WEEKLY EPIDEMIOLOGICAL REPORT

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Health Promotion-The Nairobi Call to Action (Strategies and Actions)

The preceding article carried an introduction to Health promotion and Nairobi call to Action for closing the implementation gap in Health Promotion. The recommended strategies and actions for closing the implementation gap of Health Promotion were: building capacity for health promotion, strengthening health systems, partnerships and intersectoral action, community empowerment, health literacy and health behaviours. These are discussed in detail below.

Building Capacity for Health Promotion

Building sustainable health promotion infrastructure and capacity at all levels is fundamental to closing the implementation gap

Suggested Actions

Strengthen leadership by

- Establishing good governance with respect to integrity, transparency, and accountability
- Developing individuals and institutions to create a sustainable health promotion infrastructure
- Building skills in advocacy and stewardship to address determinants of health
- Secure adequate financing
- Establishing stable and sustainable financing at all levels, for example health promotion foundations
- Levering financing from sectoral, bi-lateral and multilateral donor programmes.

Grow practitioner skill-base by

- Reorienting the understanding and skills of health promotion in current health workers
- Providing structures and incentives to train, maintain and retain health promotion capacity across the health system, and other sectors that impact on health
- Setting accreditation competencies and standards for health promotion, and revising the curricula of health and health-related professionals in training to include health promotion
- Establishing and strengthening national, regional and institutional capacity to implement systematic training to develop a critical mass of health promotion practitioners capable of performing specified competencies
- Promoting teaching of core values underlying basic human rights and equity
- Ensuring timely and accurate dissemination of information and resources for preparedness and response to emergencies and epidemics
- Expanding and strengthening WHO Collaborating Centers for Health Promotion in all regions to reflect emerging and unmet needs.

Enhance system-wide approaches by

- Assessing the national capacity for health promotion using validated tools and methods as a routine process for quality improvement
- Developing, adapting and applying quality improvement tools and methods to ensure intervention effectiveness and sustainability at all levels

Improve performance management by

- Strengthening information systems to benchmark and monitor health promotion implementation, regarding policies, processes and outcomes
- Embedding determinants of health and equity and risk factors in the current surveillance, monitoring and evaluation systems.

Strengthening Health Systems

To be sustainable, health promotion interventions must be embedded in health systems that support equity in health and meet high performance standards. Integrating health promotion in all health systems functions and at all levels improves the overall performance of health systems.

Suggested Actions

Strengthen Leadership by

- Governments advocating for promotion of health in all sectors and settings, supporting intersectoral and interdisciplinary action, including the opportunities through regulation and legislation.
- Ensuring community participation in governance of health systems at all levels
- Ensuring effective stewardship and oversight.

Enhance policy by

- Systematically integrating health promotion across the continuum of health care and other social and community services, throughout the lifecourse
- Ensuring that health promotion is mainstreamed into priority programmes such as HIV/AIDS, malaria, tuberculosis, mental health, maternal and child health, violence and injury, neglected tropical diseases and noncommunicable diseases such as diabetes
- Using targets, quality measures and incentives for systematic and sustainable health promotion

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- Developing specific approaches to reach women, in light of their unique role in ensuring the success of health promotion programmes, as both beneficiaries and primary care givers in most societies
- Implementing health promotion strategies for people with disabilities to improve quality of life, well-being and promote development.

Assure universal access
- By guaranteeing that health systems provide accessible, appropriate and comprehensive health services for all, including measuring performance for marginalized groups
- By insisting that health systems provide accessible and comprehensive information and resources for health promotion that are culturally, linguistically, age, gender and ability appropriate
- By addressing financial and other resource barriers with innovative approaches.

Build and apply the evidence base by
- Investing in research and evaluation and its dissemination to increase adoption of better practices in health promotion
- Setting up databases, including clearing-houses on research evidence and rapid response mechanisms to meet policymakers' and practitioners' needs for evidence-informed policy formulation and decision making

Partnerships and intersectoral action
Effectively addressing the determinants of health and achieving health equity requires actions and partnerships that extend beyond the health sector to implement forms of collaboration, cooperation and integration between sectors.

