WEEKLY EPIDEMIOLOGICAL REPORT

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WEEKLY EPIDEMIOLOGICAL REPORT SRI LANKA 2026

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Closing the Gap Between Outbreak and Alarm: National Event-Based Surveillance

Timely detection of public health threats remains a challenge for conventional indicator-based surveillance systems, which primarily depend on routine reporting from health facilities. These systems may fail to capture early, informal signals emerging from communities and non-health sectors. Event-based surveillance (EBS) addresses this gap by systematically identifying, capturing, and verifying such signals to facilitate rapid public health action. EBS has been successfully implemented in several countries, including Vietnam, India, Ghana, and across the African region, demonstrating its value as a complementary approach to indicator -based surveillance (WHO,2014).

Two systems, one purpose

Sri Lanka's Epidemiology Unit has run indicator -based surveillance for Several decades for the Communicable Diseases, a system built on routine, structured reporting from health facilities. It is thorough, but by design it only counts what is already defined and expected. Event-based surveillance fills the gap: it captures formal signals, rumors, media reports, and informal signals of anything unusual, verify them quickly, and feeds confirmed threats into the same response pathway. The International Health Regulations (2005) urge WHO member states to complement both systems together function as a single early-warning mechanism , precisely because indicator-based surveillance alone tends to miss the unexpected events especially at early stages (World Health Organization, 2014, 2016).

Until recently, Sri Lanka's event-based signals were captured informally, largely through the Medical Officer of Health (MOH) and hospital network and ad hoc media monitoring, without a standardized reporting system, dedicated staff training, or consistent coordination between health and non-health sectors. A new concept of Event based surveillance from the Epidemiology Unit sets out how this gap is being closed.

What has been built

The new EBS package gives Sri Lanka, for the first time, a single structured system for managing early signals nationally. Reports can now come in through several low-barrier channels: a dedicated WhatsApp number, a mobile and digitalized electronic Event Based Surveillance (eEBS), an email address, and a public Facebook group, alongside a direct link to WHO's Epidemic Intelligence from Open Sources (EIOS) platform for relevant international signals. Every signal that comes in, whatever the channel, is routed through the same workflow triage, verification, event creation, rapid risk assessment, response, follow-up, and closure with clearly assigned responsibilities at MOH, regional, and national level (Figure 1). Furthermore, an eEBS is design to create a electronic registry, recording and tracking each stage, replacing what had previously been an informal, largely undocumented process.

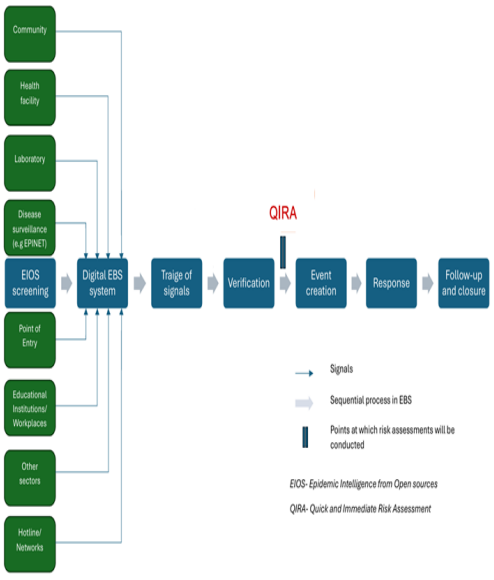

Figure 1: Event Based surveillance

Testing it on the ground

Before scaling the system nationally, the Epidemiology Unit piloted it in six MOH areas of Gampaha District. The pilot showed that the different reporting channels worked together in practice to support surveillance at subnational level, and it surfaced practical lessons that are now feeding into national rollout. Capacity-building for both health and relevant non-health stakeholders by covering signal detection, verification, risk assessment, and use of the digital tools is planned for the alongside standardized operating procedures. A formal evaluation of how quickly and complete signals are being detected, along with cost-effectiveness, is planned once this next phase is complete.

What other countries have learned

Sri Lanka's approach echoes what has worked elsewhere. In Vietnam, a community-based EBS pilot found that ordinary community members, not health workers, generated the largest share of reported signals, with a median of just 4.4 days from an event happening to a health-centre response (Clara et al., 2018). Ghana's community-reporter model similarly strengthened the country's compliance with global health security targets (Merali et al., 2020). In Kerala, India, a 2023–2024 pilot extended EBS into private hospitals, a sector public surveillance often misses and picked up clusters of febrile illness that routine reporting alone would not have caught (Vaman et al., 2025). Across Africa, Kenya's electronic EBS tool identified almost 8,800 signals and over 3,000 verified events in just 15 months, and the continental EBS framework has since shifted toward standardized event-management systems and closer collaboration across the human, animal, and environmental health sectors – a One Health approach (Mercy et al., 2023). The common thread across all these experiences is the same: multiple accessible reporting channels, a structured process for verifying and acting on signals, and a trained workforce to run it.

Why this matters for Sri Lanka

Public health threats rarely stay within neat administrative or sectoral boundaries, and Sri Lanka faces risks that can originate from human, animal, or environmental sources alike. A functioning EBS system means that a cluster of unusual illness, usual illnesses in unusual pattern, an unexplained animal die-off and behaviors, Environmental and chemical events, or a worrying rumor circulating in a community has a defined route into the health system and a defined response once it arrives, consistent with the multi-sectoral, standardized approach WHO has called for since the 2005 revision of the International Health Regulations (World Health Organization, 2014, 2016). The Epidemiology Unit's four pillars for sustaining the system structured training of trainers, digital tools that reduce the staffing burden of real-time monitoring, clear institutional guidelines and leadership backing, and genuine multi-sectoral and community participation are designed to keep it running well beyond the pilot phase, mirroring the pathway by which Vietnam's EBS tools were later adapted for use in India, Cameroon, Ghana, and Kenya (Mercy et al., 2023).

