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Ministry of Health & Mass Media

DDGs / NHSL, NH Kandy, NH Galle
All Provincial and Regional Directors of Health Services
Directors of Teaching Hospitals and District General Hospitals
Medical Superintendents of Base Hospitals
All Provincial CCPs
All Regional Epidemiologists (RE)
All Medical Officers of Epidemiology
All Medical Officers of Maternal and Child Health (MOMCH)
All Medical Officers of Health (MOOH)

Responding to Potential Measles Outbreak: Strengthened Surveillance, Vaccination and Case based Field Response

Sri Lanka achieved measles elimination status in 2019. However an outbreak occurred in 2023 to 2024 initiated predominantly among unvaccinated individuals. Following control measures the country maintained measles case-free status for 1 year and 3 months since January 2025.

As of June 2026, 06 virologically confirmed cases of measles were detected in Colombo and Gampaha districts involving 4 MOH areas. Four of the cases were among unvaccinated individuals. Gene sequencing of five samples completed to date showed that all were imported or import-related cases. Four belonged to genotype B3, which is linked to strains circulating in the Middle East and Europe which differs from the D8 genotype responsible for the 2023–2024 outbreak. The remaining sample belonged to genotype D8 and had a travel history to Chennai, matching the genotype currently circulating there

The current epidemiological pattern suggests import-related transmission with the potential to develop into an outbreak. Susceptibility is highest among vaccine-hesitant individuals, infants younger than 9 months, and young adults aged 20–30 years with a historical immunity gap.

The following measures should be implemented to prevent the current situation from escalating into an outbreak.

1. **"Fever and Maculopapular Rash" Surveillance**
   - Measles/Rubella case-based surveillance requires the reporting of all patients presenting with fever and a maculopapular (non-vesicular) rash.
   - All suspected cases identified through OPDs, clinics, wards, private hospitals/practitioners, and field settings should be notified immediately to the following authorities:

     - Chief Epidemiologist - Notification to be made using:
       Telephone: 011 2695112
       Fax: 011 2696583
       Email: chepid@sltnet.lk
       Epid 151/2022 revised "Blue Form" (Annexure I)
       EBS Hotline: 070 456 5656 with WhatsApp facility

     - Medical Officer of Health (MOH)
       Using Form H-544 (Annexure II)
       Telephone

     - Regional Epidemiologist (RE)/MO Epidemiology
       Telephone

The MOH is responsible for initiating a special field investigation for all notified cases within 24 hours of receiving the notification. A duly filled special investigation form (Annex III) should be sent to the Epidemiology Unit with a copy to the Regional Epidemiologist.

2. **Laboratory confirmation of notified cases with fever and maculopapular rash cases**
   - All suspected cases need to be laboratory confirmed.

     a. For virus detection: collect nasal and throat swabs in virus transport medium (VTM) in the first 7 days of the onset of the rash – this is essential since genotyping is required for all positive cases.
     b. To detect Measles IgM: collect a 2–3 ml blood sample within 3rd to 28th day of the onset of rash.
     c. These samples should be transported to the Medical Research Institute (MRI), the National Reference Laboratory, within 72 hours while maintaining the cold chain at 2–8°C and accompanied by a duly completed new specimen request form (Annexure IV).

   - For suspected measles cases detected in the field - sample collection should be performed by the MOH team.

3. **Prevention and response to potential measles outbreaks**

   The primary strategies for preventing and responding to a potential measles outbreak include immunizing close contacts, conducting neighborhood-wide screening, implementing Risk Communication and Community Engagement initiatives, and strengthening routine immunization programs.

Screen all household and close contacts to detect new symptomatic cases and immunity gaps early. Obtain a detailed history to detect possible source of infection. Obtain a line list of all possible contacts of the patient during the infective period (4 days before and 4 days after the onset of the rash) and check for their measles immunity status.

A. Immunization for close contacts of a laboratory-confirmed measles case:

- Infants aged 6–9 months: An additional dose of the MMR vaccine should be administered immediately, ideally within 72 hours of exposure.
- Children aged 9 months - 3 years:
  - If the child has already received one dose of MMR, an additional dose of MMR vaccine should be given immediately with a minimum gap of 6 to 8 weeks between the two doses. Routine dose should be administrated at the age of 3 years.
  - If the child is unvaccinated, one dose of MMR should be given immediately followed by a second dose 6–8 weeks later.
- Children aged 3–15 years:
  - Partially vaccinated contacts should receive one dose of MMR vaccine immediately.
  - Contacts should receive two doses of MMR vaccine, given 6–8 weeks apart.
- Adolescents and Adults aged 15–42 years (those born after 1984):
  - Partially vaccinated close contacts should receive one dose of a measles-containing vaccine (MCV) either MR or MMR immediately.
  - Unvaccinated close contacts should receive two doses of an MCV administered 6–8 weeks apart.

