WEEKLY EPIDEMIOLOGICAL REPORT

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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

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Global Programme to Eliminate Lymphatic Filariasis

Lymphatic filariasis (LF) is one of the oldest and most debilitating of the neglected tropical diseases, caused by 3 species of filarial parasites and transmitted by mosquitoes.

An estimated 120 million people in 73 countries are currently infected, and an estimated 1.393 billion live in areas where filariasis is endemic and Mass Drug Administration (MDA) is required. LF is the second leading cause of chronic disability worldwide due to its stigmatizing and disabling clinical manifestations, including 15 million people with lymphoedema (elephantiasis) and 25 million men with urogenital swelling, principally scrotal hydrocele.

The Global Programme to Eliminate Lymphatic Filariasis (GPELF) has been one of the most rapidly expanding global health programmes in the history of public health. GPELF was launched in 2000 with the goal to eliminate LF as a public health problem by 2020. GPELF aims to

- Interrupt transmission using combinations of 2 medicines delivered to entire populations at risk (MDA)
- Manage morbidity and prevent disability.

Preventive chemotherapy is the primary form of control and elimination of LF. WHO recommends 4 sequential programmatic steps to interrupt transmission

- Mapping the geographical distribution of the disease
- MDA for ≥5 years to reduce the number of parasites in the blood to levels that will prevent mosquito vectors from transmitting infection
- Surveillance after MDA is discontinued
- Verification of elimination of transmission

Of the 73 countries where LF is currently considered endemic, 53 are implementing MDA to interrupt transmission, of which 12 countries have moved to a post MDA surveillance phase. During 2000–2011, >3.9 billion doses of medicine were delivered to a cumulative targeted population of 952 million people.
By the end of 2011, 59 countries had completed the mapping of endemic foci. Mapping is in progress in 13 countries and only 1 country has yet to start mapping. MDA has been implemented in 53 countries. 20 countries, mainly in the WHO African Region (15 countries), have not yet started delivery of MDA. Of the 39 endemic countries outside the African Region that require MDA, 34 countries have implemented this strategy; only Brunei Darussalam, New Caledonia, Palau, Sudan and South Sudan have not initiated MDA.

According to WHO, during 2011, the programme targeted 736.9 million people to receive MDA and treated 538.6 million; thus, the reported coverage was 73%. The number of people who received MDA in 2011 increased by approximately 54.9 million compared with 2010.More people were treated in 2011 than in 2010 in all WHO Regions. In the African Region, although reports are yet to be received from 3 countries, 94.2 million people were treated in 2011, about 11.7 million more than the number reported in 2010.

The highest increase between 2010 and 2011 was achieved in the South-East Asia Region where 414.1 million people were treated compared with 380.4 million in 2010 – an increase of 8.2%.

In 2011 people in all endemic countries except Brazil received combination therapy comprising Diethylcarbamazine (DEC) plus Albendazole, or Ivermectin plus Albendazole. In those countries where a 2-drug combination was distributed, about 153 million children aged 2–14 years received treatment through GPELF.

South-East Asian Region

About 63% of the global population requiring MDA for LF lives in the South-East Asia Region, where there are 9 endemic countries. India accounts for 69.4% of the total population requiring MDA in the Region (610 million people). In 2011,

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overall 570.1 million people in the Region were targeted for MDA and 414.1 million (72.6%) were treated. The total number of people treated increased by 33.7 million between 2010 and 2011. India, Indonesia, Myanmar, Nepal and Thailand increased the number of people treated in 2011 compared with 2010.

Sri Lanka and Maldives achieved more than 5 rounds of MDA with >65% coverage and <1% microfilaraemia prevalence and MDA was stopped in 2007 and 2009, respectively, and moved into post-MDA surveillance phase in accordance with the former WHO guideline. In 2011, a WHO expert team visited these countries to review the situation; the team recommended that Sri Lanka should conduct Transmission Assessment Survey (TAS) in accordance with the new guideline before proceeding to the process of verification of elimination, and that Maldives should start verification of elimination. All other countries in the Region except Timor-Leste implemented MDA in 2011; as a new country, Timor-Leste needs external financial and advocacy support to re-start and scale-up MDA.

As a result of MDA, more than 200 implementation units reached <1% microfilaraemia prevalence after completing >5 MDA rounds in 2011. A WHO–SEARO Regional workshop has been organized in 2012 to build capacity in all 9 countries in the Region to plan and conduct TAS. Once the implementation units pass TAS as set out in the revised WHO guideline, they will be qualified to stop MDA and the global population requiring MDA should reduce progressively in the coming years.
An estimated 26.1 million preschool-aged children (2–4 years) and 86.6 million school-aged children (5–14 years) were treated through the programme.