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Table 1: Distribution of Notified Diseases reported by Medical Officers of Health 29th June – 05th July 2026 (27th 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	1264	11759	0	16	0	2	0	4	0	17	4	190	0	2	0	9	0	0	3	330	4	57	0	3	38	965	3	95	**92**	**100**
Gampaha	1439	9541	0	24	1	27	0	0	0	23	8	308	0	5	1	8	0	0	12	528	5	177	0	35	14	532	1	45	**82**	**86**
Kalutara	866	4734	3	33	0	3	0	8	0	62	8	253	0	6	0	17	0	0	13	512	4	85	6	12	15	319	4	48	**86**	**100**
Kandy	663	3628	0	39	0	8	0	6	0	38	0	128	0	26	1	16	0	0	10	413	3	88	0	41	14	283	1	17	**63**	**74**
Matale	81	1819	1	18	1	5	1	1	0	7	1	136	0	3	0	7	0	0	5	132	6	47	7	301	2	95	0	23	**98**	**100**
Nuwara Eliya	64	655	1	34	0	4	0	3	0	15	8	193	1	29	0	13	0	0	10	317	3	136	0	1	4	142	0	7	**91**	**100**
Galle	404	4255	0	20	0	11	0	8	2	53	15	342	1	27	0	16	0	0	16	634	4	104	0	2	9	228	2	31	**96**	**100**
Hambantota	233	1828	1	33	0	2	0	0	0	34	2	148	2	20	0	11	0	0	1	149	2	40	4	289	1	74	2	19	**95**	**100**
Matara	655	4225	0	17	0	3	0	2	0	11	13	226	0	16	0	15	0	0	3	362	1	127	1	86	7	85	1	13	**84**	**100**
Jaffna	49	784	2	45	0	6	0	19	8	88	0	52	5	224	0	1	0	0	3	257	1	32	0	1	1	100	0	11	**100**	**100**
Kilinochchi	2	606	1	10	0	1	0	7	0	1	1	74	0	11	0	3	0	1	0	91	1	11	0	2	0	20	0	2	**100**	**100**
Mannar	6	499	0	1	0	3	0	0	0	3	0	45	0	4	0	3	0	0	1	63	1	20	0	4	1	25	0	3	**100**	**100**
Vavuniya	9	255	0	18	0	4	0	2	0	8	3	96	0	4	0	1	0	0	3	112	1	29	0	21	0	41	0	6	**91**	**100**
Mullaitivu	2	64	0	6	0	1	0	0	0	8	1	34	0	2	0	2	0	0	0	11	0	8	0	8	0	17	1	5	**100**	**100**
Batticaloa	76	1240	2	51	1	8	0	2	0	16	2	129	0	2	0	15	0	0	14	197	1	68	0	21	1	85	3	62	**100**	**100**
Ampara	56	370	1	47	0	1	0	1	1	14	7	107	0	2	0	6	0	0	5	228	4	52	1	12	0	27	1	16	**100**	**100**
Trincomalee	24	612	2	17	0	6	0	2	1	14	0	69	0	8	0	2	0	0	2	139	0	26	0	18	1	90	0	6	**100**	**100**
Kurunegala	295	2180	0	18	1	15	0	3	1	64	10	274	0	23	1	10	1	1	9	513	14	248	10	246	6	174	0	41	**92**	**100**
Puttalam	137	998	1	16	0	11	0	0	0	7	4	176	0	21	0	7	0	4	2	103	6	108	0	14	3	101	0	16	**91**	**100**
Anuradhapura	80	542	0	15	0	7	0	1	0	49	6	175	0	21	0	8	0	0	18	353	9	103	20	424	4	148	3	34	**91**	**100**
Polonnaruwa	88	523	2	20	0	7	0	2	0	58	4	208	0	7	0	21	0	0	9	291	1	42	12	310	3	49	2	57	**100**	**100**
Badulla	136	902	0	31	0	8	0	3	0	12	6	173	2	29	2	103	0	0	6	271	10	188	2	81	5	145	1	14	**76**	**100**
Monaragala	99	825	1	13	0	3	0	1	0	5	2	194	1	28	0	39	0	1	1	158	7	67	0	129	5	63	0	13	**90**	**100**
Ratnapura	319	3739	0	24	0	6	0	6	1	16	16	591	2	27	0	10	0	0	7	258	3	60	0	115	8	228	0	23	**97**	**100**
Kegalle	189	1683	2	35	1	4	0	4	0	24	11	241	0	10	0	10	0	0	19	431	5	63	0	12	4	176	0	6	**65**	**99**
Kalmunai	65	742	3	35	0	1	0	1	0	18	0	54	0	1	1	2	0	0	3	344	1	24	0	0	4	67	0	23	**100**	**100**
SRILANKA	**7301**	**59008**	**23**	**636**	**5**	**157**	**1**	**86**	**14**	**665**	**132**	**4616**	**14**	**558**	**6**	**355**	**1**	**7**	**175**	**7197**	**97**	**2010**	**63**	**2188**	**150**	**4279**	**25**	**636**	**92**	**98**

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

Table 2: Selected Vaccine Preventable Diseases & AFP 29th June– 05th July 2026 (27th 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	00	39	31	25.8%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps[2]	00	01	00	00	00	00	00	00	01	01	02	74	83	-10.8 %
Measles[3]	00	01	00	00	00	00	00	00	06	07	00	27	02	1250 %
Rubella[3]	00	00	00	00	00	00	00	00	00	00	01	00	04	-100 %
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	03	04	-25 %
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	17	12	41.6 %

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.

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

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