



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health

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Emergency Risk Management for Health (Part I)

This is the first in series of two articles on Emergency Risk Management for Health

Emergencies and disasters often result in significant impacts on people's health, including the loss of many lives. Every new threat reveals the challenges for managing health risks and effects of emergencies and disasters. Deaths, injuries, diseases, disabilities, psychosocial problems and other health impacts can be avoided or reduced by emergency risk management measures involving health and other sectors.

Emergency risk management for health is multi-sectoral and refers to: the systematic analysis and management of health risks, posed by emergencies and disasters, through a combination of,

- I. Hazard and vulnerability reduction to prevent and mitigate risks,
- II. Preparedness,
- III. Response and
- IV. Recovery measures

The traditional focus of the health sector has been on the response to emergencies. The ongoing challenge is to broaden the focus of emergency risk management for health from that of response and recovery to a more proactive approach which emphasizes prevention and mitigation, and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems based on primary health care at community level can reduce underlying vulnerability, protect health facilities and services, and scale-up the response to meet the wide ranging health needs in disasters.

Advocating for emergency risk management for health

These advocacy materials are an introduction for health workers engaged in emergency risk management and for multi-sectoral partners to consider how to integrate health into their emergency risk management strategies.

This overview places emergency risk management for health in the context of multi-sectoral action and focuses on the generic elements of emergency risk management, including potential hazards, vulnerabilities of a population, and capacities, which apply across the various health domains.

The accompanying fact sheets identify key points for consideration within a number of essential health domains. However, importantly, all health domains are interlinked; each fact sheet should therefore be considered as part of the entire set and in conjunction with the overview.

Why is there a need for emergency risk management for health?

Natural, biological, technological and societal hazards put the health of vulnerable populations at risk and bear the potential to cause significant harm to public health. Examples of these hazards are as follows:

- Natural: earthquake, landslide, tsunami, cyclones, flood or drought.
- Biological: epidemic disease, infestations of pests.
- Technological: chemical substance, radiological agents, transport crashes.
- Societal: conflict, stampedes, acts of terrorism.

Emergencies, disasters and other crises may cause ill-health directly or through the disruption of health systems, facilities and services, leaving many without access to health care in times of emergency. They also affect basic infrastructure

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such as water supplies and safe shelter, which are essential for health.

International consensus views emergencies as barriers to progress on the health-related Millennium Development Goals (MDGs), as they often set back hard earned development gains in health and other sectors.

Natural Hazards

In the last year, in excess of 700 emergencies arising from natural hazards affected more than 200 million people. A comparative analysis of emergency statistics in Latin America found that for each disaster listed in global disaster databases, there are some 20 other disasters with destructive impact on local communities that are not recorded.

In Latin America, the cumulative effect of ten years of local emergencies were found to have had a greater impact on the poor than any one-off event. The incidence of emergencies arising from natural hazards has been increasing and the impact of climate change will increase the risk for millions of individuals, their homes, their communities, and the infrastructure that supports them.

Biological Hazards

During the last few decades, biological emergencies have assumed an increasing importance: major outbreaks related to new and re-emerging infectious diseases such as SARS, influenza (H1N1 and H5N1) and cholera.

Technological Hazards

The international disaster database (EM-DAT) recorded more than 1,500 people from technological disasters killed which also affected more than 17,000 individuals.

Societal Hazards

Complex emergencies, including conflict, continue to affect tens of millions of people, causing displacement of people both inside and across borders. In 2012 there were an estimated total of 20 million persons who remained internally displaced by armed conflict across the world.

Country capacities and needs

Progress has been made at global, regional, national and community levels, but the capacity of countries for risk reduction, emergency preparedness, response and recovery remains extremely variable. The 2007 WHO global assessment found that less than 50% of national health sectors had a specified budget for emergency preparedness and response. Factors affecting capacity include:

- Weak health and disaster management systems.
- Lack of access to resources and know-how.
- Continuing insecurity due to conflict.

But a number of high-risk countries have strengthened their disaster prevention, preparedness and response systems; in some countries, the health sector has led initiatives developing multi-sectoral approaches to emergency and disaster risk management.

Emergency risk management for health in context

Sustainable development

Emergency risk management has emerged as a core element of sustainable development and an essential part of a safer world in the twenty-first century. Reducing risk is a long-term development process, managed by communities and individuals working together.

Health Systems

Health care systems provide core capacities for emergency risk management for health. Some countries affected by emergencies have limited basic health services and infrastructure, which in itself hugely compounds the challenges of disaster response. Countries with well-developed systems are often much more resilient and better prepared for disasters.

Primary health care (PHC) focuses on basic services to improve health status, which in turn builds community resilience and provides the foundation for responding to emergencies. Policies and strategies focusing on PHC can contribute to decreasing vulnerability and preparing households, communities and health systems for emergencies. Following an emergency, focus is often given to acute care needs and specialist interventions; whilst important, it is usually chronic and pre-existing conditions that prove the largest burden of disease.

Community-based actions are at the front line of protecting health in emergencies because:

- Local knowledge of local risks is used to address the actual needs of the community.
- Local actions prevent risks at the source, by avoiding exposure to local hazards.
- A prepared, active and well-organized community can reduce risks and the impact of emergencies.
- Many lives can be saved in the first hours after an emergency through community response before external help arrives.

Hospitals and health infrastructure

Health systems are composed of public, private and nongovernmental facilities which work together to serve the community; these include hospitals, primary health care centres, laboratories, pharmacies and blood banks. Safe hospitals programmes ensure health facilities are safely built to withstand hazards, remaining operational in emergencies.

