



WEEKLY EPIDEMIOLOGICAL REPORT

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General Practice in COVID-19 situation – Law and Epidemiology

The COVID-19 pandemic in the past year and foreseeable future has forced general practice to react and adapt to the social circumstances of the communities while operating in the fluctuating waves of the disease. Coming years most probably would have been more challenging than previous years for General practitioners in this unprecedented crisis. Neither they have a notable role nor did primary health care focus on serious adaptations for case detections upon prevention of the diseases in early stages, specialty and platform of general practice has more accentuated within recent past.

The specificity of the general practitioner is that he/she is: “the only clinician who operates at the nine levels of care: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, palliative care and counselling”[1]. Before the COVID-19 pandemic, General Practitioners (GPs) were one of the first contact points for most infectious diseases which they treated willingly and without any spread of the disease to themselves, the clinic staff or other patients. But the practical environment became non-conducive to general practices with the emerging COVID-19 infection, due to the high transmissibility of the virus, infecting the doctor and staff in their clinics unless proper precautions are taken. Therefore maximum attention should be focused on avoiding the unnecessary burden of disease spread in institutes by protecting yourself and staff.

Primary health care (PHC) refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system.

Primary care (PC) is more than just the level of care or gatekeeping; it is a key process in the health system. It is first-contact, accessible, continuous, comprehensive and coordinated care. First-contact care is accessible at the time of need; ongoing care focuses on the long-term

health of a person rather than the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to coordinate other specialists that the patient may need. PC is a subset of PHC.

General practice is a term now rolling out in the private sector and loosely covering the “family doctor” in town areas, “village doctor” in the rural area and “estate doctor” in estate sectors as a health care personnel of curative sense at point of care delivery. The majority, among doctors too, used to follow the above concept rather than assuming general practitioner is a community-based healthcare worker and the most significant single player in the primary care field encompassing comprehensive, continuing and preventive health models. He should be the synonym for the coordinator between curative and preventive care.

Duty of Family Physicians for COVID -19 control

One of the main platforms operated in countries with fully established, accredited public health systems or performing with valued indicators of public health is posing deliverables of preventive health systems to curtail health costs of the countries by cutting down the infective disease burden. As of today, notification of infective diseases functions pivotal caste providing ample space to public health experts to control the spread of diseases. All practitioners registered under No 26 of 1927 Medical ordinance of Ceylon, to practice as medical practitioners of the country, are lawfully bound to notify any disease in nature of contagious, infective and epidemic manner in the country irrespective of their care of delivery though it is in the state sector of the private sector since notifications break the case-load down by early response [5]. At present, Sri Lanka is prevailing with a premier public health system and one of its major strategies empowered for epidemic control is the notification of diseases by the form named H-544. The diagnoses of the infective diseases captured under clinical ground need to be notified about the re-

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spective diseases, who were gazetted under section 45 of provisions in No 03 of 1897 Quarantine and Prevention of Diseases Ordinance of Ceylon as a quarantinable disease by the minister with authority vested herself/ himself by the Quarantine (Aircraft) Regulation, 1940, Regulation of Storage of Grain and Anchylostomiasis of 1925 and Regulation of 1960 [6].

"Every medical practitioner or person professing to treat disease, who attends on any person suffering from any of following diseases shall forthwith give to the proper authority written information of the name, race, sex, and age of the diseased person, his residence and the nature of the disease:".

Since COVID-19 has been gazetted as a quarantinable disease by Extra Ordinary Gazette No 2167/18 on 20/03/2020, all medical practitioners are lawfully bound to notify the diseased person with COVID-19 to the proper authority.

Duty of Family Physicians on detecting early stage of Community Transmission of COVID-19 (Phase 4 of Pandemic)

It has been defined in many places about Family Physicians role in detecting the early phase of Community Transmission in pandemic stages of the country. If they have come across with patients with COVID-19 in case of undefined or uncleared contact history of the disease, it might be alarming on the stage of disease, which is heading towards stage four of the pandemic (Community Transmission). Therefore, continuing general practice though in "Lockdown or travel restriction" situations, provides early epidemiological support for the epidemiologists to initiate control measures. But it all depends on notifying the diseases to proper authorities on the suspicious background of clinical diagnosis. It should be a mandate of the general practitioners and the governments to encourage continuing private practices in epidemic situations of the countries.

International studies show that the strength of a country's primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship is significant after controlling for determinants of population health at the macro-level (GDP per capita, total physicians per one thousand population, percentage of elderly) and micro-level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption). Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending. Studies from developed countries demonstrate that an orientation towards a specialist-based system enforces inequity in access

Challenges, responses and effects of COVID-19 on general practice

A recent research study showed more than two-thirds of respondents reported that the following challenges had had a high or medium impact on their practices: managing the safety of staff (86%), disinfecting equipment and surfaces (86%), lack of full personal protective equipment (80%), managing patients (78%), community self-isolating as instructed and not seeking care from their GP as they normally would (76%), lack of face masks (73%), telehealth reimbursement (74%) and consistency of information (71%) [2]. The price of fewer physical examinations and fewer non-verbal cues is currently unknown but could include a reduction in quality of care. The data also reflect growing concerns that COVID-19 might be contributing to antimicrobial resistance. With evidence that 70% of patients with COVID-19 receive antibiotics when not clinically indicated, the focus has centred on antibiotic misuse in the clinical management of COVID-19, but not on the additional risks posed by remote prescribing [3]. Maintaining the quality of care and safety of all patients during the COVID-19 pandemic is the utmost

priority. Many of them suffer from poor access or inadequate management of their problems. Rapid implementation of telemedicine brought both threats and opportunities [4].

