WEEKLY EPIDEMIOLOGICAL REPORT

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Together on the road to universal health coverage

What is universal health coverage?

Universal health coverage (UHC) is defined as "ensuring of all people having access to needed promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that the people do not suffer financial hardships when paying for these services".

Universal health coverage is good for sustainable development

As emphasized in Sustainable Development Goal (SDG) 3.1. UHC is central to achieving better health and well-being for all people at all ages. UHC is the goal that all people obtain a health services they need, without risking financial hardships from unaffordable out-of-pocket payment.

Further it will reduce the risk of people being pushed into poverty because unexpected illnesses requiring them to use up their life savings, sell assets, or borrow, destroying their futures and often those of their children. UHC can produce high returns, particularly when targeting those most often left behind, women, children, adolescents and older people in the poorest communities. Health has intrinsic value for individuals and their families, and also contributes significantly to social and economic development.

An active health sector can promote a broader economic growth in a country. Available evidence suggests that each dollar (US$) spent in the health sector can be contributed as much as US$ 1.77 to an economic output. Even though health systems are much less developed in low and middle income countries than in richer countries, such health system improvements can bring about a much greater impact.

It has been estimated that out-of-pocket health spending drives more than 100 million people into poverty every year. When people have to pay for health services out of their own pockets, the poor are often unable to obtain many of the services they need. Even the rich may be exposed to financial hardships in the event of severe or long-term illness, possibly spreading transmissible disease. Such as treating multi drug resistant TB, seriously affects health services both in access to health care as well as high cost. Out-of-pocket health spending will reduce purchasing of food and other essential requirements to the family.

Universal health coverage is within reach – it is technically and financially possible

Many countries are already making progress towards UHC. All countries can take actions to move more rapidly towards it, or to maintain the gains they have already made. A range of evidence-based, cost-effective interventions and health system strategies to provide financial protection can support countries in their paths towards UHC.

Higher spending does not always improve health, but making the right investments at the right time can. Best buys for the health sector are, the interventions that are effective (high impact), low cost (affordable), cost-effective (deliver good value for money) and easy to implement (feasible).

All countries could afford government funded universal access to a range of public health services delivered through cross-sectoral commu-

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nity services and periodic outreach delivery platforms. These include the public health taxes on goods that are harmful to health, such as tobacco, alcohol and sugar, and delivering vaccines and medicines for neglected tropical diseases and public awareness through mass media.

Not every country can achieve a "full UHC package" at the same speed. But every country can attempt to achieve this over the next 15 years, by looking at their resources. Each country should use the available evidence and tools to define the package of benefits, and determine its own path towards UHC, by effective use of available resources.

UHC is people-centered and politically smart

Moving towards UHC requires strengthening of health systems in all countries. Reforms in financing structures are the key to success by mobilization of a broad range of stakeholders, first and foremost citizens, civil society organizations, service providers, the private sector as well as political leaders. The people themselves should also be at the centre of decision making. Political leaders have a central role in constructing a health system that ensures the needs, opinions and rights of the people they represent.

UHC is a social contract; that provides equal access to justice based on respect for human rights, effective rule of law, good governance, and transparent, effective and accountable institutions. If the UHC is to be attained a good quality health services it must be accessible, financially affordable and should be acceptable to the patients.

In each country, UHC reforms must have people at its centre, which reflects the health needs and aspirations of the whole population. It is a tool which countries can use on the road to achieving the highest possible standards of health and well-being for all of their people. Monitoring the progress towards UHC should focus both on the proportion of a population that can access essential quality health services and the proportion of the population that spends a large amount of household income on health.

UHC can be universal only if it applies equally to all people, making equity as essential criteria. The SDG principle of "**No One Left Behind"** should guide countries to put their people first, when designing their UHC systems; people who are marginalized and underserved, faces discrimination. To achieve the above goal, we also require approaches and investments that are based on human rights, equity and gender equality. UHC enables citizens to enjoy their full health potential at every age by using health services that are appropriate to them.

Each country should begin with the question: "What is our vision for the health of our people?" Answering this will require extensive consultation with relevant authorities considering all relevant health data, including marginalized and hard -to-reach groups. Whichever the road chosen, countries should always aim to increase the equitable delivery of health services.

Sources: Together on the road to universal health coverage: A CALL TO ACTION (WHO, 2017) www.who.int/healthsystems/universal_health_coverage/en

www.who.int/mediacentre/factsheets/fs395/en/

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 26th– 01st Sep 2017 (35thWeek)

