



WEEKLY EPIDEMIOLOGICAL REPORT

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Bridge the Implementation or Action Gap– Part I

Burden of non-communicable disease

Non-communicable diseases (NCDs) are non-infectious health conditions. They are typically caused by genetic and/or environmental and lifestyle factors. Currently, NCDs are accountable for almost two-thirds of deaths globally.

Four main diseases account for the majority of deaths from NCDs:

- * cardiovascular disease
- * chronic respiratory disease
- * cancer and
- * diabetes

Importantly, these four NCDs share common behavioural risk factors including:

- * tobacco use,
- * unhealthy diet
- * physical inactivity
- * and harmful use of alcohol

A major challenge in the prevention and control of NCDs has been that despite a wide range of global, regional and national plans, initiatives, policies and interventions, the impact on health outcomes still needs to be increased significantly. There is still a very remarkable evidence in implementation or action gap.

The translation gap between research evidence and the practice is now very well recognized. A review of healthcare delivered to adults from the USA shows that up to 45% of patients fail to receive treatments that have been shown to be

effective, while 11% receive treatments that are not needed or potentially harmful.

Reducing the gap between evidence and practice is associated with reductions in morbidity and mortality and reduced healthcare costs. Therefore, in the recent past there has been increased attention on barriers to the translation of research and on how to develop evidence based implementation in order to improve patient outcomes.

Implementation research investigates the factors that affect on how a new policy or an intervention may be implemented in real-life settings. Such research remains relatively new to population-based health programmes.

Common language and terminology used in describing implementation research:

Implementation

A specified set of activities designed to put into practice a policy or intervention of known dimensions

Implementation Research

The scientific study of the processes used to implement policies and interventions and the contextual factors that affect these processes.

Implementer(s)

An individual (or group of individuals) responsible for management of the implementation process

Consumers

The group(s) of individuals that are targeted by

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an intervention, programme or a policy

Context

The setting within which a policy or intervention is to be implemented

Knowledge synthesis

The identification, assessment and collation of evidence

Knowledge exchange

The process of collaborative problem-solving

Knowledge translation

The process by which relevant research information is made accessible and available

Importance of implementation research

One of the purposes of implementation research is to support the successful selection of policies and interventions that have been shown to be efficacious . It also helps identify how to implement these policies and interventions in contexts where populations and/or resources may differ from that where they were initially formulated and evaluated, and helps identify which components of a policy or intervention are needed to obtain intended outcomes.

Moreover, when prevention and control efforts fail, implementation research can help identify whether failure was due to a policy/intervention being ineffective in the setting (intervention failure) or whether a so called good policy/intervention was deployed incorrectly (implementation failure) .

In effect, implementation research is about learning how to optimize implementation, scale up promising strategies, evaluate impact and, importantly, how to sustain these strategies over the long term. Notably, implementation research has the potential to bridge the evidence-into-action gap.

Implementation and the implementation research cycle

There is a growing number of theories and models describing implementation and the implementation research process . Implementation typically involves a stepwise, cyclical process .

- * The first step is to work with key stakeholders in order to define the specific health need and then identify an appropriate policy or intervention to address that need.
- * The second step is adaptation of the selected policy or intervention to the local context and undertaking some piloting.
- * The third step involves implementation of the adapted policy or intervention.
- * The fourth and final step is assessing if the adapted policy or intervention can be more widely implemented

or scaled up and, if so, defining the resources and further steps that will be required to achieve this .

In practice, the path from selection through to scale up is rarely direct, as it is usually determined by multiple stakeholders, the availability of resources and other contextual factors. Instead, it normally has numerous iterations involving going back and forth between two or more process steps.

Practical steps on how to undertake implementation research

Identifying evidence-based policies and interventions that are appropriate to your local context before a policy or intervention is selected and implemented it is important to ascertain that there is a need for it and that there is enough high quality evidence to suggest that it would be effective in the local context.

Situation analysis: ascertaining the need for a policy or intervention

The selection of policies and interventions for NCD prevention and control typically starts with a situational analysis. This is an information-gathering process that helps understand the specifics of the NCD burden in a particular area (e.g. health needs, risks and local context). The situational analysis also provides an opportunity to garner inter-sectoral collaboration.

The first stage of a situational analysis is usually to establish a group of relevant stakeholders and this includes implementers, potential consumers and other appropriate parties. The exact point at which this group is established and its composition depends on the local context; in some instances, the individuals who set up the situational analysis would have already done work on the topic and a group may already exist.

The stakeholder group should then engage in knowledge exchange activities; this means that they should discuss the health problem and also collate and discuss evidence about environmental, behavioural and personal determinants related to the health problem. This stage helps identify which factors are modifiable and could be prioritized as targets of policies and interventions. The group should also discuss and clearly identify expected outcomes ,such as changes in mortality, morbidity or prevalence of risk factors in a target population.

Source: A guide to implementation research in the prevention and control of non-communicable diseases. Geneva: World Health Organization; 2016. Licence: CC BY-NC-SA 3.0 IGO.