All healthcare workers are expected to be fully vaccinated with two doses of an MCV. Healthcare staff who are close contacts of a confirmed measles case should be managed based on their immunity status:

- Healthcare workers with documented history of vaccination with two doses of an MCV
  - No post-exposure prophylaxis is usually required.
  - They may continue working.
  - Daily symptom monitoring is recommended from day 5 to day 21 after exposure.
- Healthcare workers without evidence of two doses of an MCV
  - Should follow the guidelines for unvaccinated or partially vaccinated close contacts aged 15–42 years above.

The WHO recommends Vitamin A supplementation for all children diagnosed with measles. However, the administration of Vitamin A supplements should only be carried out upon the advice and recommendation of the treating clinician.

B. Screening of 50 households or households within 1 km radius around the index household:

Should be conducted for all confirmed cases of measles by the MOH and the field health staff within 48 hours. The field health staff should use the formats (Annexes V to VIII) provided by the Epidemiology Unit in performing the 50 house screening and send summary reports to the Epidemiology Unit within 48 hours of performing the screening.

Regional Epidemiologists / MOO Epidemiology should closely monitor and guide all activities following detection of a measles case and liaise with the Epidemiology Unit for any guidance. All PDHSs/RDHSs should ensure that REs / MOs Epidemiology guide and monitor the field level activities.

This screening is conducted to identify immunity gaps among individuals aged below 30 years, provide vaccination to eligible individuals, and detect any new suspected measles cases presenting with fever and rash in order to prevent a chain of transmission.

- Children aged 9 months to 3 years:
  - Unvaccinated children should receive one dose of MMR vaccine immediately, followed by a second dose at 3 years of age.
- Children aged 3–15 years:
  - Partially vaccinated children should receive one dose of MMR vaccine.
  - Unvaccinated children should receive two doses of MMR vaccine administered 6–8 weeks apart.
- Adolescents and young adults aged 15 to 30 years
  - Partially vaccinated individuals should receive one dose of an MCV.
  - Unvaccinated individuals should receive two doses of an MCV administered 6–8 weeks apart.

C. Risk Communication and Community Engagement (RCCE)

- Conduct community awareness activities emphasizing early care seeking for all fever with rash illnesses.
- Encourage parents of partially vaccinated and unvaccinated children receive age-appropriate MMR vaccination.
- Identify and engage vaccine-hesitant families through interpersonal communication and counseling by field health staff.
- Utilize materials provided by the Epidemiology Unit (short videos, mini book, and flash cards) during community engagement and awareness activities.
- Strengthen collaboration established during the recent "Advocacy and Capacity Building" programmes and engage with religious leaders, community leaders, school communities, and General Practitioners to address vaccine hesitancy.
- Inform and sensitize General Practitioners, OPD medical officers, pediatricians, physicians and ward medical officers to maintain a high index of suspicion for measles and promptly notify suspected cases.
- Conduct public announcements in the community requesting:
  - Immediate medical attention for all fever with rash cases.
  - Vaccination of all non-fully vaccinated eligible children with MMR vaccine.
- Promote school and preschool awareness on identifying fever with rash illnesses and encouraging early medical consultation.
- Ensure rapid field follow-up and response for every suspected measles case to prevent further transmission.

4. **Strengthened routine immunization- Measles Vaccination for children with missed doses**

- All MOHs need to screen eligible children for vaccination in their area and ensure all missed children are fully immunized with MMR vaccine.
- If any hesitant families are identified, MOH of the area should be informed at the earliest by the field staff.
- Public Health Midwives should maintain a 'Vaccine Hesitant Individuals' Register" for their area with an updated activity log including the latest outcomes.
- MOH should maintain a 'Vaccine Hesitant Individuals' Register" of eligible unvaccinated children of the area.
- Field health staff should pay home visits to provide counseling on importance of vaccination and motivation to build vaccine confidence and encourage vaccine acceptance.
- Get the support from all the possible community and religious supportive groups in improving vaccine acceptance.
- All children presenting to the OPD, clinics, or wards for other illnesses should have their vaccination status checked (refer to the CHDR) and be referred for any due vaccine doses after recovery from the acute illness, as part of opportunistic vaccination.

Focal point at the Epidemiology Unit – Dr. Athula Liyanapathirana 071 5999757
Measles Reference Laboratory – MRI - 0112693532 – Ext 452

All hospital directors should reproduce and disseminate Annexes IX among OPD medical officers and all RDHSs should reproduce and disseminate Annex X and XI among general practitioners in their districts through the MOH offices.

While appreciating your continued support for control and prevention of communicable disease activities, I request your kind cooperation to this national requirement.

Dr. Asela Gunawardena
Director General of Health Services

Dr. ASELA GUNAWARDENA
Director General of Health Services
Ministry of Health and Mass Media
"Suwasiripaya"
Rev. Baddegama Wimalawansa Thero Mawatha
Colombo 10.

Cc:

1. Secretary Health
2. DDG (PHS) I,
3. DDG (PHS) II,
4. DDG (MS) I,
5. DDG (LS)
6. Chief Epidemiologist
7. Director, MCH-FHB
8. Director, HPB
9. Director MRI
10. Director, Private Health Sector Development