Progress on the GPELF milestones

One of the milestones set in the Strategic Plan 2010–2020 was to publish revised guidance for monitoring and evaluation of the national LF elimination programmes, to provide clearer and more feasible methodologies to achieve the global target of eliminating LF by 2020. Accordingly, WHO published the Monitoring and Epidemiological Assessment of Mass Drug Administration: A Manual for National Elimination Programmes in 2011. Of particular importance in this manual is a new methodology to conduct a TAS in order to make decisions on whether MDA can be successfully stopped and post-MDA surveillance started for areas that have achieved >5 rounds of MDA with >65% coverage and <1% microfilaraemia prevalence. To support national programmes in implementing TAS according to the new guidelines, 3-day training modules are being developed and a series of WHO Regional TAS training workshops are to be held in 2012.

The GPELF Strategic Plan has also set as a milestone the development of a strategy for interrupting transmission of LF in loiasis-endemic countries. In March 2012, an expert consultation was held to discuss and identify strategies for countries where delivery of MDA with Ivermectin presents safety challenges. The recommendation of the meeting has been published as a provisional strategy of preventive chemotherapy in combination with vector control. The same meeting also recommended the development of an entomology manual to guide national LF elimination programme managers, entomologists and parasitologists on appropriate vector control strategies for national elimination programmes.

Another key milestone set in the GPELF Strategic Plan was to develop GPELF guidance on morbidity-management and disability-prevention activities. In 2011, WHO published the Position statement on managing morbidity and preventing disability in GPELF, which set out the aim to provide access to a package of basic recommended care for every person with Acute Dermato-Lymphangio-Adenitis (ADLA)/ acute attacks, lymphoedema, elephantiasis or hydrocele in all areas where LF is endemic. It urged member states to adopt an integrated approach to managing morbidity and preventing disability from LF among control programmes targeting similar diseases. A WHO manual is being developed to guide national programmes with the framework, basic principles and provide operational and managerial guidance for planning and implementing morbidity management and disability-prevention activities.

Note-Sri Lanka has started conducting Transmission Assessment Surveys before the final step (Verification of elimination of transmission).

Source-
Global Programme to Eliminate Lymphatic Filariasis: Progress Report, 2011-available from *http://www.who.int/entity/wer/2012/wer8737.pdf*

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Table 3 : Water Quality Surveillance
Number of microbiological water samples - August/ 2011

District	MOH areas	No: Expected *	No: Received
Colombo	12	72	30
Gampaha	15	90	48
Kalutara	12	72	18
NHIS	2	12	14
Kandy	23	138	58
Matale	12	72	0
Nuwara Eliya	13	78	0
Galle	19	114	NR
Matara	17	102	0
Hambantota	12	72	15
Jaffna	11	66	44
Kilinochchi	4	24	13
Manner	5	30	27
Vavuniya	4	24	12
Mullatvu	4	24	NR
Batticaloa	14	84	42
Ampara	7	42	54
Trincomalee	11	66	14
Kurunegala	23	138	99
Puttalam	9	84	15
Anuradhapura	19	114	30
Polonnaruwa	7	42	0
Badulla	15	90	53
Moneragala	11	66	42
Rathnapura	18	108	0
Kegalle	11	66	31
Kalmunai	13	78	0

* No of samples expected (6 / MOH area / Month)
NR = Return not received

Table 1: Vaccine-preventable Diseases & AFP

08th – 14th September 2012 (37th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2012	Number of cases during same week in 2011	Total number of cases to date in 2012	Total number of cases to date in 2011	Difference between the number of cases to date in 2012 & 2011
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	01	00	00	00	00	01	00	00	00	02	02	57	64	- 10.9 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	01	00	00	00	00	00	01	00	00	02	01	44	106	- 58.5 %
Tetanus	01	00	00	00	00	00	00	00	00	01	02	09	20	- 55.0 %
Whooping Cough	00	00	00	00	00	00	00	00	01	01	08	71	40	+ 77.5 %
Tuberculosis	24	55	02	20	12	15	09	05	06	148	158	6255	6615	- 05.4 %

