



WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit
Ministry of Health, Nutrition & Indigenous Medicine

231, de Saram Place, Colombo 01000, Sri Lanka

Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@slt.net.lk

Epidemiologist: +94 11 2681548, E mail: chepid@slt.net.lk

Web: <http://www.epid.gov.lk>

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International Health Regulations and Global Public health security in COVID-19

Having International health Security by International Health Regulations convinced states to assurance of public health safety in travel and trade and further, it encapsulates rapid collective response over any public health risk and emergencies of international concern. A public health emergency of international concern (PHEIC) is defined as "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response". The International Health Regulations (IHR) are a very effective tool for reinforcing the connection between the surveillance systems and in establishing rapid-reaction mechanisms. The predecessor, the IHR 1969, was replaced with the current Regulation, IHR 2005. IHR 2005 is an international agreement that is legally binding on 194 countries (States Parties), including all WHO Member States. The IHR define their "purpose and scope" as: "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". Since their entry into force on 15 June 2007, the IHR operates in a way of guiding and reviewing the state parties and WHO in line with protecting global communities from public health risk and emergencies when people are crossing the borders of countries. Following steps need to be implemented from member states for IHR.

1. Know the IHR
2. Update of national legislation
3. Recognize shared realities and the need for collective defences

4. Monitor and report IHR implementation progress
5. Notify, report, consult and inform WHO
6. Understand WHO's role in international event detection, joint assessment and response
7. Participate in the PHIEC determination and WHO recommendations
8. Strengthen national surveillance and response capacities
9. Increase public health security at ports airports and ground crossings
10. Use and disseminate IHR health documents at the port of entry

The above activities are conducted in compliance with other international laws and mandates with full respect for the dignity, human rights and fundamental freedom of persons. Through the collaborative legal framework defined to all member states, prevention, detection of public health risks at the source and collective actions is well convinced. Notification is required under IHR for all "events that may constitute a public health emergency of international concern". In this regard, the broad new definitions of "event", "disease" and "public health risk" in the IHR are the building blocks of the surveillance obligations for States Parties and WHO. Consequently, events of potential international concern, which require States Parties to notify WHO can extend beyond communicable diseases and arise from any origin or source.

The responsibility for implementing the IHR lies with jointly States Parties and WHO in case of notifying diseases, public health emergencies and events. Established national surveillance systems and infrastructure are the fundamentals to facilitate the streamlined functioning of the system.

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The world's governments of the necessity for collective and coordinated defence against emerging public health threats, providing the impetus needed to complete the revision process. The IHR was adopted by the Health Assembly on 23 May 2005 and entered into force on 15 June 2007.

Global public health security

Global public health security is defined as the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries.

With rapid and uncontrolled use of industrial elements, growth of the population and urbanization disrupt the social and natural equilibrium of the world-leading and allowing the gaps of new emerging diseases, like COVID-19, to threaten global health at unprecedented rates causing social and economic impacts. Increasing traffic over the ports, airports and country border crossings pose the unconditional risk to the invasion of a disease or vector.

Pandemics, health emergencies and weak health systems not only cost lives but pose some of the greatest risks to the global economy and security faced today.

COVID-19 over the economy, social, regional and statistical impacts

Aviation stimulates global economies through employment, trade and tourism. The slump in air traffic has further caused severe financial pressure on all stakeholders in the aviation sector. Only in March 2020, airlines are estimated to lose USD 28 billion in revenues, and airports and air navigation service providers have lost around USD 8 billion and USD 824 million, respectively. In response to the exponential rise in COVID-19 infections, many countries across regions are implementing lockdowns, travel restrictions, social distancing policies, and workplace and school closures. Elaborating on this, the tourism sector, which is one of the key service sectors in the country, contributes to around 5% of the country's GDP. However, owing to the worldwide travel bans imposed during the pandemic period, the arrival of tourists in the country decreased by 71% in March 2020 and tourists arrivals were nil in the following months of April, May and June 2020.

Similarly, a recent labour market survey conducted among 2764 private sector establishments revealed that while 1465 establishments were fully closed, 1025 enterprises were functioning under their maximum capacity and only 94 establishments were functioning in their full capacity during the pandemic period. Out of the total number of enterprises involved in the survey, 1084 employers were unable to pay salaries to their workers during the pandemic period in the country. High levels of unemployment, loss of job security and pay cuts resulted in anxiety and economic stress among the population in the country

Depending on the scenario, monthly household income will decrease by 21 – 31 per cent and household income

among male-headed households is likely to decrease more than female-headed households because of the COVID crisis in Sri Lanka. The agriculture sector in most countries are also exposed to labour shortages, but particularly in labour-intensive low-income countries, where subsistence farming systems prevail and therefore labour shortages would also have repercussions for food security.

