



WEEKLY EPIDEMIOLOGICAL REPORT

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National Immunization Programme Implementation: Operational Experience from managing an ISRR cluster following HPV vaccination in Puttlam District, Sri Lanka

This is the second article of two in a series on “National Immunization Programme Implementation: Operational Experience from managing an ISRR cluster following HPV vaccination in Puttlam District, Sri Lanka”

Incident Response: ISRR Cluster Following HPV Vaccination

A cluster of adverse events was reported following a school-based HPV vaccination session in the Mahawewa MOH area (February 2025). Six female students developed symptoms, with four requiring hospital admission. The clinical presentations included:

- Chest tightness, abdominal pain, dizziness
- Urticaria and mild allergic manifestations in some
- One probable vasovagal syncope episode

The cluster was consistent with a combination of Immunization Stress-Related Responses (ISRR) and two mild hypersensitivity reactions. Importantly all students recovered fully and no severe anaphylaxis or vaccine quality issues were identified.

District technical team played a central role in the rapid field investigation within 24 hours (based on the national level input and the assistance with the MOH team), clinical case review and classification, assessment of vaccine logistics, cold chain and administration practices, and coordination with hospital teams and laboratory services. The investigation confirmed satisfactory vaccine management and cold chain maintenance (except that returned unopened vials were mixed with the existing stock on return from the vaccination session), with no pro-

grammatic errors contributing to the cluster. However, several system gaps were identified, including suboptimal layout of vaccination sites marked by lack of privacy and crowding, inadequate separation of observation and vaccination areas, minor gaps in emergency preparedness, such as pediatric mask availability, and clinical management inconsistencies, including over-treatment of vasovagal syncope.

Ensuring Programme Continuity

Despite the ISRR cluster, routine immunization activities continued without interruption in Puttlam District, reflecting strong leadership confidence, effective risk communication, and trust in the health system. The ability to maintain programme continuity during adverse events is a key indicator of system resilience.

This system resilience is a result of structured evidence based development of the preventive health system through:

1. Strengthening Programme Confidence and Workforce Capacity

A key challenge identified in Puttlam was variable confidence among Medical Officers of Health (MOOH) in managing adverse events following immunization (AEFI) and addressing vaccine hesitancy.

The district technical focal point implemented a series of targeted capacity-building interventions, including:

- Training on AEFI surveillance and reporting
- Basic and advanced life support training (adult and pediatric)
- Communication and community engagement training for managing community concerns.

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- Programme-specific training (e.g., Vaccin-Preventable Disease (VPD), ISRR management)
- MOH conferences focused on strengthening trust in the NIP

These interventions were *tailor-made based on initial needs assessments*, representing a shift from generic to *context-specific workforce development*.

2. Microplanning and Programme Strengthening

Routine school immunization in Puttlam was strengthened through systematic planning since August 2024. Improvements included:

- Structured session planning
- Enhanced supervision of school vaccination sessions

Clear delineation of staff roles during immunization clinics. These efforts resulted in a *more organized and resilient service delivery model*, which was critical during subsequent adverse event scenarios.

3. Risk Communication and Stakeholder Engagement

A structured risk communication strategy was implemented targeting provincial and regional health directors, hospital administrators, clinical teams, field health staff, and parents, teachers, and students. Communication was targeted and controlled, avoiding unnecessary escalation while ensuring transparency. This approach helped prevent panic and misinformation, maintain public trust in the immunization programme, and ensure continuity of vaccination services.

4. Adaptive System Strengthening Following the Incident

1 Based on lessons learned, the district team initiated corrective actions encompassing the reorganization of school vaccination layouts to ensure privacy and reduce visual triggers, reinforcement of AEFI management protocols, strengthening of emergency preparedness through equipment and drug availability, improved vaccine stock handling practices such as segregation of returned vials, and enhanced clinical training for frontline hospital staff. These actions demonstrate a continuous quality improvement approach embedded within district leadership.

Discussion

The Puttlam experience highlights that district technical leadership extends beyond routine programme management to include crisis management and rapid response, workforce capacity development, behavioral and psychosocial understanding of dynamics such as ISRR, and system-level quality improvement. The ISRR cluster underscores the importance of proper session organization, minimizing anxiety triggers in school children, and strengthening clinical decision-making at the hospital level. Importantly, the incident demonstrates that perceived adverse events can significantly impact programme performance if not managed appropriately, even when vaccines are safe.

Conclusion

The district technical team is central to the success of the implementation of immunization programmes. In Puttlam District, proactive capacity building, strong coordination, and effective incident management ensured sustained programme performance despite complex challenges. The experience demonstrates that the technical team must be adaptive and context-specific, that building workforce confidence is as important as technical competence, and that effective risk communication is critical in maintaining public trust. Strengthening district-level systems will remain essential for achieving future immunization goals and sustaining Sri Lanka's public health achievements.