Suggested Actions

Strengthen leadership by
- Negotiating and adopting shared goals and objectives and working towards common results across sectors and institutions, at all levels of governance
- Ensuring that the private sector and other players accept their responsibilities to safeguard and promote the health of their clients, workers, customers and communities.

Enhance policy by
- Developing political momentum and leadership for health in all policies and settings
- Mainstreaming health promotion and social determinants of health approaches across all policies, programmes, and research agendas which focus on health equity, ensuring integrated planning, capacity building and resource allocation
- Establishing health equity as a key social indicator to measure the performance of intersectoral initiatives
- Creating functional inter-governmental regional bodies, such as an African Health Promotion Partnership, to set a vision and agenda for health promotion, advocate and mobilize resources in the region to achieve these.

Enhance implementation by
- Developing and adapting to country context, tools, mechanisms and capacities to create opportunities at local, regional and national levels for intersectoral action on health equity
- Encouraging credible role modelling for healthy living
- Strengthening and supporting civil society to develop common and effective approaches
- Utilizing opportunities of 'mass events' for health promotion such as international sports tournaments
- Being proactive and partnering with the media in an informed and mutually supportive way.

Build and apply the evidence base by
- Developing and incorporating indicators of equity and intersectoral action, focusing both on health outcomes and determinants;
- Evaluating initiatives to determine critical success factors for scaling up.

Community Empowerment
Communities must share power, resources and decision-making to assure and sustain conditions for health equity.

Suggested Actions
Enable community ownership by
- Listening to and starting with the voices and aspirations of the community in planning and action
- Recognizing and appreciating indigenous culture, traditional ways, and the contribution of migrant groups
- Assuring meaningful and equitable participation and control in decision making among all groups including those experiencing social, economic or political exclusion
- Involving people with passion, people with power and people with influence in partnerships for change and improvement
- Building community capacity during planning, implementation, monitoring and evaluation.

Develop sustainable resources by
- Establishing financing mechanisms that assure coordinated, integrated and holistic responses to community-determined goals over an extended time frame.

Build and apply the evidence base by
- Including narratives and empirical evidence of success and lessons learned;
- Incorporating indigenous knowledge systems into planned curriculum and mainstreaming its application across key sectors.

Health Literacy and Health Behaviours.
Basic literacy is an essential building block for development and health promotion. Health literacy interventions need to be designed based on health, social and cultural needs.

Suggested Actions
Support empowerment by
- Ensuring basic education for all citizens
- Building on existing community resources and networks to ensure sustainability and enhance community participation
- Designing health literacy interventions based on community needs and priorities in their political, social and cultural context, with particular consideration for the needs of people with disability
- Ensuring that communities are able to access and act on knowledge and overcome any barriers

Embrace information and communication technologies (ICT) by
- Formulating a strategic framework on ICT to equitably improve health literacy
- Ensuring that public policies increase affordable access to ICT through wider coverage of remote and underserved areas
- Building the ICT capacity of health professionals and communities, and maximize the use of available ICT tools.

Build and apply the evidence base by
- Developing a core set of evidence-based health literacy indicators and tools based on constructs and concepts relevant to health using quantitative and qualitative methods
- Surveying and monitoring health literacy levels of individuals and communities
- Setting up a system to monitor, evaluate, document and disseminate health literacy interventions

Source
Nairobi Call To Action, available from

http://www.gesundheitsfoerderung.ch/pdf_doc_xls/e/GFPstaerken/Netzwerke/Nairobi-Call-to-Action-Nov09.pdf

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 1: Vaccine-preventable Diseases & AFP

01st – 07thOctomber 2011 (40th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	01	00	00	01	00	00	00	00	02	00	72	66	+ 09.0 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	00	00	00	00	01	00	00	00	00	01	00	110	81	+ 35.8 %
Tetanus	00	00	00	00	00	00	00	01	00	01	00	21	18	+ 16.7 %
Whooping Cough	01	00	01	00	00	00	00	01	00	02	02	45	27	+ 66.7 %
Tuberculosis	88	00	02	02	23	00	06	10	21	152	129	7203	7799	- 07.6 %

Table 2: Newly Introduced Notifiable Disease

01st – 07thOctomber 2011 (40th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2011	Number of cases during same week in 2010	Total number of cases to date in 2011	Total number of cases to date in 2010	Difference between the number of cases to date in 2011 & 2010
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	03	05	16	01	04	04	09	06	04	52	62	3417	2696	+ 26.7 %
Meningitis	02 GM=1 CO=1	00	01 GL=1	00	00	03 KN=2 PU=1	01 AP=1	00	03 RP=1 KG=2	10	09	695	975	- 28.7 %
Mumps	04	02	05	00	05	06	03	05	07	37	14	2501	1492	+ 67.6 %
Leishmaniasis	00	00	21 HB=21	00	00	00	10 AP=10	00	00	31	08	641	560	+ 14.6 %

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.