Source

Emergency Risk Management for Health Fact Sheet (WHO-Global Platform- May 2011) available at http://www.who.int/hac/events/drm_fact_sheet_overview.pdf

Compiled by Dr. H. A. Shanika Rasanjalee of the Epidemiology Unit

Table 1: Selected notifiable diseases reported by Medical Officers of Health 16th - 22nd Aug 2014 (34th 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	161	9766	1	97	0	9	3	69	0	169	1	94	0	2	1	32	0	0	7	319	2	42	0	3	75	25
Gampaha	146	4769	0	102	1	9	2	29	0	20	5	141	0	9	1	162	0	5	0	229	5	46	0	2	80	20
Kalutara	43	1893	4	124	0	6	1	33	0	57	4	174	0	2	0	9	0	1	2	179	1	56	0	0	85	15
Kandy	48	1024	0	71	0	4	0	18	3	14	1	33	6	65	8	106	0	0	2	148	1	20	1	4	100	0
Matale	4	320	0	49	0	2	0	14	0	16	1	30	0	2	1	111	0	1	1	41	0	40	1	26	69	31
NuwaraEliya	11	212	1	188	0	3	0	15	1	68	1	13	1	53	0	24	0	0	0	91	0	22	0	0	77	23
Galle	0	697	0	78	0	4	0	5	0	32	0	122	0	66	0	5	0	0	0	319	0	28	0	3	5	95
Hambantota	3	439	0	33	0	4	0	10	0	12	0	67	0	53	0	11	0	0	5	113	1	34	12	239	83	17
Matara	17	371	2	73	0	4	0	21	0	18	1	53	1	37	0	26	0	0	1	140	0	25	2	62	100	0
Jaffna	27	776	15	321	0	6	3	161	3	52	0	7	0	265	0	8	0	0	1	103	0	27	0	1	100	0
Kilinochchi	0	42	0	68	0	1	0	20	0	0	0	1	0	17	0	0	0	0	0	14	0	6	0	9	50	50
Mannar	3	46	0	29	0	10	0	33	0	9	0	4	1	24	0	1	0	0	1	10	0	6	0	2	80	20
Vavuniya	1	100	0	26	0	1	1	22	0	18	0	9	0	5	1	5	0	0	2	10	0	13	0	2	75	25
Mullaitivu	2	80	0	44	0	0	0	9	0	17	0	8	0	11	0	0	0	1	0	5	0	5	0	7	100	0
Batticaloa	9	646	3	195	0	2	0	22	0	29	0	14	0	2	0	7	0	1	0	42	1	6	0	0	86	14
Ampara	3	118	0	45	0	1	0	2	0	8	0	15	0	12	0	4	0	1	2	74	0	8	0	8	57	43
Trincomalee	0	484	2	33	0	1	0	2	0	5	0	16	3	18	0	2	0	0	2	80	2	12	1	4	67	33
Kurunegala	48	1347	4	97	0	23	0	16	0	20	1	69	0	37	0	33	0	1	6	311	0	61	4	101	78	22
Puttalam	2	461	0	51	0	2	0	11	0	10	0	56	0	20	0	3	0	3	0	67	1	18	0	6	62	38
Anuradhapura	4	387	4	102	0	3	0	3	0	28	0	76	0	27	0	9	0	0	6	173	2	40	20	277	74	26
Polonnaruwa	2	382	2	31	0	4	0	6	0	0	0	55	0	5	0	6	0	0	0	122	0	20	2	97	71	29
Badulla	16	441	2	96	0	9	0	10	0	6	1	41	3	73	2	107	0	0	0	54	4	88	0	0	82	18
Monaragala	8	195	1	41	1	4	0	6	0	33	0	60	3	124	4	95	0	2	1	60	1	16	1	25	100	0
Ratnapura	42	2211	0	177	0	19	0	21	0	25	5	246	1	74	9	307	0	0	1	155	1	32	0	21	89	11
Kegalle	34	1187	2	87	1	9	0	29	0	34	3	117	1	46	38	138	0	0	3	195	2	53	1	2	91	9
Kalmune	8	117	1	87	0	1	0	5	0	68	0	1	0	0	0	0	0	0	1	83	0	6	0	0	69	31
SRILANKA	642	28511	44	2345	3	141	10	592	7	768	24	1522	20	1049	65	1211	0	16	44	3137	24	730	45	901	77	23

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 22nd August, 2014. Total number of reporting units 337. Number of reporting units data provided for the current week: 263. C**=Completeness
A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

16th – 22nd Aug 2014 (34th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2014	Number of cases during same week in 2013	Total number of cases to date in 2014	Total number of cases to date in 2013	Difference between the number of cases to date in 2013 & 2014
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	02	02	00	58	58	0%
Diphtheria	00	00	00	00	00	00	00	00	00	00	-	00	-	%
Mumps	01	04	02	00	01	00	01	00	02	11	14	491	1081	-54.6%
Measles	16	03	04	01	01	04	00	02	04	35	114	2490	2335	+6.6%
Rubella	00	00	00	00	00	00	00	00	00	00	00	14	21	-33.3%
CRS**	00	00	00	00	00	00	00	00	00	00	00	04	06	-33.3%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	10	13	-23.1%
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	%
Japanese Encephalitis	01	00	00	00	00	00	00	00	00	01	00	21	65	-67.7%
Whooping Cough	01	02	01	00	00	00	00	00	00	04	03	38	41	-7.3%
Tuberculosis	70	17	65	00	22	16	00	05	12	207	91	6345	5638	+12.6%

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.
 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

AFP and all clinically confirmed Vaccine Preventable Diseases except Tuberculosis and Mumps should be investigated by the MOH

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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