



WEEKLY EPIDEMIOLOGICAL REPORT

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Ministry of Health & Mass Media

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The EPI Coverage Assessment Survey – 2025 – Colombo District - II

This is the second article of two in a series on "The EPI Coverage Assessment Survey – 2025 – Colombo District"

Looking beyond coverage

The 2025 Colombo EPI Coverage Assessment Survey represents more than an exercise in measuring vaccination percentages. In a country that has maintained high routine immunization performance for decades, the continuing challenge is to ensure that these achievements are sustained and that no population groups are missed.

By combining household-level assessment with examination of vaccination records, parental perspectives and private-sector vaccination, the survey provides an opportunity to look beyond administrative coverage figures. It can help identify underserved populations, understand barriers to vaccination, assess the public-private interface and guide targeted programme improvements.

Periodic independent assessment is particularly important in an evolving immunization environment, where population mobility, changing patterns of healthcare utilization, misinformation and the increasing contribution of private providers can influence vaccination uptake. The

findings of such surveys can therefore support evidence-based planning, resource allocation and strengthening of immunization services.

Ultimately, the value of the EPI coverage survey lies not only in validating the achievements of Sri Lanka's National Immunization Programme, but also in identifying where further action is required. Sustaining high and equitable immunization coverage will remain essential to protect the country's population and maintain the gains achieved against vaccine-preventable diseases.

Evidence generated from the EPI Coverage Survey

The survey demonstrated high overall immunization coverage (>95%) for the infant and childhood vaccines assessed. However, HPV vaccination coverage was comparatively lower, with coverage of 81.0% for HPV1 and 63.8% for HPV2. Marked disparities were observed between RDHS Colombo and the Colombo Municipal Council (CMC) area with regard to HPV vaccination coverage. HPV coverage was substantially higher in the RDHS Colombo area for both doses (HPV1 - 87.7% and HPV 2 - 70.6%), compared with CMC (HPV 1 - 62.7% and HPV 2 - 45.3%). The lower coverage in the CMC area highlights the need for targeted strategies to improve access to and uptake of HPV vaccination in this area.

Vaccine	Survey Coverage	National coverage for 2025
BCG	100%	95.0%
Pentavalent 1/Hexavalent 1	100%	96.3%
Pentavalent 2/ Hexavalent 2	99.4%	
Pentavalent 3/ Hexavalent 3	98.4%	95.5%
MMR 1	97.8%	96.7%
Japanese Encephalitis vaccine	96.2%	97.9%
MMR 2	99.2%	95.4%
DT	97.2%	97.6%
HPV 1	81%	95.5%
HPV 2	63.8%	73.6%

Table 2: Comparison of vaccine coverages from EPI coverage survey and administrative data

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The survey findings were broadly consistent with the administrative coverage estimates, providing independent confirmation of the reported levels of immunization coverage. The findings also highlight the importance of strengthening HPV vaccination activities in areas with comparatively lower coverage to ensure equitable protection against HPV-related diseases.

Age-appropriateness of immunization

In addition to vaccination status, the survey assessed the age-appropriateness of receiving the recommended immunization schedule, which ranged from 89% for BCG vaccine to 58.9% for MMR2 vaccine.

The survey therefore identified greater attention should be given by the health care providers to ensure timely completion of the immunization schedule.

Dropout between vaccine doses

The dropout rate between vaccine doses is an important quality indicator of the immunization programme, reflecting both continuity in vaccination services and the quality of data recording and reporting. High dropout rates may indicate missed opportunities for vaccination, inadequate follow-up, or errors in data collection and reporting. The survey reported very low loss to follow-up during the early childhood vaccination schedule, with dropout rates of approximately 1% between the first and third doses of pentavalent vaccine and between BCG and MMR1.

Reasons for non-immunization and missed vaccination

Majority of non-vaccination was detected among adolescents for HPV vaccine. The reasons for vaccine hesitancy were assessed according to the WHO's 3C model for vaccine hesitancy. This framework categorizes the reasons into 3 categories, namely convenience-related, confidence-related, and complacency-related. The reasons for non-immunization against HPV vaccination were predominantly related to convenience, accounting for 52.6% of missed HPV1 vaccinations and 55.8% of missed HPV2 vaccinations, mainly due to lack of awareness of the vaccination venue, date and time, and absence from school on the vaccination day. Confidence-related concerns were the second most common category, particularly poor awareness or misinformation about vaccines and fear of AEFI, while complacency-related reasons accounted for only a small proportion of missed vaccinations. Overall, the findings suggest that most missed HPV vaccinations were due to practical and access-related barriers rather than vaccine refusal, highlighting the need to improve communication, follow-up of absent students, and addressing misinformation and safety concerns.

