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Ebola Disease
Current Global Situation and Preparedness Measures for Sri Lanka - II

This is the second article of two in a series on "Ebola Disease: Current Global Situation and Preparedness Measures for Sri Lanka"

Transmission

Ebola disease is primarily a zoonotic disease. Fruit bats are considered the natural reservoir hosts of *Orthoebolavirus*. The virus may spread from bats to other primates such as chimpanzees, gorillas, monkeys, forest antelope, and porcupines.

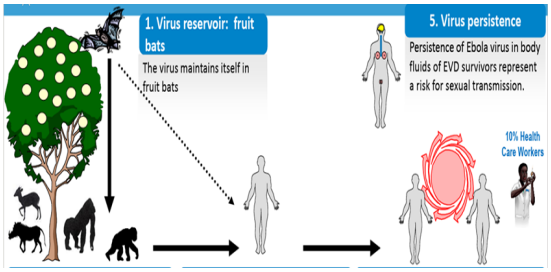

Figure 2: Hypothesis of Ebola virus transmission at the human-animal interface
Image credit: World Health Organization

Primary Transmission: Primary transmission to humans occurs through direct contact with blood, secretions, organs, or other bodily fluids of infected animals found ill or dead in rainforest areas.

Secondary Transmission: Human-to-human transmission occurs via direct contact with the blood or body fluids of infected individuals. Transmission may occur through mucous membranes, broken skin, needle-stick injuries, or contact with contaminated surfaces and objects. Funeral practices involving direct contact with deceased individuals also contribute significantly to transmission.

The incubation period ranges from 2 to 21 days. Individuals are not infectious before the onset of symptoms. Infectivity begins once symptoms appear and continues while the virus remains present in body fluids.

Clinical Features

The early clinical presentation is often non-specific, making diagnosis difficult during the initial stages. Early manifestations include "Dry symptoms", fever, fatigue, malaise, muscle pain, headache, and sore throat. As the illness progresses, patients may develop "Wet symptoms", vomiting, diarrhoea, abdominal pain, rash, and impaired liver and kidney function. In some cases, internal and external bleeding manifestations such as bleeding gums or blood in the stools may occur. Due to the non-specific nature of the initial presentation, clinical diagnosis can be difficult during the early stages of illness. Therefore, travel history, contact history, and epidemiological links are essential components of case identification and risk assessment.

High-Risk Groups

Groups at increased risk of infection include:

- Healthcare workers
- Burial workers and individuals handling dead bodies
- Family members and caregivers of infected patients
- Laboratory personnel handling specimens

Healthcare workers are particularly vulnerable in the absence of adequate infection prevention and control measures and personal protective equipment (PPE).

Diagnosis

Early diagnosis of Ebola disease is challenging because symptoms resemble many other infectious diseases, such as malaria, typhoid fever, dengue fever, and other viral haemorrhagic fevers.

Travel history, exposure history, and epidemiological links are essential in identifying suspected cases.

Laboratory confirmation can be performed using:

- Reverse transcriptase polymerase chain reaction (RT-PCR)

- Antibody-capture enzyme-linked immunosorbent assay (ELISA)
- Antigen-capture detection tests
- Virus isolation by cell culture

Treatment

Early intensive supportive care significantly improves survival in Ebola disease. Management primarily consists of prompt fluid resuscitation, correction of electrolyte imbalances, nutritional support, management of fever and pain, and treatment of complications such as vomiting, diarrhoea, and secondary infections. WHO currently recommends the monoclonal antibody therapies mAb114 (Ansuvimab™) and REGN-EB3 (Inmazeb™) for Ebola virus disease caused by EBOV. However, there are currently no approved therapeutics for Sudan virus disease or Bundibugyo virus disease.

Prevention and Control

Prevention and control measures remain the cornerstone of Ebola outbreak management. Licensed vaccines are available only for Ebola virus disease caused by EBOV. These include Ervebo, manufactured by Merck & Co., and the Zabdeno and Mvabea vaccine regimen developed by Janssen Pharmaceutica. The Ervebo vaccine is widely recommended as part of outbreak response activities. At present, there are no approved vaccines for Sudan virus disease or Bundibugyo virus disease. Community engagement and public awareness are critical components of outbreak control. Risk communication should focus on reducing human-to-human transmission by discouraging direct contact with infected individuals and their body fluids and promoting safe burial practices.

