



WEEKLY EPIDEMIOLOGICAL REPORT

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Invasive Meningococcal Disease: Current Outbreak in the UK and the Sri Lankan Context II

This is the second article of two in a series on “Invasive Meningococcal Disease: Current Outbreak in the UK and the Sri Lankan Context”

Broader Context of Bacterial Meningitis

In Sri Lanka and the wider South Asia Region, the epidemiology of bacterial meningitis differs from that seen in many high-income countries. Historically, pathogens such as *Haemophilus influenzae* type b (Hib) contributed significantly to the burden of disease prior to vaccine introduction, while meningococcal disease accounts for a small proportion of bacterial meningitis cases. Regional estimates suggest that *Neisseria meningitidis* contributes to approximately 1% of bacterial meningitis cases in South Asia.

Globally, there are well recognized differences in the distribution of meningococcal serogroups. Serogroup A disease has historically occurred predominantly in developing regions of Africa and parts of Asia, whereas serogroup B is the major cause of sporadic meningococcal disease in most developed countries. This distinction is important in understanding both the epidemiology of the recent outbreak in the United Kingdom, where serogroup B was identified, and the comparatively low prominence of meningococcal disease in Sri Lanka.

Despite this low burden, it is important to recognise that effective vaccines against meningococcal disease are available in Sri Lanka, although not included in the routine National Immunization Programme (NIP). The National Immunization Handbook (2012) published by the Epidemiology Unit does not include meningococcal

The National Immunization Handbook (2012) published by the Epidemiology Unit does not include meningococcal vaccines within the routine schedule, reflecting the low incidence of disease and prioritization of other vaccine-preventable diseases (VPDs). However, the handbook clearly outlines that meningococcal

vaccination is recommended for specific indications rather than for universal use. These include:

- Travellers to high-risk areas, such as Hajj and Umrah pilgrims, where vaccination is mandatory.
- Individuals at increased risk of infection, including those with certain medical conditions.
- Situations of outbreak control, where vaccination may be deployed as part of a public health response.

In Sri Lanka, meningococcal vaccination is therefore targeted rather than routine. The vaccine most commonly used is the quadrivalent meningococcal conjugate vaccine (MenACWY), which provides protection against serogroups A, C, W, & Y. This is administered predominantly through government travel health services such as the Assistant Port Health Office at the Medical Research Institute.

In contrast, meningococcal serogroup B (MenB) vaccines, which played a central role in outbreak control in the recent United Kingdom setting, are not routinely used and have very limited availability in Sri Lanka, reflecting the absence of documented local disease burden and policy requirement.

Importantly, deliberations at the National Immunization Summit (NIS) 2025 indicated that although there are sporadic cases of IMD that occur in closed settings such as prisons and military camps, no significant IMD burden exists in the general population, while mortality and complications associated with IMD were low in the country. In contrast, laboratory confirmation of sporadic bacterial meningitis with serogroups was minimal due to limited diagnostic facilities in Sri Lanka. Thus, based on the available evidence, the introduction of meningococcal vaccines in the NIP was not justified in the current context. However, vaccination of high-risk groups, such as those travelling to endemic countries, students leaving for overseas

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universities and individuals having high-risk conditions, is justified. Emphasis was placed on strengthening surveillance and generating evidence before considering policy decisions.

Public Health Implications for Sri Lanka

Meningococcal disease, although rare in Sri Lanka, remains of public health relevance. In the absence of routine meningococcal vaccination, a proportion may remain susceptible; however, current evidence suggests that the overall risk of transmission is low. Nevertheless, in the event of introduction, transmission may be facilitated in settings characterized by close contact, such as universities, boarding schools, and other institutional living arrangements, as observed in the recent outbreak in the United Kingdom.

At present, surveillance gaps exist, including limited laboratory confirmation and absence of serogroup-specific data. These constraints restrict comprehensive understanding of the disease burden and transmission patterns within the country. Strengthening preparedness is therefore essential, especially in ensuring rapid outbreak response capacity, including timely diagnosis, contact tracing and provision of chemoprophylaxis.