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 22nd - 28th May 2021 (22nd 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	42	1330	0	8	0	0	0	3	0	3	1	99	0	1	0	2	0	2	0	20	0	6	0	1	56	87
Gampaha	10	650	0	1	0	1	0	1	0	0	1	122	0	2	0	3	0	2	0	13	0	5	0	3	35	68
Kalutara	11	479	0	11	0	2	0	0	0	0	1	286	0	3	0	1	0	1	1	56	0	9	0	0	40	990
Kandy	8	293	0	15	0	1	0	1	0	2	0	75	1	25	0	1	0	0	0	27	0	9	0	16	59	100
Matale	0	43	0	4	0	4	0	0	0	0	0	33	0	4	0	1	0	0	0	9	0	1	0	100	100	
NuwaraEliya	1	27	0	11	1	2	0	1	0	0	0	34	0	32	0	2	0	0	3	22	0	4	0	1	34	91
Galle	1	114	0	2	0	1	0	5	1	5	2	362	0	20	0	2	0	0	0	27	0	18	0	1	47	94
Hambantota	2	144	0	6	0	2	0	2	0	4	1	133	0	36	0	6	0	0	0	29	0	15	0	207	75	100
Matarata	4	162	0	3	0	1	0	1	0	0	0	131	0	12	0	2	0	0	0	39	0	3	0	169	41	100
Jaffna	1	106	1	32	0	3	0	12	0	25	0	13	1	409	0	0	1	2	1	24	0	2	0	2	19	88
Kilinochchi	0	21	0	13	0	0	0	0	0	9	0	39	0	52	0	0	0	0	0	8	0	0	0	1	50	100
Mannar	0	19	0	0	0	0	0	4	0	0	0	23	0	2	0	0	0	0	0	3	0	12	0	1	52	80
Vavuniya	2	30	0	2	0	1	0	0	0	0	0	17	0	2	0	1	0	0	0	5	0	1	0	1	40	100
Mullaitivu	0	5	0	1	0	0	0	0	0	0	0	23	0	7	0	0	0	0	0	8	0	4	0	0	24	97
Batticaloa	19	2910	0	17	0	3	0	2	0	15	0	32	0	0	0	1	0	0	0	8	0	17	0	0	45	100
Ampara	1	21	0	5	0	0	0	1	0	0	0	37	0	0	0	1	0	0	0	26	0	9	0	3	62	100
Trincomalee	0	93	0	0	0	0	0	0	0	0	0	3	0	0	0	2	0	0	0	14	0	2	0	0	39	81
Kurunegala	3	480	0	11	0	3	0	0	0	3	1	166	0	7	0	0	0	1	0	31	1	73	0	193	44	94
Puttalam	0	191	0	2	0	1	0	0	0	0	0	16	0	14	0	0	0	1	0	14	2	23	0	8	48	93
Anuradhapur	6	108	0	8	0	0	0	0	0	3	1	180	0	20	0	2	0	0	0	22	1	19	5	117	34	80
Polonnaruwa	0	39	0	3	0	0	0	2	0	1	0	78	0	2	0	1	0	0	0	18	0	1	2	214	39	100
Badulla	0	55	0	9	0	0	0	1	0	0	2	167	0	27	0	8	0	0	0	27	0	11	1	13	48	94
Monaragala	0	51	0	5	0	0	0	2	0	3	4	188	1	14	0	40	0	0	0	19	2	35	0	12	46	98
Ratnapura	3	266	0	21	0	5	0	0	0	4	5	438	0	16	1	6	0	1	0	35	1	43	0	44	39	97
Kegalle	4	239	0	4	0	6	0	0	0	1	8	157	1	8	0	1	0	0	1	70	1	15	0	11	44	100
Kalmune	8	246	1	10	0	2	0	1	0	1	0	14	0	0	0	2	0	2	0	10	0	7	0	2	43	100
SRI LANKA	126	8122	2	204	1	38	0	39	1	79	27	2866	4	715	1	85	1	12	6	584	8	344	8	1120	46	93

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

*T=Timeliness refers to returns received on or before 28th May, 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

22nd – 28th May 2021 (22nd 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*	01	00	01	00	00	01	00	00	00	02	01	23	13	76.92%
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	03	43	74	-41.89%
Measles	00	00	00	00	01	00	00	00	00	00	00	09	28	-67.85%
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	02	03	-33.33%
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	02	00	05	-100%
Tuberculosis	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	145	2580	1946	32.57%

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

ON STATE SERVICE

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