WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health & Indigenous Medical Services

231, de Saram Place, Colombo 01000, Sri Lanka
Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@sltnet.lk
Epidemiologist: +94 11 2681548, E mail: chepid@sltnet.lk
Web: http://www.epid.gov.lk

WER SRI LANKA 2020

Vol. 47 No. 20 09th – 15th May 2020

Lessons Learned: Different Country Models and Their Responses to Covid-19 Part II

This is the secound of a series of 3 articles.

Italy

Within a few short weeks, Italy went from its first confirmed case to a government enforced lock-down that extended to almost the whole territory and prohibited almost all movement of people including closure of all non-essential business activities. The country has been one of the worst hit by the COVID-19 pandemic with 226,699 cases and 32,169 deaths at the time of writing[1]. The failure in resolving this crisis could have been due to several factors. Although, a state of emergency was declared during the early stage, it was met by skepticism from the public and many policy makers even with several expert warnings. Secondly, a series of gradually increasing restrictions were put in place in lockdown areas which then expanded to cover the entire country which backfired as it was inconsistent with the exponential spread of the virus, and also triggered a mass exodus of people moving to different regions of the country where the infection had not been present previously. The trajectory of cases in Italy could also have been due to the increased population density in the harder hit areas such as Lombardy, which also applied only few measures such as social distancing and closure of businesses to contain the virus. Another factor which could have contributed is the large elderly population in Italy who have been shown to be more at risk of suffering from COVID-19. There were also issues of timely collection and dissemination of data including difficulty in recording infection peaks in some hospitals. These delays in implementing swift measures to combat the virus, led to periods where there were nearly 1,000 deaths due to COVID-19 daily.[7]

United Kingdom (UK)

The first case of COVID-19 in the UK was diagnosed on 31 January, 2020. Since then, UK has had 248,822 confirmed cases and 35,341 deaths from COVID-19 at the time of writing[1]. The British predisposition to “Keep calm and carry on” was the public face of the U.K. government response to COVID-19.[8] Their strategy focused mainly on taking a “contain” and “research” approach with detection of early cases and follow up of close contacts accompanied by research on various diagnostics, drugs and vaccines.[9] However, by mid-March, even with several clinicians and scientists raising alarms; confusion arose due to a change in strategy where the government decided that they would no longer try to track and trace the contacts of every suspected case, and it would test only people admitted to hospitals. With regard to social-distancing measures, modest restrictions such as people with symptoms staying home, no school trips abroad, and people over 70 avoiding overseas trips were given to the public which seemed out of step with almost all other European countries.[8] The theory was that if more severe restrictions came into place too early, people would become increasingly uncooperative as the outbreak eventually reaches its peak. To avoid a 2nd peak in the winter which usually is accompanied by seasonal influenza outbreaks,

Contents Page

the UK's strategy was to suppress the virus but not get rid of it completely, while focusing on protecting vulnerable groups such as the elderly. The premise was that since the virus tended to cause a milder illness in the younger age groups, most would recover and develop immunity to the virus. This concept of "herd immunity" was thought to potentially reduce transmission in the event of a resurgence during the winter season. The UK also imposed minimal travel restrictions including other soft measures such as still allowing going outside for food, health reasons or work only and to maintain a gap of two meters away from other people when outside, along with washing hands as soon as the individual gets home. However, these measures were not adequate to stem the tide of increasing cases and due to backlash from health experts and scientists, the UK government abruptly changed tactics and revised their action plans which included increased surveillance testing, and advising people with mild illness to self-isolate at home, including stepping up resources in hospitals to manage severe cases with the health system. The health system has also undergone restructuring by increasing efforts to test health workers, retraining specialists to work in other clinical areas, final year medical students being given provisional license to practice, and GPs having online consultations[8,9].