Strict Infection Prevention and Control (IPC) measures are critical in healthcare settings. These include: early identification and isolation of suspected patients, barrier nursing techniques, appropriate use of PPE, safe handling of clinical waste, environmental cleaning and disinfection, and availability of Water, Sanitation and Hygiene (WASH) services.

Healthcare workers involved in patient management should receive regular training on IPC procedures and proper use of PPE.

Countries should maintain strong surveillance systems for early detection and rapid response. Preparedness measures should include: screening of travellers arriving from Ebola-affected countries at designated Points of Entry, identification and preparation of designated treatment hospitals, availability of trained healthcare staff and adequate PPE supplies, laboratory preparedness for diagnostic testing, continuous monitoring of the evolving global situation, and coordination between national authorities and WHO.

WHO Recommendations and Implications for Sri Lanka

WHO currently categorizes Sri Lanka as a low-risk country for Ebola disease. WHO does not recommend border closures or restrictions on travel and trade, as such measures lack scientific evidence and may negatively affect outbreak response activities and economies.

WHO advises countries to:

- Provide accurate public information regarding Ebola disease
- Educate travellers about preventive measures
- Coordinate with the transport and tourism sectors to avoid unnecessary travel restrictions
- Facilitate the evacuation and repatriation of exposed nationals if necessary
- Maintain preparedness for case detection and management

WHO also states that routine entry screening at airports outside affected regions is generally not required.

Preparedness Measures in Sri Lanka

Although Sri Lanka is currently categorized as low risk, preparedness remains essential due to international travel and trade connectivity.
Key preparedness activities should include:

- Strengthening surveillance systems and risk assessment
- Enhancing screening and health information dissemination at Points of Entry
- Ensuring the availability of PPE and isolation facilities
- Strengthening laboratory capacity through the Medical Research Institute
- Maintaining effective risk communication with the public
- Close coordination between the Epidemiology Unit, the Ministry of Health, and the WHO

Preparedness activities are focused on early detection, rapid isolation, safe clinical management, and prevention of healthcare-associated transmission.

Conclusion

Ebola disease remains a major global public health threat due to its high mortality, potential for rapid spread, and impact on healthcare systems. The ongoing Bundibugyo virus outbreak in the DRC and Uganda highlights the continued risk of emerging and re-emerging infectious diseases.

Although Sri Lanka is currently considered a low-risk country, strengthening national preparedness capacities is essential to ensure timely detection and effective response to any suspected imported case. Continuous surveillance, healthcare worker training, public awareness, laboratory preparedness, and strong infection prevention and control practices remain critical components of national preparedness efforts.