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 23rd - 29th June 2018 (26th 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	335	4584	0	44	0	5	1	30	0	23	1	104	0	6	0	3	0	0	10	403	0	26	0	2	62	100
paha	212	2430	1	35	0	5	0	12	0	14	2	126	0	4	0	10	0	0	17	423	0	23	0	19	67	100
Kalutara	93	1682	0	40	0	3	0	5	0	36	11	298	0	5	0	6	0	0	9	337	0	39	0	9	52	100
Kandy	93	1780	2	43	0	4	0	3	0	9	1	31	1	64	0	15	0	0	2	184	0	17	0	14	60	100
Matale	16	552	0	8	0	1	0	1	0	31	0	49	0	2	0	3	0	0	0	21	0	7	2	56	59	100
NuwaraEliya	1	94	1	33	0	3	0	9	0	9	1	16	0	84	0	17	0	0	2	137	1	23	0	0	30	100
Galle	22	564	2	28	0	7	0	0	0	2	9	234	1	17	0	2	0	1	3	175	0	31	0	5	13	100
Hambantota	11	511	1	10	0	3	0	2	0	4	3	30	0	23	1	2	0	1	2	156	0	2	28	349	74	100
Matarata	14	485	0	25	0	5	0	4	0	21	2	125	1	22	0	6	0	0	3	165	0	5	3	213	53	100
Jaffna	84	1782	5	93	0	1	1	31	3	208	0	8	2	234	0	1	0	2	3	188	0	9	0	3	38	93
Kilinochchi	8	180	0	19	0	1	0	8	0	1	0	2	0	8	0	0	0	1	0	28	0	2	0	1	49	100
Mannar	4	36	4	15	0	0	0	2	0	2	0	1	0	0	0	0	0	0	1	26	0	1	0	2	38	100
Vavuniya	33	304	4	14	0	3	0	30	2	11	2	24	0	7	0	0	0	1	1	37	0	3	0	3	59	100
Mullaitivu	5	51	0	5	0	0	0	8	0	10	0	8	0	3	0	0	0	0	0	6	0	1	0	1	20	100
Batticaloa	131	3716	1	95	0	5	0	2	0	20	1	29	0	1	0	2	0	2	1	84	0	11	0	0	65	100
Ampara	7	113	0	30	0	1	0	1	0	2	0	30	0	0	0	4	0	1	4	132	1	12	0	1	66	100
Trincomalee	60	656	0	33	0	1	0	4	0	10	0	37	1	17	0	1	0	0	5	137	1	4	0	18	28	100
Kurunegala	52	1394	2	75	0	8	1	10	0	3	6	73	0	11	2	11	0	1	6	297	1	48	4	126	67	100
Puttalam	18	1191	0	23	0	4	0	3	0	4	3	21	0	6	0	2	0	0	0	88	2	43	0	1	71	100
Anuradhapura	31	500	1	28	2	6	0	2	1	38	7	84	1	14	0	4	0	1	5	251	2	22	13	203	42	95
Polonnaruwa	2	164	0	15	1	2	0	0	0	12	2	70	0	0	0	3	0	0	1	138	0	8	6	121	59	88
Badulla	16	261	7	67	1	5	0	6	0	10	2	93	1	39	0	18	0	0	4	282	3	63	0	5	46	100
Monaragala	16	562	2	46	0	2	0	1	0	2	2	197	0	76	1	15	0	0	4	97	9	45	1	22	65	100
Ratnapura	59	1188	3	93	0	26	0	15	1	4	21	303	0	21	0	12	0	1	7	185	3	62	0	135	44	100
Kegalle	34	741	1	37	0	7	0	4	0	71	3	120	1	49	0	8	0	0	4	214	1	26	0	5	65	100
Kalmune	13	1318	0	24	0	0	0	1	0	20	0	3	0	0	0	1	0	0	3	117	1	7	0	1	50	100
SRILANKA	1370	26839	37	978	4	108	3	194	7	577	79	2116	9	713	4	146	0	12	97	4308	25	540	57	131	53	99

Source: Weekly Returns of Communicable Diseases (WRCD).
 *T=Timeliness refers to returns received on or before 29th June, 2018. Total number of reporting units 353. Number of reporting units data provided for the current week: 351. C**=Completeness
 A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

23rd – 29th June 2018 (26th 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*	01	00	00	00	00	01	00	00	00	02	01	32	40	- 20 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	01	00	01	02	00	00	01	00	05	02	186	169	10 %
Measles	01	02	00	00	00	01	01	00	00	05	01	67	180	-62.7 %
Rubella	00	00	00	00	00	00	00	00	00	00	00	04	06	-33.3%
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	11	09	22.2 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	01	00	00	00	01	00	16	21	- 23.8 %
Whooping Cough	00	00	00	00	00	00	00	01	00	01	00	29	09	222.2 %
Tuberculosis	83	00	00	00	00	09	00	00	04	96	51	3978	3949	0.7 %

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

Dengue Prevention and Control Health Messages

Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them free of water collection.

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

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