



WEEKLY EPIDEMIOLOGICAL REPORT

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

This is the first article of two in a series on “The EPI Coverage Assessment Survey–2025–Colombo District ”

Strengthening evidence for a high-performing National Immunization Programme

Immunization is one of the most successful and cost-effective public health interventions worldwide, preventing millions of deaths and protecting individuals and communities from vaccine-preventable diseases. Sri Lanka introduced the Expanded Programme on Immunization (EPI) in 1978, four years after its global launch, with the aim of ensuring equitable access to life-saving vaccines for all children. Over the past four decades, the programme has expanded considerably from protection against five childhood diseases to protection against 12 vaccine-preventable diseases, while also contributing to the prevention of neonatal tetanus and congenital rubella syndrome.

Today, the EPI, referred to as the National Immunization Programme (NIP), remains a cornerstone of Sri Lanka's public health system. The country has maintained high immunization coverage and very low incidence of vaccine-preventable diseases. The Epidemiology Unit serves as the national focal point for the NIP, providing technical guidance, strategic direction, and monitoring and evaluation of programme performance. Routine immunization coverage is continuously monitored through administrative data submitted by Medical Officers of Health through EPINET, the electronic information management system of the Epidemiology Unit. Historically, Sri Lanka has maintained vaccine coverage above 95% at both national and sub-national levels.

However, high reported administrative coverage does not, by itself, guarantee that every eligible individual has received the required vaccines. Routine data can be affected by denominator inaccuracies, incomplete documentation, reporting errors and other data-quality limitations.

Immunization coverage surveys therefore provide an important independent mechanism to validate administrative data, identify missed populations and understand factors affecting access to and utilization of vaccination services. WHO recommends periodic coverage surveys using standardized methods for this purpose.

In Sri Lanka, EPI Coverage Assessment Surveys are conducted periodically in selected districts to independently validate the administrative immunization coverage information generated from routinely collected programme data.

Why Colombo District?

The 2025 EPI Coverage Assessment Survey was conducted in Colombo District, including the Colombo Municipal Council (CMC) area. Colombo provides a particularly important setting for assessing immunization coverage because of its large and diverse population, complex health-service environment and substantial involvement of the private health sector.

According to the 2024 Census of Population and Housing, Colombo District has a resident population of 2,374,461 and one of the highest population densities in the country. The district includes metropolitan, urban, semi-urban and rural communities with diverse socioeconomic and educational characteristics. The CMC area alone covers approximately 37 km² and represents a highly urbanized setting.

Colombo also has a well-developed and diverse healthcare system comprising Medical Officer of Health (MOH) services, government hospitals, specialized and teaching hospitals, and a substantial private health sector. While routine immunization is primarily delivered through the government public health system, private hospitals make an important complementary contribution. This makes Colombo an important setting in which to assess the interface between public and private immunization services.

The district was also selected in view of recent programme concerns, including measles transmission, localized vaccine hesitancy and

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misinformation. Approximately 40% of measles cases during the outbreak that began in 2023 were reported from Colombo District. Assessing vaccination coverage and reasons for non- or partial immunization was therefore considered particularly relevant for identifying opportunities to strengthen the programme.

What did the survey aim to assess?

The overall objective of the survey was to assess routine immunization coverage in Colombo District, understand reasons for non- or partial immunization, and assess the contribution of the private sector to routine immunization.

The specific objectives were:

- To assess the immunization coverage for vaccines given in infancy and protection against Congenital Rubella Syndrome (CRS) and Neonatal Tetanus (NNT) among 13–24-month-old children.
- To assess coverages for the MMR 2 vaccine at 3 years, and DT and OPV booster given at 5 years among 72–83 months old children.
- To assess HPV1, HPV2 vaccination coverages among adolescents aged 13–15 years.
- To assess Measles and Rubella immunization coverage among 16–44-year-old eligible females.
- To understand reasons for non- or partial immunization

A scientifically rigorous household survey

The survey methodology was based on the WHO Vaccination Coverage Cluster Surveys Reference Manual (2018). A multi-stage cluster sampling design using probability proportional to size (PPS) was employed, with census enumeration areas from the 2024 national census serving as the primary sampling units. The survey covered 18 MOH areas, including six MOH areas within the CMC.

The survey plan included 65 clusters and approximately 6,064 households, with three respondents targeted per cluster. Selected census blocks were visited systematically, with all households within selected clusters included. Closed households were revisited on the next day.

The Department of Census and Statistics supported the sampling process following a formal agreement with the Ministry of Health.

Ensuring quality and reliability

Considerable emphasis was placed on data quality. Survey teams underwent classroom and field training covering the use of maps, interviewing techniques, completion of questionnaires, verification of vaccination records and use of the mobile data collection application. A total of 65 survey teams were deployed, supported by supervisors, while Public Health Midwives served as local guides to facilitate access and participation.

Data was entered via a mobile application. Hard copies were also made available as a backup. There were a total of five main forms and three additional forms, as listed below: (Table1)

Vaccination information was obtained primarily from the Child Health Development Record or other available vaccination records, with parental recall used when documentation was unavailable. Photographs of vaccination records were collected for evidence, and selected information was cross-checked against facility registers. Digital data collection incorporated built-in validation checks and enabled near real-time monitoring of field progress and data quality.

The analysis included crude and valid vaccination coverage, age-appropriate vaccination, access to immunization services, dropout between selected vaccine doses, private-sector utilization and reasons for non-vaccination. It incorporated the cluster sampling design and unequal probabilities of selection. Weighted estimates were therefore calculated to provide population-representative coverage estimates, with 95% confidence intervals.