**Compiled by: Dr Krishan Hirimuthugoda
MBBS(Colombo)Msc(Com.med),MD(Com.med.),
MRSPH (UK), LLB (reading)
Senior Registrar in Community Medicine,
Epidemiology Unit.**

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 29th - 04th Jun 2021 (23rd 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	75	1405	0	8	0	0	0	3	0	3	0	99	0	1	0	2	0	2	0	20	0	6	0	1	56	87
Gampaha	19	669	0	1	0	1	0	1	0	0	0	122	0	2	0	3	0	2	2	15	0	5	0	3	34	67
Kalutara	25	504	0	11	0	2	0	0	0	0	0	286	0	3	0	1	0	1	0	56	0	9	0	0	40.5	98
Kandy	6	299	0	15	0	1	0	1	0	2	0	75	0	25	0	1	0	0	0	27	0	9	0	16	60	100
Matale	2	45	0	4	0	4	0	0	0	0	0	33	0	4	0	1	0	0	1	10	0	1	0	100	58	100
NuwaraEliya	0	27	0	11	0	2	0	1	0	0	0	34	0	32	0	2	0	0	0	22	0	4	0	1	34	91
Galle	0	114	0	2	0	1	0	5	0	5	1	363	0	20	0	2	0	0	1	28	0	18	0	1	48	93
Hambantota	5	149	0	6	0	2	0	2	0	4	2	135	1	37	0	6	0	0	0	29	0	15	1	208	74	100
Matarata	5	167	0	3	0	1	0	1	0	0	1	132	0	12	0	2	0	0	2	41	0	3	0	169	42	100
Jaffna	0	106	1	33	0	3	0	12	0	25	0	13	1	410	0	0	0	2	0	24	1	3	0	2	20	88
Kilinochchi	1	22	2	15	0	0	0	0	0	9	3	42	3	55	0	0	0	0	2	10	0	0	0	1	49	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	53	80
Vavuniya	0	30	0	2	0	1	0	0	0	0	0	17	0	2	0	1	0	0	0	5	0	1	0	1	41	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	96
Batticaloa	18	2928	1	18	0	3	0	2	0	15	0	32	0	0	0	1	0	0	0	8	0	17	0	0	46	100
Ampara	0	21	0	5	0	0	0	1	0	0	0	37	0	0	0	1	0	0	6	32	0	9	0	3	60	100
Trincomalee	1	94	0	0	0	0	0	0	0	0	0	3	0	0	0	2	0	0	0	14	0	2	0	0	38	80
Kurunegala	11	491	0	11	0	3	0	0	0	3	1	167	0	7	0	0	0	1	1	32	0	73	4	197	45	93
Puttalam	5	196	0	2	0	1	0	0	0	0	0	16	0	14	0	0	0	1	0	14	0	23	0	8	46	93
Anuradhapur	2	110	0	8	0	0	0	0	0	3	0	180	0	20	0	2	0	0	0	22	0	19	0	117	33	79
Polonnaruwa	0	39	0	3	0	0	0	2	0	1	0	78	0	2	0	1	0	0	2	20	0	1	3	217	39	100
Badulla	2	57	0	9	0	0	0	1	0	0	2	169	0	27	4	12	0	0	0	27	0	11	0	13	49	93
Monaragala	1	52	0	5	0	0	0	2	2	5	6	195	0	14	0	40	0	0	0	19	0	35	0	12	45	100
Ratnapura	7	273	0	21	0	5	0	0	0	4	8	446	0	16	0	6	0	1	1	36	0	43	6	50	39	97
Kegalle	2	241	0	4	1	7	0	0	0	1	4	161	0	8	0	1	0	0	0	70	0	15	0	11	43	100
Kalmune	2	248	0	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	189	8311	4	208	1	39	0	39	2	81	28	2895	5	720	4	89	0	12	18	602	1	345	14	1134	45	93

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

*T=Timeliness refers to returns received on or before 04th June , 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

29th – 04th Jun 2021 (23rd 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	00	00	00	00	00	00	00	00	00	02	23	15	53.33%
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	04	43	78	-44.87%
Measles	00	00	00	00	00	00	00	00	01	01	00	10	28	-64.28%
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	03	00	11	-100%
Whooping Cough	00	00	00	00	00	00	00	00	00	00	00	00	05	-100%
Tuberculosis	00	11	00	00	00	00	00	00	00	11	60	2591	2006	30.90%

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**

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Dr. Samitha Ginige
 Actg. CHIEF EPIDEMIOLOGIST
 EPIDEMIOLOGY UNIT
 231, DE SARAM PLACE
 COLOMBO 10