From a policy perspective, meningococcal vaccination in Sri Lanka remains targeted rather than routine with use primarily limited to travellers and high risk situations. While current evidence does not support routine introduction, future consideration may be warranted depending on emerging epidemiological trends and local data.

Strengthening Surveillance & Future Directions

Strengthening meningitis surveillance, including laboratory confirmed surveillance, is essential for early outbreak detection and response. The establishment of a comprehensive case-based line-listing system would improve the timely identification of clusters, facilitate detailed epidemiological analysis, and support rapid public health action.

In addition, there is a need to better understand meningococcal carriage patterns within local populations, especially among adolescents and young adults, who are known to play a key role in transmission. Such data would provide valuable insights into potential outbreak risks and inform targeted interventions.

Monitoring of circulating serogroups is also critical, especially in the context of emerging strains such as serogroup X, which has been associated with outbreaks in other regions. The limited availability of serogroup-specific surveillance data in Sri Lanka represents a gap that needs to be addressed. Collectively these efforts would support development of tailored vaccination strategies based on local epidemiology, ensuring that future policy decisions regarding meningococcal vaccine introduction are both evidence-based and context-specific.

Conclusion

The recent outbreak of IMD in the United Kingdom underscores a fundamental principle of public health: that the rarity of a disease does not diminish its potential impact. Even in well prepared systems, gaps in population immunity and patterns of social interaction can lead to rapid and serious outbreaks.

In Sri Lanka, maintaining vigilance through strengthened surveillance, improved diagnostic capacity, and preparedness for rapid response is essential to ensure timely detection and control of potential future events.

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KEY MESSAGES

- **IMD, though rare, can lead to rapid and severe outbreaks.**
- **The 2026 UK outbreak highlights the role of immunity gaps and high-contact settings.**
- **In Sri Lanka, IMD remains uncommon and under-characterized.**
- **Available surveillance and limited laboratory data may not fully capture the disease burden.**
- **Meningococcal vaccines (MenACWY) are available but used in a targeted manner.**
- **MenB vaccines are not routinely used in Sri Lanka.**
- **Strengthening surveillance, laboratory capacity, and data systems is essential.**
- **Future vaccine policy should be guided by locally generated epidemiological evidence.**