Table 2: Newly Introduced Notifiable Disease

08th – 14th September 2012 (37th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2012	Number of cases during same week in 2011	Total number of cases to date in 2012	Total number of cases to date in 2011	Difference between the number of cases to date in 2012 & 2011
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	07	34	04	01	04	03	02	06	05	66	80	3310	3187	+ 03.8 %
Meningitis	02 CB=1 GM=1	00	04 GL=2 MT=2	01 JF=1	01 AM=1	03 KR=3	01 AP=1	00	05 KG=3 RP=2	17	14	579	638	- 09.2 %
Mumps	10	07	09	04	06	09	03	00	09	57	64	3561	2338	+ 52.3 %
Leishmaniasis	01 CB=1	00	08 HB=7 MT=1	01 VU=1	01 TR=1	02 KN=2	07 AP=7	00	00	20	09	775	554	+ 39.9 %

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.

DPDHS 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, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008.

Dengue Prevention and Control Health Messages

Thoroughly clean the water collecting tanks bird baths, vases and other utensils once a week to prevent dengue mosquito breeding.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

08th – 14th September 2012 (37th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	107	7410	4	108	0	8	9	161	8	39	5	143	0	3	1	93	1	5	**77**
Gampaha	45	5833	0	70	0	12	0	48	0	25	5	182	1	17	2	245	0	0	**47**
Kalutara	23	2107	3	80	0	3	0	38	2	28	6	186	0	3	0	28	0	2	**69**
Kandy	29	1886	7	91	0	2	2	20	0	56	1	55	3	98	18	79	0	0	**87**
Matale	10	411	1	72	0	5	0	9	0	7	0	33	0	3	0	32	0	0	**67**
Nuwara	2	268	6	154	0	3	1	24	0	8	0	31	0	55	0	17	0	1	**77**
Galle	17	1218	4	104	0	6	1	12	0	17	3	99	2	61	0	2	0	0	**79**
Hambantota	6	437	2	29	0	2	0	6	2	30	0	63	2	42	0	18	0	0	**100**
Matara	34	1254	5	61	0	8	3	19	0	19	11	124	3	68	7	105	0	0	**100**
Jaffna	8	339	6	142	1	14	5	302	0	71	0	2	1	251	0	15	0	1	**100**
Kilinochchi	0	69	0	11	0	2	0	28	0	43	0	4	0	29	0	4	0	1	**50**
Mannar	0	124	0	51	0	4	0	21	0	16	0	20	0	42	0	2	0	0	**40**
Vavuniya	7	67	1	25	0	21	1	9	0	15	0	18	0	3	0	1	0	0	**100**
Mullaitivu	0	20	0	16	0	1	0	9	0	2	0	3	0	5	0	0	0	0	**25**
Batticaloa	0	602	10	171	0	2	0	15	0	307	0	8	0	0	0	7	0	4	**71**
Ampara	3	111	1	68	0	2	0	6	0	9	1	24	0	0	0	2	0	0	**57**
Trincomalee	1	124	8	148	0	2	0	16	0	12	0	37	0	17	0	4	0	0	**92**
Kurunegala	59	1800	6	149	0	14	2	77	0	34	1	118	1	26	2	117	0	4	**85**
Puttalam	42	988	4	69	0	6	1	12	0	10	2	33	0	14	0	5	0	2	**67**
Anuradhapu	7	287	2	66	0	6	0	12	0	18	0	74	0	21	0	55	0	1	**53**
Polonnaruw	2	203	2	45	0	2	0	2	0	1	0	45	0	3	0	37	0	1	**57**
Badulla	3	261	2	96	0	4	1	48	0	3	0	34	4	93	2	38	0	0	**71**
Monaragala	2	214	0	49	0	4	2	20	0	7	1	60	1	68	0	152	0	2	**91**
Ratnapura	63	3186	5	171	0	25	1	43	0	12	3	240	1	37	6	92	0	1	**89**
Kegalle	42	3135	1	49	0	9	0	21	0	10	2	136	4	53	12	461	0	0	**100**
Kalmune	0	173	0	210	0	1	0	5	0	80	1	4	0	0	0	7	0	3	**62**
SRI LANKA	**512**	**31527**	**80**	**2305**	**01**	**168**	**29**	**983**	**02**	**879**	**42**	**1776**	**23**	**1012**	**50**	**1618**	**01**	**28**	**77**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 14thseptember, 2012 Total number of reporting units 329. Number of reporting units data provided for the current week: 255
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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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.**

ON STATE SERVICE

Dr. P. PALIHAWADANA
CHIEF EPIDEMIOLOGIST
EPIDEMIOLOGY UNIT
231, DE SARAM PLACE
COLOMBO 10