Compiled By:

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Form 1	Tally Sheet – to collect household information from all the households visited
Form 2	To collect information from children between 13 months – 24 months
Form 3	To collect information from children between 72 months – 83 months
Form 4	To collect information from adolescents aged 13–15 years
Form 5	To collect information from females 16–44 years
Form (Pvt Sector)	Form to collect information on private sector vaccination
Form (AEFI)	Form to collect information on serious AEFI (<i>this form was to be completed by the SUPERVISOR</i>).
Form 6	Reasons for inability to provide immunization

Table 1

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

26th – 02nd Aug 2026 (31st 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	993	17081	0	17	0	2	0	4	0	19	6	211	0	2	2	14	0	0	10	365	5	73	0	4	35	1111	7	106	99	100
Gampaha	922	14508	0	32	2	32	0	0	0	23	10	350	1	6	0	9	0	0	11	566	3	203	0	39	24	627	1	48	78	100
Kalutara	379	6848	0	34	0	3	0	9	0	62	4	284	0	7	0	17	0	0	12	568	2	94	1	13	0	346	0	58	80	100
Kandy	428	5859	1	40	0	8	0	7	0	38	0	143	0	26	1	19	0	0	18	467	0	99	0	41	8	315	0	19	66	99
Matale	38	2101	0	19	0	5	0	2	0	7	1	145	0	3	0	8	0	0	2	144	1	58	10	338	5	112	0	24	91	100
Nuwara Eliya	62	975	1	36	0	5	0	3	0	15	1	211	5	39	0	13	0	0	3	343	2	148	0	2	10	162	0	9	96	100
Galle	263	5636	1	25	0	11	0	8	1	57	8	389	0	30	1	19	0	0	16	698	2	123	0	2	10	263	1	39	97	100
Hambantota	114	2505	1	39	0	2	0	0	0	39	10	183	1	23	0	11	0	0	3	160	1	48	2	322	3	89	0	21	100	100
Matara	275	6047	0	18	1	4	0	2	0	11	6	272	0	17	0	15	0	0	3	381	2	136	3	99	7	101	1	17	95	100
Jaffna	38	957	1	61	0	6	0	19	2	92	0	53	3	234	0	1	0	0	6	274	0	37	0	1	1	114	0	11	99	100
Kilinochchi	2	637	0	12	0	1	0	8	0	1	0	76	0	12	0	3	0	1	1	93	1	13	0	2	0	20	0	2	100	100
Mannar	4	531	0	1	0	3	0	0	0	3	0	45	0	4	0	3	0	0	0	63	0	20	0	5	1	30	0	3	100	100
Vavuniya	5	317	0	19	0	4	0	2	0	8	1	99	0	4	0	1	0	0	1	118	2	32	1	22	0	42	0	7	100	100
Mullaitivu	5	91	0	6	0	2	0	1	0	8	0	34	1	5	0	2	0	0	0	11	0	9	0	10	1	19	0	7	85	100
Batticaloa	44	1444	4	59	0	10	0	2	0	21	1	142	0	2	0	16	0	0	4	221	1	71	0	22	4	97	2	75	100	100
Ampara	42	589	2	52	0	1	0	1	0	16	2	117	0	2	0	8	0	0	7	245	1	60	0	13	3	34	0	19	100	100
Trincomalee	23	714	0	18	0	6	0	2	0	14	2	77	0	8	1	3	0	0	7	163	0	28	0	18	5	98	0	6	98	100
Kurunegala	171	3114	0	19	2	18	0	3	0	65	2	294	1	27	2	12	0	1	9	559	5	288	9	293	4	198	1	48	98	100
Puttalam	139	1651	0	16	0	11	0	0	0	9	2	188	2	24	0	7	0	4	4	116	3	126	0	15	0	107	1	20	75	100
Anuradhapura	56	951	0	18	0	8	0	2	3	1	50	5	189	1	23	1	9	0	9	402	2	119	23	516	6	165	3	40	94	100
Polonnaruwa	35	754	0	23	0	7	0	2	0	59	1	221	0	7	0	24	0	0	18	354	2	53	4	361	1	55	2	60	100	100
Badulla	116	1536	0	32	0	8	0	3	0	13	6	192	3	40	3	115	0	0	9	313	2	202	2	88	1	156	0	15	91	100
Monaragala	69	1173	0	14	0	3	0	1	2	10	6	212	1	29	0	42	0	1	5	172	4	80	2	150	2	76	2	16	100	100
Ratnapura	175	4917	2	28	1	7	0	6	0	18	5	641	1	30	1	13	0	0	4	272	1	76	2	141	4	255	1	26	100	100
Kegalle	161	2495	3	44	0	5	0	4	1	25	15	293	1	11	0	12	0	0	14	488	2	74	0	13	2	193	2	9	63	100
Kalmunai	35	927	0	39	1	3	0	1	1	20	1	61	0	1	0	3	0	0	7	364	0	33	0	0	1	74	0	25	98	100
SRILANKA	4594	84358	16	721	7	175	2	93	8	703	95	5122	21	616	12	399	0	7	183	7920	44	2303	59	2530	138	4859	24	730	92	100

Source: WRCD module of the EPINET.

T* = Timeliness refers to returns received on or before 02nd 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

26th – 02nd July 2026 (31st 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	7.7%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps ²	00	00	00	00	00	02	00	00	01	01	03	88	97	-9.3
Measles ³	00	00	00	00	00	00	00	00	00	00	00	39	02	1850 %
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	00	04	03	33.3 %
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	01	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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ON STATE SERVICE

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