Table 1: Distribution of Notified Diseases reported by Medical Officers of Health 30th Mar-05th Apr 2026 (14th 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	9	5190	0	3	1	2	0	4	0	11	6	121	0	0	2	5	0	0	6	179	2	19	0	1	28	509	0	58	96	96
Gampaha	10	3004	1	14	0	11	0	0	0	8	4	172	0	3	1	4	0	0	7	260	2	75	9	15	13	292	0	23	91	93
Kalutara	10	1208	0	14	0	2	0	6	0	6	6	149	3	4	6	8	0	0	9	256	1	18	1	1	14	174	0	29	83	100
Kandy	42	876	1	21	1	2	0	3	3	12	0	65	0	17	0	9	0	0	2	193	1	12	0	23	4	159	3	8	100	100
Matale	256	600	3	6	0	1	0	0	0	0	4	70	0	2	0	5	0	0	8	73	4	16	0	160	1	42	9	15	77	100
Nuwara Eliya	113	226	1	21	0	1	0	2	3	9	9	96	0	19	1	9	0	0	44	185	4	38	0	0	6	69	0	2	98	100
Galle	170	1627	0	8	0	2	1	4	0	35	5	176	0	11	1	8	0	0	12	310	0	47	1	2	9	112	4	14	75	100
Hambantota	28	670	0	23	0	0	0	0	0	6	3	63	1	11	0	8	0	0	11	98	2	14	21	101	0	34	2	8	0	100
Matara	21	1542	0	3	0	1	1	1	0	11	3	103	8	12	0	7	0	0	6	212	3	16	0	48	4	50	0	6	4	98
Jaffna	32	500	0	16	0	3	0	14	1	6	0	38	0	165	0	0	0	0	13	182	2	13	0	0	4	54	0	7	95	100
Kilinochchi	117	153	0	1	0	0	2	5	0	0	15	32	0	8	0	2	0	1	15	67	3	4	0	0	1	10	0	1	100	100
Mannar	47	73	0	0	2	3	0	0	1	1	2	20	1	2	1	1	0	0	11	37	0	2	1	3	1	11	0	1	100	100
Vavuniya	39	88	3	8	0	1	0	1	0	6	3	28	0	3	0	0	0	0	22	57	0	7	0	9	4	24	0	1	100	100
Mullaitivu	1	34	0	3	1	1	0	0	1	2	2	22	1	1	1	2	0	0	0	3	1	3	0	3	0	10	0	4	100	100
Batticaloa	28	616	0	26	0	3	0	1	0	15	4	66	0	0	0	6	0	0	20	116	3	13	10	10	0	48	2	39	15	100
Ampara	1	166	0	20	0	1	0	1	0	6	0	55	0	1	0	3	0	0	0	126	0	15	0	5	1	17	1	14	90	100
Trincomalee	18	265	0	9	0	2	0	2	0	6	2	33	0	7	0	2	0	0	6	61	0	14	6	11	4	47	0	2	98	100
Kurunegala	96	587	0	4	0	7	0	3	0	55	5	121	0	20	1	5	0	0	24	260	0	44	3	131	8	89	2	19	52	100
Puttalam	29	351	1	10	0	5	0	0	4	5	12	105	0	14	0	2	0	2	7	66	2	29	2	8	3	51	1	11	30	66
Anuradhapura	2	247	0	8	0	3	0	0	0	33	1	114	0	16	0	6	0	0	3	148	0	22	0	251	6	73	0	19	97	58
Polonnaruwa	4	149	1	8	0	2	0	0	0	19	2	95	0	3	0	13	0	0	10	177	1	13	2	190	5	27	0	22	93	99
Badulla	14	326	2	15	0	5	0	3	1	6	6	85	1	12	1	48	0	0	8	125	0	19	7	37	6	75	1	6	53	100
Monaragala	18	276	0	9	0	3	0	1	0	0	4	104	1	17	0	20	1	1	5	99	5	21	1	62	1	25	1	10	82	100
Ratnapura	92	1265	1	16	0	4	0	3	0	9	15	274	0	15	1	6	0	0	3	147	3	18	1	63	10	125	2	12	93	100
Kegalle	16	565	1	14	0	2	0	2	0	14	1	108	0	5	0	3	0	0	7	228	1	23	0	6	10	96	0	2	99	100
Kalmunai	4	354	0	16	0	0	0	0	0	12	2	32	0	1	0	1	0	0	11	180	0	16	0	0	4	39	0	15	96	100
SRILANKA	1217	20958	15	296	5	67	4	56	14	293	116	2347	16	369	16	183	1	4	270	3845	40	531	65	114	147	2262	28	348	77	96

Source: WRCD module of the EPINET. T*=Timeliness refers to returns received on or before 05th Apr. 2026. Total number of reporting units 360. C**=Completeness; A = Cases reported during the current week; B = Cumulative cases for the year. C**=Completeness;

Table 2: Selected Vaccine Preventable Diseases & AFP

30th Mar – 05th Apr 2026 (14th 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	01	00	00	01	04	23	19	21
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps ²	01	00	00	00	00	00	00	00	00	01	02	48	41	17.1 %
Measles ³	01	00	00	00	00	00	00	00	00	01	00	02	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	01	02	-50 %
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	01	01	00	08	07	-14.2 %

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.

Take prophylaxis medications for Leptospirosis during the paddy cultivation and harvesting seasons.

It is provided free by the MOH office / Public Health Inspectors.

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

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