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	358	29825	0	45	0	3	0	25	0	31	9	90	0	2	0	12	0	0	12	279	0	22	0	1	**21**	**100**
Gampaha	410	27704	0	25	0	12	0	16	0	8	1	41	0	10	1	14	0	1	5	213	0	25	0	2	**6**	**100**
Kalutara	158	8923	1	45	0	3	0	15	0	50	8	207	0	6	0	5	0	1	8	412	0	103	0	1	**1**	**98**
Kandy	252	10183	0	55	0	4	0	5	0	10	0	38	0	102	0	10	0	1	1	187	1	29	1	11	**13**	**98**
Matale	34	2431	0	17	0	4	0	1	0	9	0	30	0	2	0	7	0	0	0	39	1	50	0	5	**12**	**99**
NuwaraEliya	9	774	0	20	0	8	2	30	0	50	1	42	1	143	0	18	0	0	2	261	0	36	0	0	**55**	**100**
Galle	110	5204	1	42	0	12	2	18	1	16	9	248	5	50	1	5	0	1	11	315	1	52	0	1	**16**	**100**
Hambantota	28	2770	0	17	0	6	0	7	0	17	1	43	1	46	0	7	0	1	1	153	1	19	33	240	**9**	**100**
Matara	95	5486	2	29	0	8	1	3	0	5	1	151	0	20	0	6	0	1	6	184	0	6	4	106	**9**	**100**
Jaffna	48	3768	9	212	3	16	1	31	0	52	0	26	1	401	0	3	0	0	1	152	0	31	0	0	**42**	**88**
Kilinochchi	6	417	4	17	0	1	0	11	0	1	0	3	1	13	0	2	0	0	0	3	1	9	1	3	**25**	**100**
Mannar	0	504	0	5	0	0	0	2	0	1	0	2	0	2	0	0	0	0	0	13	0	0	0	0	**15**	**100**
Vavuniya	4	649	0	13	0	0	0	30	0	6	0	24	0	7	0	1	0	0	0	22	0	2	0	9	**14**	**95**
Mullaitivu	3	285	0	8	1	3	0	4	0	5	1	16	0	4	0	1	0	1	0	15	0	5	0	1	**8**	**98**
Batticaloa	34	4530	4	93	0	8	0	13	0	20	1	21	0	0	0	4	0	1	7	142	1	23	0	1	**22**	**100**
Ampara	11	749	0	19	0	2	0	1	1	1	1	15	0	1	0	3	0	0	3	160	1	35	0	3	**33**	**100**
Trincomalee	9	4612	2	20	0	2	0	5	0	20	0	18	0	12	0	17	0	0	3	114	0	18	0	9	**19**	**96**
Kurunegala	148	9164	4	59	2	8	0	3	18	35	0	53	0	24	1	17	0	2	4	409	4	58	1	116	**10**	**100**
Puttalam	105	4854	0	33	0	2	0	2	0	9	0	22	0	11	0	1	0	0	2	118	0	38	0	3	**9**	**100**
Anuradhapur	20	2396	0	30	0	3	0	1	0	12	0	57	0	15	1	11	0	1	3	321	0	52	0	185	**7**	**98**
Polonnaruwa	12	1119	1	13	0	5	0	9	0	6	0	32	0	7	1	8	0	0	1	175	0	12	1	97	**4**	**95**
Badulla	48	2923	0	74	0	7	0	7	3	5	3	84	1	83	0	52	0	1	7	289	4	152	0	12	**8**	**97**
Monaragala	53	2015	3	47	0	3	0	1	0	9	2	103	2	97	0	17	0	1	0	70	2	51	0	15	**26**	**100**
Ratnapura	133	9829	5	120	4	73	0	9	0	8	7	450	0	23	1	62	0	0	3	236	0	133	0	17	**9**	**99**
Kegalle	217	8246	1	31	0	10	0	4	0	17	0	67	0	60	0	11	0	0	15	221	5	57	0	9	**10**	**100**
Kalmune	29	2102	5	68	0	4	0	4	1	281	0	8	0	0	0	2	0	0	2	118	3	20	0	0	**12**	**99**
SRILANKA	**2334**	**151462**	**42**	**1157**	**10**	**207**	**6**	**257**	**24**	**684**	**45**	**1891**	**12**	**1141**	**6**	**296**	**0**	**13**	**97**	**4621**	**25**	**1038**	**41**	**847**	**15**	**98**

Source: esurveillance.epid.gov.lk

*T=Timeliness refers to returns received on or before 01st Septembert , 2017 Total number of reporting units 344 Number of reporting units data provided for the current week: 342 C**-Completeness

Table 2: Vaccine-Preventable Diseases & AFP

26th– 01st Sep 2017 (35thWeek)

Disease	No. of Cases by Province									Number of cases during current week in 2017	Number of cases during same week in 2016	Total number of cases to date in 2017	Total number of cases to date in 2016	Difference between the number of cases to date in 2017 & 2016
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	01	47	50	- 6%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	01	00	03	00	01	02	00	00	00	07	04	226	279	- 18.9%
Measles	00	00	00	00	02	01	01	00	00	04	04	169	316	- 46.5%
Rubella	00	00	00	00	00	00	00	00	00	00	00	06	07	- 14.2%
CRS**	00	00	00	00	00	00	00	00	00	00	00	01	00	0%
Tetanus	00	00	00	00	00	00	00	00	00	00	01	11	08	37.5%
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	21	13	61.5%
Whooping Cough	00	00	00	01	00	00	00	00	00	01	03	12	49	- 75.5%
Tuberculosis	62	10	16	00	24	02	00	02	04	120	189	5647	6452	-12.4%

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

Dengue Prevention and Control Health Messages

Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them

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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. Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

ON STATE SERVICE

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