United States of America (US)

The US has topped all other countries as having the largest number of confirmed cases with over 1.4 million cases and 89,271 deaths at the time of writing[1]. Following their first confirmed case on 20 January 2020, while other countries were taking aggressive actions to detect and isolate the virus, the US procrastinated and became distracted due to a lack of proper leadership, which led to the current health emergency they are facing now. While government leadership imposed a travel ban on several countries including China, the delay in developing a rapid diagnostic test and testing for COVID-19, accompanied by questionable sensitivity of the test kits and delays in providing adequate resources to hospitals, led to the current high spike in number of confirmed cases and deaths. Overburdening of the health sector and health care professionals, and the lack of hospital beds, PPE equipment and ventilators across the country collectively led to the emergency situation that is being currently witnessed in the US. Even as the situation worsens, more States are easing social-distancing requirements and allowing several businesses to open up in stages which has prompted revision of mortality models of the coronavirus predicting nearly 135,000 deaths from COVID-19 in the US by early August.[10,11]

Sri Lanka

The Sri Lankan public health system is one which is free of charge and caters to all citizens with the Ministry of Health regulating and setting guidelines for future health policies. Since the first confirmed case of COVID-19 infection in Sri Lanka on 27 January 2020, the authorities have been especially vigilant in combating this infection. By mid-March, public holidays were in force with closure of schools and universities, and quarantine centers were set up to examine foreigners and returnees from high risk countries for 14 days. Major hospitals in all districts were given resources to accept suspected COVID-19 patients with testing facilities for the infection extended to several hospitals as well. By the third week of March, a curfew was imposed on almost all districts of Sri Lanka with movement between districts being restricted along with complete cessation of incoming flights. At the same time, public health authorities and the defense forces including the police swiftly kicked into high gear; carrying out rigorous contact tracing and quarantining close contacts. Regular updating of clinical guidelines on management of the infection in conjunction with health experts across all sectors and regular updates of confirmed and suspected infections along with frequent health promotive messages on social distancing and hand hygiene via various modes of media ensured that the public was well aware of the dangers of contracting COVID-19. The coordination between the health sector and defense forces in combating its spread, and other state and private sector enterprises in arranging home deliveries of essential food and medicines were strong policy decisions that has led to a total of 1027 cases and 9 deaths only at the time of writing.[1] Currently, ease of curfew restrictions in stages, based on district-wise totals of coronavirus cases along with opening up of several businesses has begun under the close scrutiny of the government. However, further steps will need to be taken to improve and increase allocation of resources to the hospitals and health staff who are currently treating COVID-19 patients including hospitals which are housing isolation units to cater to suspected patients with COVID-19 so that our case fatality rate remains low from this disease.[12]

Compiled by : Dr Dhivya A. Nathaniel

PG Trainee – MSc Community Medicine,
Epidemiology Unit,
Ministry of Health.

to be continued ...

