reasons, risk communication has been identified as one of the major challenges in a public health emergency.

Massive public health emergencies and disasters that took place in early 2000 made the officials responsible to think and work more on reducing the risk of disasters and saving lives of people. It was clear that proper risk communication mechanisms

assured people at risk to make well-informed decisions in order to take prompt actions.

As to improve the risk communication mechanisms International Health Regulations (IHR) were revised in 2005, after the global spread of the Severe Acute Respiratory Syndrome (SARS) coronavirus in 2003. The main intention of this revision was to strengthen the country capacity in risk communication in an emergency. According to the revised IHR, all WHO member states agreed to assess their country capacity while allowing external evaluation through joint external evaluation (JEE) mechanism. All the parties who signed to this IHR 2005 requested the support and guidance of WHO in improving the country capacity in practising effective and timely risk communication. Even revised, the recent outbreaks of Ebola virus disease outbreak and Zika virus syndrome could identify further gaps in risk communication strategies which rendered the further development of strategies used.

After the West African Ebola virus disease outbreak, In January 2015, the WHO Executive Board held a special session and declared a resolution explaining the necessity of implementation of IHR 2005. The resolution highlighted the importance of improving communication, health messages regarding preventive measures and exposing information to media. The manuals and guidelines WHO has developed on risk communication were mostly prepared by lessons learnt, when controlling massive global outbreaks such as SARS (2003), and the H1N1 influenza pandemic (2009). These guidelines are not compiled based on systematic analysis of evidence. WHO uses the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to assess the evidence and develop recommendations.

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. However, a modification of WHO guidelines was needed to develop complex public health risk communication interventions. This was done by the Guideline Development Group (GDG) – a group of experts in disaster preparedness, public health emergencies and risk communication. They prepared the SPICE format which was used to provide search terms for 12 systematic reviews commissioned in 2016. SPICE was a format used to formulate questions where qualitative evidence and mixed methods were also considered. SPICE refers to,

- Setting,
- Perspective
- phenomenon of Interest
- Comparison
- Evaluation of impact.

This is a much superior format compared to PICO (T) format.

- Population
- Intervention
- Comparator
- Outcome

(Time period may also be set)

PICO(T) did not cover qualitative evidence and mixed method. After receiving all the systematic reviews an evidence profile was made using the DECIDE framework. DECIDE is an Evidence to Decision (EtD) framework tool enabling assessment of interventions in six domains:

- Effects
- Values
- Resources
- Equity
- Acceptability
- Feasibility

The recommendations mentioned in these guidelines provide a good base on how risk communication should be practised in a public health emergency. Further, they guide and support countries to build up capacity for effective and prompt risk communication during health emergencies.

It is expected that all countries will adhere to this evidence-based guidance in all types of public health disasters to occur. It surely would be the next challenge to ensure prompt and proper implementation of risk communication in order to mitigate the damage of disasters.

**References**

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Table 1 : Water Quality Surveillance Number of microbiological water samples February 2018			
District	MOH areas	No: Expected *	No: Received
Colombo	15	90	<b>79</b>
Gampaha	15	90	<b>NR</b>
Kalutara	12	72	<b>NR</b>
Kalutara NIHS	2	12	<b>NR</b>
Kandy	23	138	<b>NR</b>
Matale	13	78	<b>NR</b>
Nuwara Eliya	13	78	<b>29</b>
Galle	20	120	<b>NR</b>
Matara	17	102	<b>61</b>
Hambantota	12	72	<b>NR</b>
Jaffna	12	72	<b>NR</b>
Kilinochchi	4	24	<b>19</b>
Manner	5	30	<b>15</b>
Vavuniya	4	24	<b>NR</b>
Mullatvu	5	30	<b>NR</b>
Batticaloa	14	84	<b>73</b>
Ampara	7	42	<b>35</b>
Trincomalee	11	66	<b>50</b>
Kurunegala	29	174	<b>66</b>
Puttalam	13	78	<b>50</b>
Anuradhapura	19	114	<b>18</b>
Polonnaruwa	7	42	<b>29</b>
Badulla	16	96	<b>144</b>
Moneragala	11	66	<b>71</b>
Rathnapura	18	108	<b>97</b>
Kegalle	11	66	<b>12</b>
Kalmunai	13	78	<b>65</b>

