

NATIONAL GUIDELINE ON PREVENTION, CONTROL AND MANAGEMENT OF HUMAN RABIES

REVISED AND EXPANDED EDITION

2026



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Ministry of Health and Mass Media



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EPIDEMIOLOGY UNIT



**National Guideline on Prevention,
Control and Management of
Human Rabies:
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Rabies post exposure prophylaxis and prevention guideline committee

No.	Name	Designation / Institution
01	Dr Palitha Karunapema	Chief Epidemiologist, Epidemiology Unit
02	Dr Athula Liyanapathirana	Consultant Epidemiologist (Rabies Focal Point), Epidemiology Unit
03	Dr Hasitha Tissera	Consultant Epidemiologist, Epidemiology Unit
04	Dr Omala Wimalaratne	Senior Consultant Virologist
05	Prof Rohini Fernandopulle	Senior Professor of Clinical Pharmacology, KDU Ratmalana
06	Dr Kanthi Nanayakkara	Senior Consultant Virologist
07	Dr Ranjith Batuwanthudawe	Director, Health Promotion Bureau
08	Dr Niroshan Gamage	Director, Public Health Veterinary Services
09	Dr Rohitha Muthugala	Consultant Virologist, Medical Research Institute
10	Dr Sewwandi Abeywardana	Consultant Virologist, North Colombo Teaching Hospital
11	Dr Dhanushka Dasanayake	Consultant Immunologist, Medical Research Institute
12	Dr Vigeetha Vitharana	Consultant Virologist, Medical Research Institute
13	Dr Amila Gunsekera	Technical Advisor on Rabies - WHO
14	Dr Indumini Gunatilake	Associate Specialist in Community Medicine, Epidemiology Unit
15	Dr Darshanie Dissanayake	Public Health veterinary services
16	Dr Senal Fernando	Medical Officer, Health Promotion Bureau
17	Dr Chamila Abeywickrama	Medical Officer, Epidemiology Unit
18	Dr Nadeeka Sandanayake	Medical Officer, Epidemiology Unit
19	Dr. Kulanga Warnakulahewa	Senior Registrar, Community Medicine

Foreword

Rabies prevention and control programme in Sri Lanka has made significant progress over the years and is widely recognised for its sustained reduction in human rabies deaths. The national Rabies Post-Exposure Prophylaxis (PEP) programme plays a critical role in this achievement by ensuring timely, equitable, and effective access to life-saving interventions following exposure to potentially rabid animals.

The provision of rabies PEP services constitutes an essential public health responsibility of the Ministry of Health and is delivered through government health institutions across the country. National guidelines were introduced to standardise clinical and public health practices related to rabies prevention, with periodic revisions undertaken to reflect emerging scientific evidence and programmatic experience.

As the epidemiological pattern of rabies has evolved and new evidence has become available - particularly in relation to vaccines, immunoglobulin use, diagnostics, and observation of biting animals - the need to update the Rabies PEP guideline has become increasingly important. In addition, updated recommendations from the World Health Organization and the national goal of achieving zero human rabies deaths have necessitated a comprehensive revision of this guideline.

In response to these developments, the Ministry of Health has revised the Rabies PEP Guideline to ensure clarity, consistency, and practicality for health-care providers at all levels. We are confident that this revised edition will support health professionals in delivering safe, evidence-based, and high-quality rabies PEP services across the country.

The revision process has been informed by extensive stakeholder consultation, including clinical experts, public health professionals, and veterinary authorities, and is part of Sri Lanka's broader strategy to eliminate human rabies.

This guideline is intended for use by all categories of healthcare providers involved in the assessment and management of potential rabies exposures, including treating clinicians, nursing staff, public health staff, and health administrators. Through its widespread dissemination and consistent application, the Ministry of Health aims to further reduce rabies-related morbidity and mortality, ensuring a safer and healthier future for all Sri Lankans.

The successful completion of this publication reflects the dedication and voluntary commitment of many experts and institutions who contributed their technical expertise and time. We wish to extend our sincere appreciation to all contributors and reviewers for their valuable inputs and timely support. Appreciation is also extended to partner agencies for their assistance in the development of this important publication.

We trust that this revised Rabies PEP Guideline will serve as a valuable reference for health professionals and will contribute meaningfully to strengthening rabies prevention and control efforts in Sri Lanka.

