WEEKLY EPIDEMIOLOGICAL REPORT

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Implementing and adjusting public health and social measures in the context of COVID-19 Part-ii

Adjusting public health and social measures
Key principals

- Measures with the highest level of acceptability and feasibility and proven effectiveness should be adopted. Acceptability and feasibility should be determined through participatory approaches and a shift away from directives and one□way communications.
- If the epidemic is worsening additional measures should be considered as soon as possible. Delays in the implementation of measures will lead to increased morbidity and mortality; more stringent measures may be needed to regain control. In particular, every effort should be made to prevent intensification in transmission from 'clusters' to 'community transmission'.
- When adjusting PHSMs it should be done in a controlled, stepwise manner to allow a better understanding of the effects of each measure on transmission dynamics.
- Public health surveillance data and findings from the case and cluster investigations may provide important information on conditions associated with transmission or severity. Eg- VOC, disease severity
- Any decision to maintain, lift or intensify PHSMs should be based on multiple factors - the level of immunity in the general population- either natural or vaccine-induced, and health & public health systems capacities to rapidly respond to any new increase in cases.
- The risk of outbreaks and/or severe disease in settings with vulnerable individuals should be minimized. Key drivers of transmission must be well understood using local surveillance data, and the ability to re -implement PHSM should be in place. A particular focus should be on prevention and early detection of potential supers spreading events.
- Basic risk mitigation measures aimed at reducing travel-associated exportation, importation and onward transmission of SARS-CoV-2 should always be maintained.

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Community engagement and risk communication strategy

- It is critical to build and foster trust, especially in contexts where there is little or no involvement of the local population in decision-making. Before adjusting PHSMs communities should be informed, engaged and enabled before changes are made.
- Civil society organizations, faith-based organizations (FBOs) and volunteers play a critical role in fortifying community services (e.g. provision of food, medicines, mental health and other support services, tests and vaccinations) for those in need (e.g. people who are isolated or quarantined).
- Feedback mechanisms should be established to ensure that any societal impact of changes to PHSMs is quickly identified and reported for action. Communities should lead solutions to ensure the adoption of measures that best meet local needs (for example by considering local cultural practices), which can increase the likelihood of adherence. Local community -level networks should be leveraged for sustained efforts by building capacity through the training of local leaders.
- The infodemic that has emerged from COVID-19 information overload and misinformation should be managed at all stages of the response by providing the right information at the right time to the right people through trusted channels (e.g. community and faith leaders, family doctors and other influential members of society). There should be a monitoring system in place to capture emerging trends (e.g. vaccine confidence and hesitancy, adherence to PHSM) to enable the delivery of a targeted communication package.
- A communication and community engagement strategy should be developed before any changes to PHSMs are implemented or adjusted. The strategy should be developed in consultation with relevant stakeholders from the government, civil society, FBOs and community groups. Plans should include, at a minimum, behavioural objectives, target audiences, priority channels and a mix of strategies and activities to inform and engage the community.
- The key messages of such plans should cover information important to the community, such as the extent and the estimated duration of the measures in place.
- Governments should regularly communicate epidemiological data to the public to further foster trust and increase acceptance and sustained adherence to PHSMs.
- Measures should be time-bound and regularly re-assessed, at least every two weeks, along with the situational level. The adherence to PHSMs should also be monitored, using sources such as mobility data, and this should be used to further inform future adjustment of PHSMs and the risk communications and community engagement strategy (World Health Organization, 2021).

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to be continue…..

Table 1: Selected notifiable diseases reported by Medical Officers of Health 20th - 26th Feb 2021 (9th Week)