Documentation and immunization records

The Child Health Development Record (CHDR) was the primary source used to assess immunization status. Over 95% of the children interviewed among 1–2 years had retained the CHDR, while it declined to approximately 87% for childhood and adolescent vaccines. However, CHDR availability among women aged 15–45 years was considerably lower at 28.5%, highlighting the need to increase public awareness on

the importance of retaining CHDRs throughout adulthood as a lifelong record of immunization.

Place of vaccination

Most vaccines were provided through government institutions, particularly MOH clinics, while HPV vaccination was predominantly provided through school vaccination centres. The private sector contributed mainly to infant vaccination, accounting for 13.5%–18.4% of infant vaccinations. This highlights the importance of strengthening monitoring and quality assurance of vaccination services in the private sector.

Key Programme Implications

The EPI Coverage Survey demonstrated high overall immunization coverage, broadly consistent with administrative estimates, while identifying several areas for further strengthening. Priority areas include improving school vaccination services, ensuring age-appropriate vaccination, promoting retention of CHDRs into adulthood, and strengthening regulation and monitoring of private-sector immunization services. As approximately 18% of infants received at least one vaccine from the private sector, quality assurance of these services is particularly important. Importantly, most reported reasons for non-vaccination, particularly for HPV vaccination, were related to convenience rather than vaccine hesitancy or refusal, highlighting the need to make vaccination services more accessible, convenient, and responsive to the needs of families.

Conclusion

The EPI Coverage Survey provides valuable independent evidence on the performance of routine immunization services and complements administrative coverage data by providing an objective assessment of vaccination uptake at the community level. The findings help identify gaps in coverage, dropout between vaccine doses, age-appropriate vaccination, and the reasons for missed or delayed vaccinations, thereby supporting evidence-based programme planning and targeted interventions. Maintaining the achievements of the National Immunization Programme will require continued efforts to sustain high and equitable coverage across all population groups, ensure timely completion of the recommended vaccination schedule, strengthen follow-up of children who miss vaccination opportunities, and address the underlying barriers to vaccination. Particular attention should be given to improving the accessibility and convenience of vaccination services, and addressing vaccine-related concerns and misinformation. Strengthening the quality, completeness and timeliness of immunization data, including data from the private sector, will also be essential for accurate monitoring, identification of underserved populations, and effective programme decision-making.

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Table 1: Distribution of Notified Diseases reported by Medical Officers of Health

03rd – 09th Aug 2026 (32nd Week)