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Table 1: Distribution of Notified Diseases reported by Medical Officers of Health 18th – 24th May 2026 (21st 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	358	7294	0	7	0	2	0	4	1	14	11	162	0	1	1	9	0	0	17	280	2	23	0	3	34	733	2	71	**92**	**92**
Gampaha	406	4526	1	18	1	18	0	0	1	15	17	247	0	5	1	6	0	0	21	413	6	107	1	18	10	410	4	35	**89**	**91**
Kalutara	181	2152	1	20	0	3	0	7	0	16	7	205	0	5	0	11	0	0	12	376	2	29	1	2	3	224	3	38	**92**	**99**
Kandy	180	1520	0	33	0	2	0	5	0	34	7	103	1	23	2	14	0	0	23	339	9	27	2	36	5	224	0	10	**98**	**100**
Matale	15	690	1	11	1	3	0	0	0	1	4	98	0	3	0	5	0	0	4	104	0	21	10	242	2	76	0	20	**82**	**95**
Nuwara Eliya	17	287	0	27	0	3	1	3	0	14	11	132	0	24	0	11	0	0	17	263	15	74	0	0	12	109	0	3	**82**	**98**
Galle	137	2257	0	11	1	8	1	5	1	43	17	266	4	22	0	11	0	0	17	520	2	64	0	2	9	170	2	19	**94**	**99**
Hambantota	53	961	0	30	0	2	0	0	1	31	7	98	1	14	0	11	0	0	3	129	2	20	17	232	2	53	0	11	**100**	**100**
Matara	181	2281	1	5	0	1	0	1	0	11	14	181	0	13	0	15	0	0	19	324	2	88	2	77	2	68	3	12	**79**	**100**
Jaffna	18	640	2	29	0	4	2	19	0	74	2	44	2	208	0	1	0	0	2	225	1	20	0	0	4	81	0	7	**90**	**100**
Kilinochchi	6	168	0	4	0	0	2	7	0	1	2	39	0	10	0	3	0	1	1	68	1	5	1	1	0	16	0	1	**100**	**100**
Mannar	1	90	0	0	0	3	0	0	1	3	0	21	0	2	0	1	0	0	0	42	0	2	0	3	0	19	0	1	**100**	**100**
Vavuniya	2	102	1	14	0	1	0	1	0	8	0	30	0	3	0	0	0	0	0	85	0	11	0	18	0	34	0	2	**100**	**100**
Mullaitivu	4	48	0	3	0	1	0	0	0	8	0	26	0	1	0	2	0	0	0	8	2	5	2	8	1	15	0	4	**100**	**100**
Batticaloa	47	886	1	41	0	5	0	2	0	16	5	84	0	0	0	11	0	0	3	149	0	20	0	10	3	66	2	46	**100**	**100**
Ampara	14	228	1	43	0	1	0	1	0	8	9	94	0	2	0	4	0	0	7	198	3	29	0	9	0	21	0	15	**100**	**100**
Trincomalee	25	426	0	14	0	4	0	2	2	11	4	46	0	8	0	2	0	0	2	119	1	19	0	12	1	73	0	6	**100**	**100**
Kurunegala	43	875	1	14	1	11	0	3	0	62	7	173	0	20	0	6	0	0	27	437	29	124	8	184	8	142	2	35	**67**	**96**
Puttalam	30	477	0	11	1	7	0	0	0	7	7	133	1	17	1	5	0	2	2	87	16	67	0	10	9	86	1	14	**63**	**89**
Anuradhapura	13	325	0	11	0	6	0	1	0	41	7	164	1	18	0	8	0	0	9	261	12	50	13	343	6	118	1	29	**95**	**100**
Polonnaruwa	16	255	0	14	0	4	0	2	0	24	20	162	1	4	1	19	0	0	3	231	1	18	12	259	4	36	0	45	**98**	**100**
Badulla	19	443	5	27	0	6	0	3	1	7	6	121	3	20	3	71	0	0	10	201	44	76	5	55	7	108	3	11	**93**	**100**
Monaragala	13	427	0	12	0	3	0	1	0	5	8	168	2	25	2	33	0	1	4	142	2	40	9	107	3	47	0	10	**94**	**100**
Ratnapura	219	2293	0	22	1	6	0	4	0	15	38	481	0	21	0	7	0	0	7	219	4	32	11	100	9	175	1	19	**92**	**100**
Kegalle	69	943	5	28	0	3	0	4	0	19	22	190	0	9	0	7	0	0	11	356	1	33	2	10	5	136	1	4	**97**	**99**
Kalmunai	27	564	0	26	0	0	0	0	1	15	1	44	0	1	0	1	0	0	13	300	1	19	0	0	2	55	2	21	**100**	**100**
SRILANKA	2094	31158	**20**	**475**	**6**	**107**	**6**	**75**	**9**	**503**	**233**	**3512**	**16**	**479**	**11**	**274**	**0**	**4**	**234**	**5876**	**158**	**1023**	**96**	**1741**	**141**	**3295**	**27**	**489**	**92**	**98**

Source: WRCD module of the EPINET.
A = Cases reported during the current week;
T*=Timeliness refers to returns received on or before 24th May, 2026.
B = Cumulative cases for the year.
Total number of reporting units 360
C**-Completeness;
C**-Completeness;

Table 2: Selected Vaccine Preventable Diseases & AFP 18th – 24th May 2026 (21st 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	00	01	31	28	10.7%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps[2]	00	01	01	00	00	00	01	00	01	04	01	62	65	-4.6 %
Measles[3]	00	00	00	00	00	00	00	00	00	00	00	05	01	400 %
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	02	02	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	01	13	11	18.1 %

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.

AFP[1] = No Polio cases
Mumps[2], CRS[2], Tetanus[2], Neonatal Tetanus[2], Whooping Cough[2]—Clinically and/ or laboratory confirmed cases
Measles[3], Rubella[3], Japanese Encephalitis[3]— 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 on May 2026,

02

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, 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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