DPDHS 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, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008. .

Dengue Prevention and Control Health Messages

Thoroughly clean the water collecting tanks bird baths, vases and other utensils once a week to prevent dengue mosquito breeding.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

01st – 07thOctomber 2011 (40th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	66	7629	1	162	0	6	4	196	0	55	3	350	0	7	0	57	0	2	**54**
Gampaha	35	3032	1	114	0	16	1	75	0	27	5	439	1	24	3	268	0	6	**80**
Kalutara	18	1029	1	138	0	6	2	64	0	21	15	303	0	3	1	8	0	1	**75**
Kandy	58	870	6	339	0	7	3	30	2	40	2	147	0	96	0	48	0	0	**100**
Matale	3	274	3	151	0	4	1	29	1	20	1	153	0	14	0	9	0	0	**83**
Nuwara	7	174	0	304	0	4	1	53	0	89	1	47	0	61	1	28	0	1	**77**
Galle	15	697	2	90	0	6	1	24	0	6	5	190	0	36	0	10	0	5	**89**
Hambantota	4	348	2	54	0	4	0	4	0	29	5	478	0	56	1	13	0	1	**75**
Matara	21	424	0	77	0	2	1	15	0	30	10	314	4	69	1	18	0	1	**94**
Jaffna	4	279	11	257	0	3	7	226	2	83	0	2	0	194	1	28	0	1	**82**
Kilinochchi	0	51	0	29	0	3	0	9	0	12	0	2	0	11	0	3	0	0	**0**
Mannar	1	27	1	22	0	1	1	30	0	82	0	13	0	32	0	2	0	0	**100**
Vavuniya	2	69	2	30	0	12	0	9	1	49	0	44	0	2	0	1	0	0	**50**
Mullaitivu	1	16	7	60	0	1	0	4	0	9	0	5	0	1	0	2	0	0	**100**
Batticaloa	13	736	1	540	0	5	1	7	0	25	0	27	0	3	0	2	0	6	**64**
Ampara	3	132	38	166	0	1	0	10	0	47	0	57	0	1	0	8	0	0	**71**
Trincomalee	0	142	7	603	0	2	0	10	0	12	0	88	0	7	0	7	0	0	**75**
Kurunegala	17	763	3	301	0	12	1	85	3	77	14	1465	0	69	1	39	0	4	**61**
Puttalam	3	403	2	166	0	1	1	27	0	9	0	113	0	17	0	7	0	2	**67**
Anuradhapu	7	236	4	120	0	2	0	4	0	33	1	238	0	16	0	18	0	1	**74**
Polonnaruw	2	252	5	106	0	1	0	11	0	22	0	82	0	1	0	16	0	0	**57**
Badulla	7	497	2	302	0	5	0	50	15	24	2	74	1	76	0	57	0	0	**88**
Monaragala	9	215	9	106	0	4	2	33	0	13	3	177	2	68	5	76	0	0	**100**
Ratnapura	21	802	5	444	0	7	1	47	0	20	17	487	1	27	4	46	0	2	**72**
Kegalle	40	703	1	99	0	12	2	68	0	24	9	299	0	31	11	197	0	0	**91**
Kalmune	1	30	4	523	0	0	0	1	0	66	0	6	0	2	0	3	0	1	**62**
SRI LANKA	**358**	**19830**	**118**	**5303**	**00**	**127**	**30**	**1121**	**24**	**924**	**93**	**5600**	**09**	**924**	**29**	**971**	**00**	**34**	**77**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 07th October , 2011 Total number of reporting units =329. Number of reporting units data provided for the current week: 253
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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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.**

ON STATE SERVICE

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