RDHS	Dengue Fever		Dysentery		Encephaliti		Enteric Fever		Food Poi-		Leptospirosis		Typhus Fe-		Viral Hep-		Human		Chickenpox		Meningitis		Leishmania-		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	51	319	0	3	0	0	0	0	0	0	2	34	0	0	0	1	0	1	0	3	0	3	0	0	**57**	**94**
Gampaha	25	214	0	1	0	1	0	1	0	0	15	30	0	0	1	1	0	0	0	2	0	3	1	2	**31**	**75**
Kalutara	14	146	0	2	0	0	0	0	0	0	6	48	0	1	0	1	0	1	2	23	1	1	0	0	**34**	**100**
Kandy	15	114	1	5	0	1	0	0	0	0	3	48	1	8	0	1	0	0	1	10	0	3	2	7	**61**	**99**
Matale	1	17	0	2	0	1	0	0	0	0	3	15	0	3	0	1	0	0	2	6	0	1	8	55	**63**	**100**
NuwaraEliya	0	6	0	0	0	1	0	0	0	0	1	14	0	14	0	0	0	0	0	7	0	0	0	1	**35**	**96**
Galle	1	34	0	2	0	1	0	1	0	0	8	119	1	10	0	2	0	0	2	8	1	9	0	1	**46**	**100**
Hambantota	7	46	1	4	0	1	0	0	0	1	7	50	2	19	0	4	0	0	0	11	0	6	8	116	**76**	**100**
Matara	12	61	0	0	0	0	0	1	0	0	4	49	0	8	0	2	0	0	1	20	1	2	19	79	**36**	**100**
Jaffna	3	63	4	24	0	0	1	8	1	1	1	7	23	304	0	0	0	0	1	12	0	2	0	1	**17**	**88**
Kilinochchi	0	16	1	6	0	0	0	0	0	3	1	18	0	30	0	0	0	0	0	4	0	0	0	1	**53**	**100**
Mannar	1	8	0	0	0	0	1	3	0	0	1	14	0	1	0	0	0	0	0	0	0	6	0	1	**47**	**80**
Vavuniya	3	15	0	1	0	0	0	0	0	0	0	6	0	0	0	0	0	0	1	4	0	0	0	0	**31**	**100**
Mullaitivu	0	3	0	1	0	0	0	0	0	0	0	10	1	4	0	0	0	0	0	1	0	2	0	0	**22**	**100**
Batticaloa	155	2120	1	5	0	1	0	1	3	4	1	8	0	0	0	1	0	0	0	2	0	7	0	0	**50**	**100**
Ampara	1	6	1	5	0	0	0	1	0	0	1	8	0	0	0	0	0	0	0	17	1	6	0	0	**57**	**100**
Trincomalee	8	46	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	9	1	2	0	0	**37**	**94**
Kurunegala	10	116	0	4	1	2	0	0	0	3	10	103	0	6	0	0	0	0	2	14	1	47	8	93	**46**	**100**
Puttalam	9	81	0	1	0	1	0	0	0	0	1	8	0	6	0	0	0	1	0	4	2	13	0	3	**49**	**95**
Anuradhapur	2	22	0	4	0	0	0	0	0	1	14	120	2	17	0	2	0	0	0	8	1	7	3	64	**34**	**93**
Polonnaruwa	2	8	0	1	0	0	0	0	0	0	1	32	0	0	0	1	0	0	0	5	0	1	8	95	**42**	**100**
Badulla	0	16	1	3	0	0	0	0	0	0	10	61	1	12	0	2	0	0	0	13	4	6	0	7	**46**	**98**
Monaragala	2	14	0	3	0	0	0	1	0	0	0	46	0	6	4	16	0	0	0	7	6	15	0	5	**13**	**100**
Ratnapura	9	82	0	9	0	0	0	0	0	1	15	182	0	8	0	2	0	1	0	17	0	22	5	22	**37**	**100**
Kegalle	11	54	0	2	1	1	0	0	0	0	9	61	0	3	0	0	0	0	8	22	3	8	0	1	**40**	**100**
Kalmune	12	77	1	4	0	1	0	1	0	0	1	6	0	0	0	0	0	0	0	1	1	1	0	0	**44**	**100**
SRILANKA	**354**	**3704**	**11**	**92**	**2**	**12**	**2**	**18**	**4**	**14**	**115**	**1098**	**31**	**460**	**5**	**37**	**0**	**4**	**21**	**230**	**23**	**173**	**62**	**554**	**44**	**96**

Source: Weekly Returns of Communicable Diseases (esurvillance.epid.gov.lk).

*T=Timeliness refers to returns received on or before 26th February, 2021 Total number of reporting units 357 Number of reporting units data provided for the current week: 352 C**-Completeness

Table 2: Vaccine-Preventable Diseases & AFP

20th - 26th Feb 2021 (9th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2021	Number of cases during same week in 2020	Total number of cases to date in 2021	Total number of cases to date in 2020	Difference between the number of cases to date in 2021& 2020
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	01	00	00	00	00	00	00	00	01	00	13	06	116.66%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	00	00	00	00	00	00	01	00	00	01	06	17	35	-51.42%
Measles	00	00	00	00	00	00	00	00	00	00	07	03	13	-76.92%
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	01	03	-66.66%
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	01	00	08	-100%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	00	02	-100%
Tuberculosis	46	21	04	04	00	00	04	00	00	79	207	1037	1198	-13.43%

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

Covid-19 Prevention & Control
For everyone's health & safety, maintain physical distance, often wash hands, wear a face mask and stay home.

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**

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