Table 1: Selected notifiable diseases reported by Medical Officers of Health 02nd– 08th May 2020 (19 th 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	6	2739	0	13	0	5	0	4	0	14	1	67	0	0	0	2	0	0	1	156	0	16	0	0	**60**	**96**
Gampaha	10	1627	0	5	0	0	0	4	0	19	1	45	0	1	0	2	0	0	3	196	0	8	0	17	**51**	**84**
Kalutara	12	987	0	5	0	4	0	3	0	4	10	139	0	9	0	1	0	0	2	175	0	9	0	0	**52**	**98**
Kandy	44	1168	0	8	0	1	0	7	0	7	2	27	1	41	0	3	0	0	2	111	1	15	1	31	**63**	**9**
Matale	4	450	0	4	0	2	0	1	0	4	6	29	0	2	0	2	0	1	2	39	0	1	0	140	**63**	**100**
NuwaraEliya	0	109	0	10	0	0	0	0	0	0	2	15	2	39	0	1	0	0	3	53	0	6	0	0	**23**	**94**
Galle	6	988	0	13	0	8	0	2	0	12	1	185	1	22	0	1	0	0	1	202	0	18	0	2	**57**	**76**
Hambantota	0	262	0	4	0	0	0	2	0	37	1	54	0	14	0	2	0	0	1	105	0	8	0	231	**73**	**85**
Matara	0	351	0	7	0	3	0	0	0	0	0	81	0	4	0	6	0	0	0	68	0	5	0	117	**49**	**51**
Jaffna	18	1779	0	41	0	0	0	17	0	17	1	11	0	441	0	0	0	1	0	72	0	6	0	0	**36**	**93**
Kilinochchi	1	105	3	25	0	0	2	5	3	3	0	7	1	22	0	0	0	0	1	9	2	7	0	4	**69**	**99**
Mannar	0	117	0	0	0	0	0	1	0	0	0	3	0	1	0	0	0	0	0	1	0	3	0	0	**40**	**89**
Vavuniya	0	232	0	5	0	0	0	4	0	2	0	32	0	1	0	0	0	0	0	22	0	4	0	1	**63**	**99**
Mullaitivu	0	64	0	4	0	0	0	4	0	1	0	12	0	3	0	1	0	1	0	4	1	3	0	5	**40**	**82**
Batticaloa	14	2084	0	42	0	2	0	0	0	10	0	14	0	0	0	1	0	1	0	69	1	11	0	1	**56**	**97**
Ampara	0	285	0	10	0	1	0	0	0	0	0	51	0	0	0	1	0	0	3	86	0	11	0	4	**64**	**100**
Trincomalee	0	2205	0	4	0	0	0	0	0	2	3	15	0	2	0	0	0	0	1	70	0	5	0	0	**47**	**91**
Kurunegala	1	650	0	5	0	4	0	2	0	29	0	54	0	10	0	1	0	0	4	240	0	8	0	153	**56**	**80**
Puttalam	3	347	0	6	0	1	0	2	0	1	0	16	0	9	0	0	0	1	0	58	0	17	0	2	**61**	**94**
Anuradhapur	0	311	1	11	0	1	0	2	0	19	2	120	0	13	0	2	0	1	3	111	0	18	0	81	**52**	**84**
Polonnaruwa	1	185	0	4	0	0	0	0	0	0	3	58	0	0	0	12	0	1	2	84	0	9	3	103	**65**	**95**
Badulla	1	366	0	8	0	2	0	3	0	3	2	120	2	28	0	6	0	0	0	110	0	20	1	5	**58**	**100**
Monaragala	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Ratnapura	30	662	3	35	0	11	0	2	0	14	71	428	2	14	1	11	0	0	0	124	1	38	0	43	**50**	**95**
Kegalle	13	388	0	6	0	3	0	1	0	12	4	79	1	18	0	5	0	0	0	118	1	12	0	9	**57**	**99**
Kalmune	6	835	1	26	0	2	0	0	0	1	1	8	0	2	0	0	0	0	7	228	0	19	0	0	**73**	**100**
SRILANKA	**170**	**19296**	**8**	**301**	**0**	**50**	**2**	**66**	**3**	**211**	**11**	**1670**	**10**	**696**	**1**	**60**	**0**	**7**	**36**	**2511**	**7**	**277**	**5**	**949**	**56**	**87**

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 08th May , 2020 Total number of reporting units 356 Number of reporting units data provided for the current week: 249 C**-Completeness

A = Cases reported during the current week. **B** = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

02nd– 08th May 2020 (19 th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2020	Number of cases during same week in 2019	Total number of cases to date in 2020	Total number of cases to date in 2019	Difference between the number of cases to date in 2020 & 2019
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	02	09	34	- 73.5 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	00	00	00	00	00	00	00	00	00	00	11	62	150	- 54 %
Measles	00	00	00	00	00	00	00	00	00	00	08	26	90	- 67.9 %
Rubella	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
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	03	06	- 50 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	01	00	00	00	00	00	00	00	00	01	01	09	09	0 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	04	27	- 85.1 %
Tuberculosis	00	00	00	00	00	00	00	00	00	00	202	1455	3037	- 52.0 %

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.

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

Dr. Sudath Samaraweera
CHIEF EPIDEMIOLOGIST
EPIDEMIOLOGY UNIT
231, DE SARAM PLACE
COLOMBO 10