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

16th-22nd Feb 2026 (08th 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	347	3645	0	2	0	1	0	4	3	7	5	99	0	0	0	0	0	0	0	9	110	0	8	0	1	42	283	2	41	93	96
Gampaha	219	2052	1	12	1	6	0	0	1	8	16	132	0	2	0	2	0	0	25	153	11	55	1	4	24	167	6	18	88	93	
Kalutara	78	750	0	8	0	1	0	2	0	2	9	76	0	0	0	0	0	0	32	146	0	9	0	0	1	96	2	22	93	100	
Kandy	47	563	1	10	0	0	0	1	0	4	8	49	2	12	0	6	0	0	13	103	1	7	2	10	10	101	0	2	100	100	
Matale	27	245	2	3	0	1	0	0	0	0	0	58	0	2	1	4	0	0	6	49	0	5	14	107	0	18	1	3	82	98	
Nuwara Eliya	13	81	4	16	0	0	0	1	1	3	10	59	2	12	0	5	0	0	19	94	3	23	0	0	4	34	0	2	100	100	
Galle	109	952	0	2	0	2	0	1	5	23	9	117	1	9	0	4	0	0	20	165	4	30	0	1	14	62	0	8	79	100	
Hambantota	15	457	0	19	0	0	0	0	0	1	4	43	1	6	1	3	0	0	5	63	2	10	1	45	3	26	0	5	21	100	
Matara	40	1027	0	2	0	1	0	0	0	9	2	50	0	4	0	5	0	0	5	128	1	7	0	30	0	27	1	3	26	98	
Jaffna	24	338	2	12	0	2	0	7	1	4	0	29	8	103	0	0	0	0	14	104	1	6	0	0	5	35	0	3	90	92	
Kilinochchi	9	26	0	1	0	0	0	2	0	0	0	12	0	5	0	2	0	0	0	48	1	1	0	0	0	4	0	1	100	100	
Mannar	1	19	0	0	0	1	0	0	0	0	2	16	0	0	0	0	0	0	0	25	0	2	0	2	0	8	0	1	100	100	
Vavuniya	5	34	0	5	0	0	0	1	0	0	0	17	1	3	0	0	0	0	1	27	0	5	1	5	1	14	0	1	100	100	
Mullaitivu	2	25	0	2	0	0	0	0	0	1	3	11	0	0	0	1	0	0	1	1	0	1	0	1	3	7	0	3	100	100	
Batticaloa	25	330	2	17	1	2	0	0	1	12	3	44	0	0	0	3	0	0	4	65	2	5	0	0	5	32	6	26	69	100	
Ampara	12	121	2	14	0	1	0	0	0	4	1	33	0	1	0	1	0	0	10	57	1	9	0	2	0	11	2	7	87	100	
Trincomalee	16	149	0	8	0	2	1	2	1	2	3	22	1	7	1	1	0	0	3	28	2	8	1	4	2	25	0	2	98	100	
Kurunegala	25	330	0	3	1	5	0	1	0	55	4	88	0	15	0	4	0	0	19	165	6	31	12	96	7	55	2	13	46	100	
Puttalam	26	216	1	7	1	4	0	0	0	1	1	78	0	9	0	0	0	1	3	36	1	19	0	4	4	24	1	8	93	77	
Anuradhapura	15	165	2	5	0	2	0	0	0	3	7	80	0	7	1	2	0	0	13	76	2	10	25	153	6	34	1	8	83	100	
Polonnaruwa	17	105	2	4	0	1	0	0	2	15	6	59	0	0	1	5	0	0	18	85	1	6	25	91	0	15	2	11	98	99	
Badulla	20	212	1	10	0	1	1	1	0	2	4	53	2	6	3	35	0	0	4	76	2	12	1	21	2	38	0	2	86	100	
Monaragala	13	172	1	6	0	3	0	0	0	0	4	64	0	11	1	10	0	0	5	61	0	9	2	42	0	12	0	9	84	100	
Ratnapura	101	735	2	9	0	2	0	2	0	5	18	150	1	12	0	3	0	0	10	82	0	9	0	30	6	68	1	8	98	100	
Kegalle	47	358	3	9	0	2	0	1	0	13	5	66	1	5	0	2	0	0	13	112	6	17	0	3	5	52	0	2	89	100	
Kalmunai	18	205	0	11	0	0	0	0	0	3	5	18	0	1	0	0	0	0	16	72	2	12	0	0	3	20	0	5	100	100	
SRILANKA	1271	13312	26	197	4	40	2	26	15	177	129	1523	20	232	9	98	0	1	268	2131	49	316	86	654	147	1268	27	214	85	98	

Source: WRCD module of the EPINET. T*=Timeliness refers to returns received on or before 22nd Feb, 2026. Total number of reporting units 360.
 A = Cases reported during the current week; B = Cumulative cases for the year. C**=Completeness;

Table 2: Selected Vaccine Preventable Diseases & AFP

16th – 22nd Feb 2026 (08th Week)

Disease	No. of Cases by Pro'vince									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	01	01	00	00	01	01	00	01	00	03	01	16	11	45.5%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps ²	01	00	00	00	00	01	00	01	00	03	04	24	22	0 %
Measles ³	00	00	00	00	00	00	00	00	00	00	00	00	01	-100 %
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	00	01	-100 %
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	00	00	04	-100 %
Whooping Cough ²	00	00	00	00	00	00	00	00	00	00	00	03	06	-50 %

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 except Mumps should be investigated by the MOH Personally.

Number of Malaria Cases Up to End of February 2025,

03

All are Imported!!!

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. The Epidemiology Unit should be formally acknowledged in all resulting publications as the primary data source.

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