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

Table 1: Selected notifiable diseases reported by Medical Officers of Health 10<sup>th</sup> - 16<sup>th</sup> Mar 2018 (11<sup>th</sup> 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	77	2099	3	17	0	3	2	14	0	5	4	40	1	3	0	2	0	0	21	171	1	15	0	1	59	100
Gampaha	41	1281	1	10	0	3	0	8	0	7	5	57	0	1	0	2	0	0	21	200	0	11	0	2	74	100
Kalutara	50	951	4	16	0	2	0	1	0	16	16	89	0	2	0	4	0	0	20	148	3	22	0	1	55	100
Kandy	35	851	4	16	1	4	0	1	0	2	1	12	3	28	1	5	0	0	13	76	1	7	0	5	58	100
Matale	21	255	0	3	0	1	0	0	2	8	2	12	0	1	2	3	0	0	0	8	0	3	2	27	60	100
NuwaraEliya	2	46	2	4	0	1	1	5	0	2	1	5	10	40	1	7	0	0	8	76	1	10	0	0	22	100
Galle	5	123	1	4	2	5	0	0	0	1	4	42	0	7	0	0	0	1	5	16	1	9	0	1	40	34
Hambantota	31	331	0	3	0	0	0	1	0	0	0	9	2	19	0	0	0	0	4	69	1	2	5	133	72	100
Matarra	22	319	4	10	0	3	0	2	1	14	8	47	1	10	1	2	0	0	11	85	1	3	12	89	55	100
Jaffna	45	1083	5	38	0	0	1	15	162	174	0	4	9	183	0	0	0	0	11	88	0	5	0	0	33	93
Kilinochchi	6	89	1	6	1	1	0	8	0	0	0	1	0	2	0	0	0	1	3	18	0	0	0	0	45	100
Mannar	1	19	0	9	0	0	0	2	2	2	0	1	0	0	0	0	0	0	0	10	0	1	0	0	31	100
Vavuniya	10	149	0	2	2	3	0	17	1	7	1	12	0	6	0	0	0	1	0	10	0	1	0	0	52	100
Mullaitivu	2	21	0	2	0	0	0	4	4	9	0	4	0	2	0	0	0	0	0	1	0	0	1	1	15	100
Batticaloa	109	1423	5	50	0	4	0	0	0	7	0	8	0	1	0	1	0	1	8	33	0	7	0	0	63	100
Ampara	4	44	3	12	0	0	1	1	1	1	2	16	0	0	0	3	0	0	6	58	1	4	1	1	65	100
Trincomalee	4	225	0	15	0	0	0	1	1	7	0	11	0	9	0	1	0	0	6	66	0	1	0	6	33	99
Kurunegala	42	939	5	35	0	2	0	4	0	2	2	34	0	6	1	3	0	1	15	138	3	22	1	49	69	100
Puttalam	18	888	1	13	1	3	0	3	1	3	0	10	0	4	0	0	0	0	13	38	4	20	0	0	74	100
Anuradhapura	10	274	0	13	0	1	0	1	1	1	2	45	0	11	1	1	0	0	15	101	0	5	19	92	45	100
Polonnaruwa	2	74	0	9	0	1	0	0	0	6	1	43	0	0	0	1	0	0	2	48	0	4	1	42	68	94
Badulla	4	128	0	33	0	0	0	5	0	5	2	34	1	16	2	8	0	0	35	133	4	26	0	2	51	98
Monaragala	21	371	2	28	0	2	0	1	0	2	6	84	3	41	0	4	0	0	2	44	1	6	1	9	55	100
Ratnapura	41	474	2	45	0	18	1	5	0	2	8	76	3	13	0	4	0	1	9	86	4	33	2	89	40	100
Kegalle	24	363	4	17	0	4	0	2	4	44	2	26	4	23	0	6	0	0	15	95	3	11	0	0	68	100
Kalmune	26	890	0	14	0	0	0	1	0	13	0	1	0	0	0	1	0	0	16	43	0	3	0	1	47	100
<b>SRILANKA</b>	<b>653</b>	<b>13710</b>	<b>47</b>	<b>424</b>	<b>7</b>	<b>61</b>	<b>6</b>	<b>102</b>	<b>180</b>	<b>340</b>	<b>67</b>	<b>723</b>	<b>37</b>	<b>428</b>	<b>9</b>	<b>58</b>	<b>0</b>	<b>6</b>	<b>259</b>	<b>1859</b>	<b>29</b>	<b>231</b>	<b>45</b>	<b>551</b>	<b>55</b>	<b>95</b>

Source: Weekly Returns of Communicable Diseases (WRCD).  
 \*T=Timeliness refers to returns received on or before 16<sup>th</sup> March, 2018 Total number of reporting units 349 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**

10<sup>th</sup> - 16<sup>th</sup> Mar 2018 (11<sup>th</sup> 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	00	00	00	02	11	24	- 54.2 %
Diphtheria	00	00	00	00	00	00	00	00	00	02	00	00	00	0 %
Mumps	01	01	02	02	00	02	00	00	01	09	04	68	65	4.6 %
Measles	00	00	00	00	01	00	00	00	00	01	03	22	79	- 72.1 %
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	06	05	20 %
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	01	00	01	01	12	21	- 42.8%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	07	04	75 %
Tuberculosis	101	29	05	03	07	11	11	11	00	178	182	1628	1723	- 5.6 %

**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
March	290	44	19	25	885	435	0

Source: Medical Research Institute & Veterinary Research Institute

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