RDHS	Dengue Fever		Dysentery		Encephalitis		En. Fever		F. Poison-		Leptospirosis		Typhus		Viral Hep.		H. Rabies		Chickenpox		Meningitis		Leishman.		Tuberculosis		Leprosy		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	A	B	A	B	T*	C**
Colombo	799	17880	0	17	0	2	0	4	0	19	10	221	0	2	1	15	0	0	6	371	6	79	0	4	48	1159	3	109	97	100
	720	15228	1	33	2	34	0	0	1	24	10	360	0	6	0	9	0	0	16	582	7	210	0	39	29	656	3	51	75	99
Gampaha	406	7254	0	34	0	3	1	10	0	62	5	289	2	9	0	17	0	0	22	590	2	96	0	13	15	361	1	59	87	98
	380	6239	0	40	1	9	0	7	0	38	2	145	1	27	0	19	0	0	12	479	2	101	0	41	1	316	0	19	85	99
Kandy	57	2158	0	19	0	5	0	2	0	7	2	147	0	3	0	8	0	0	4	148	3	61	15	353	7	119	0	24	82	100
	41	1016	1	37	0	5	0	3	0	15	1	212	0	39	1	14	0	0	4	347	2	150	0	2	9	171	0	9	100	100
Nuwara Eliya	203	5839	2	27	0	11	0	8	2	59	10	399	0	30	0	19	0	0	11	709	5	128	0	2	10	273	3	42	84	100
Galle	103	2608	3	42	0	2	0	0	1	40	2	185	0	23	0	11	0	0	0	160	2	50	10	332	2	91	0	21	100	100
	204	6251	1	19	0	4	0	2	0	11	5	277	0	17	0	15	0	0	5	386	1	137	2	101	3	104	4	21	96	100
Matara	45	1002	3	64	0	6	0	19	1	93	2	55	2	236	0	1	0	0	3	277	1	38	0	1	3	117	0	11	99	100
Jaffna	2	639	0	12	0	1	0	8	0	1	0	76	0	12	0	3	0	1	2	95	0	13	0	2	1	21	0	2	100	100
Kilinochchi	1	532	0	1	0	3	0	0	0	3	0	45	0	4	0	3	0	0	0	63	0	20	0	5	3	33	0	3	100	100
Mannar	8	325	1	20	0	4	0	2	0	8	2	101	0	4	0	1	0	0	0	118	2	34	1	23	1	43	0	7	100	100
Vavuniya	6	97	0	6	0	2	0	1	5	13	1	35	0	5	0	2	0	0	0	11	0	9	0	10	0	19	0	7	100	100
Mullaitivu	40	1484	0	59	1	11	0	2	0	21	0	142	0	2	0	16	0	0	6	227	0	71	0	22	1	98	3	78	100	100
Batticaloa	21	610	1	53	0	1	0	1	0	16	2	119	0	2	0	8	0	0	9	254	1	61	2	15	1	35	0	19	100	100
Ampara	16	730	1	19	0	6	0	2	0	14	0	77	0	8	0	3	0	0	7	170	0	28	0	18	4	102	0	6	98	100
Trincomalee	132	3246	2	21	0	18	0	3	1	66	9	303	2	29	0	12	0	1	22	581	3	291	13	306	8	206	3	51	97	100
Kurunegala	101	1752	1	17	0	11	0	0	0	9	4	192	0	24	0	7	0	4	2	118	7	133	0	15	4	111	1	21	98	100
Puttalam	52	1003	1	19	0	8	0	3	1	51	4	193	0	23	2	11	0	0	10	412	1	120	11	527	10	175	4	44	94	100
Anuradhapura																														
Polonnaruwa	47	801	1	24	0	7	0	2	0	59	3	224	0	7	1	25	0	0	14	368	2	55	10	371	0	55	4	64	100	100
Badulla	86	1622	1	33	0	8	0	3	0	13	3	195	0	40	3	118	0	0	10	323	0	202	2	90	5	161	0	15	100	100
Monaragala	43	1216	0	14	0	3	1	2	0	10	4	216	0	29	3	45	0	1	4	176	0	80	7	157	5	81	2	18	92	92
Ratnapura	174	5091	0	28	0	7	0	6	0	18	13	654	1	31	0	13	0	0	7	279	4	80	6	147	15	270	0	26	91	100
Kegalle	141	2636	2	46	1	6	1	5	0	25	10	303	0	11	0	12	0	0	29	517	4	78	0	13	7	200	0	9	94	100
Kalmunai	37	964	2	41	0	3	0	1	0	20	1	62	0	1	0	3	0	0	2	366	2	35	0	0	5	79	0	25	100	100
SRILANKA	3865	88223	24	745	5	180	3	96	12	715	105	5227	8	624	11	410	0	7	207	8127	57	2360	79	2609	197	5056	31	761	95	100

Source: WRCD module of the EPINET.

T* = Timeliness refers to returns received on or before 09th Aug, 2026.

A = Cases reported during the current week;

C** = Completeness;

B = Cumulative cases for the year.

Total number of reporting units 360

C** = Completeness;

Table 2: Selected Vaccine Preventable Diseases & AFP

03rd – 09th July 2026 (32nd Week)

Disease	No. of Cases by Province									Number of cases during current week in 2026	Number of cases during same week in 2025	Total number of cases to date in 2026	Total number of cases to date in 2025	Difference between the number of cases to date in 2026 & 2025
	W	C	S	N	E	NW	NC	U	Sab					
AFP ¹	00	00	00	00	00	00	00	00	00	00	02	42	39	7.6%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps ²	00	00	00	00	02	00	01	01	01	05	03	93	100	-7%
Measles ³	00	00	00	00	00	03	00	00	01	04	00	43	02	2050 %
Rubella ³	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
CRS ²	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Tetanus ²	00	00	00	00	00	00	00	00	00	00	01	04	04	0 %
Neonatal Tetanus ²	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis ³	00	00	00	00	00	00	00	00	00	00	01	00	04	-100 %
Whooping Cough ²	00	00	00	00	00	00	00	00	00	00	00	19	13	46.1 %

Key to Table 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Mumps, Tetanus, Neonatal Tetanus, Whooping Cough.

Special Surveillance: AFP, Measles, Rubella, CRS.

AFP¹ = No Polio cases

Mumps², CRS², Tetanus², Neonatal Tetanus², Whooping Cough²—Clinically and/ or laboratory confirmed cases

Measles³, Rubella³, Japanese Encephalitis³— Laboratory Confirmed cases

AFP—Acute Flaccid Paralysis

CRS = Congenital Rubella Syndrome

NA = Not Available

AFP and all Vaccine Preventable Diseases should be investigated by the MOH Personally.

All patients presenting with fever and a maculopapular rash must be promptly notified and investigated. Blood samples and throat swabs should be collected at the appropriate time window

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, Epidemiology Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@slt.net.lk. The Epidemiology Unit should be formally acknowledged in all resulting publications as the primary data source.

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