Dr Asela Gunawardena

Director General of Health Services

Abbreviation

A&E	Accident and Emergency Unit
AEFI	Adverse Events Following Immunization
AGS	Alpha-gal Syndrome
ARV	Anti-Rabies Vaccine
BSL	Biosafety Level
CNS	Central Nervous System
CSF	Cerebrospinal Fluid
DAPH	Department of Animal Production and Health
dFAT (DFA)	Direct Fluorescent Antibody Test
DGHS	Director General of Health Services
ETU	Emergency Treatment Unit
ERIG	Equine Rabies Immunoglobulin
GBS	Guillain–Barré Syndrome
HIV	Human Immunodeficiency Virus
HRIG	Human Rabies Immunoglobulin
ICD-10	International Classification of Diseases, 10th Revision
ICU	Intensive Care Unit
ID	Intradermal
IgE	Immunoglobulin E
IM	Intramuscular
IU	International Unit
LFA	Lateral Flow Immunoassay
MOH	Medical Officer of Health
MRI	Medical Research Institute
MSD	Medical Supplies Division
NMRA	National Medicines Regulatory Authority
OIE	World Organisation for Animal Health (formerly Office International des Epizooties)
PCU	Primary Care Unit
PCEC	Purified Chick Embryo Cell Vaccine
PEP	Post-Exposure Prophylaxis
PHI	Public Health Inspector
PHVS	Public Health Veterinary Services
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
PVRV	Purified Vero Cell Rabies Vaccine
QC	Quality Control
RE	Regional Epidemiologist
RIG	Rabies Immunoglobulin
RNA	Ribonucleic Acid
RT-PCR	Reverse Transcription Polymerase Chain Reaction
ST	Skin Test
VTM	Viral Transport Medium
WHO	World Health Organization
WOAH	World Organisation for Animal Health

01 Introduction

Rabies is a zoonotic viral disease that is invariably fatal but nearly 100% preventable with proper post exposure prophylaxis (PEP). Rabies is transmitted by mammals, primarily dogs, followed by cats and, less frequently, wild animals in Sri Lanka. It continues to pose a significant public health threat in Sri Lanka. Over the years, substantial progress has been made in reducing human rabies deaths through the provision of timely PEP, dog vaccination, and strengthened surveillance.

In PEP, prompt wound care, timely administration of anti-rabies vaccines (ARV), and rabies immunoglobulin (RIG) when indicated, effectively prevent the infection following exposure to a potentially rabid animal.

This National Guideline on Rabies PEP has been developed according to the latest recommendations and incorporates updated scientific evidence, simplified risk categorization, and practical guidance to ensure that health care providers across all levels can assess exposure risk and administer appropriate prophylaxis with confidence. It also incorporates considerations for special populations such as immunocompromised individuals, user-friendly formats, case scenarios, and a photo gallery to enhance its applicability and usability in clinical settings.

This revised Rabies Post-Exposure Prophylaxis (PEP) Guideline is aligned with the World Health Organization's target of achieving zero human deaths from dog-mediated rabies by 2030. By incorporating the latest WHO recommendations, the guideline strengthens Sri Lanka's capacity to prevent rabies following an exposure.

This guideline provides comprehensive guidance on the assessment and management of human exposures to potentially rabid animals in Sri Lanka. It covers the full continuum of rabies post-exposure care, including initial wound management, exposure categorization, administration of anti-rabies vaccines and immunoglobulin, management of special populations, laboratory diagnosis of rabies, observation of the involved animal, surveillance, reporting and public-health response. The guideline applies to all levels of the health system and is intended for use in government health institutions, ensuring uniform standards of care across clinical, preventive, and field settings.

Purpose of the rabies post-exposure prophylaxis (PEP) guideline

- The purpose of this guideline is to provide standardized, clear, updated, and evidence-based directions for assessing rabies exposure and administering appropriate PEP in order to prevent rabies, a fatal but fully preventable zoonotic disease.

- It aims to ensure that all healthcare providers across clinical and public health settings can confidently determine the risk of animal exposure, correct wound care and timely delivery of anti rabies vaccination and immunoglobulin when indicated.
- It guides the management of special populations, including immunocompromised individuals, thereby strengthening the quality and equity of rabies prevention services.

02 Protocol for anti-rabies post exposure prophylaxis (PEP)

2.1 Initial management of a patient following an animal exposure

- Wounds should be washed immediately with soap and water, at least for 15 minutes. In an exposure to mucous membranes, it should be irrigated with water/ saline.
- Wounds should be cleaned thoroughly at the hospital with 70% alcohol or povidone iodine.
- Anti tetanus immunization should be administered when necessary (DT / aTd for children).
- Antimicrobials should be prescribed if necessary to control bacterial infection.
- Wound dressing could be done to prevent wound infection.
- If suturing is necessary in a case where Rabies Immunoglobulin (RIG) is indicated, it should be done after infiltration of the wound/s with RIG. Suturing should be delayed to allow diffusion of the immunoglobulin through the tissues.
- However, as a life saving measure, profuse bleeding could be arrested with a minimum number of sutures with minimum tension prior to infiltration with RIG.

It is essential to, screen the patient, animal concerned and the encounter before a decision is made regarding Rabies Post Exposure Prophylaxis (PEP)

Risk assessment before deciding PEP

1. Screening of the patient -

Category of exposure

- Major exposure – Category III
- Minor exposure – Category II
- No exposure – Category I

Medical history

- Immunocompetent / Immunocompromised
- History of previous PEP / PrEP with record
- History of allergies
- Bleeding disorders

2. Screening of the Animal

- Observable/ Unobservable
- Healthy / Unhealthy
- Any change in usual behaviour
- Rabies vaccination status

3. Incident /situation/ encounter analysis

- Provoke /Unprovoked
- Reliable history

2.2 Screening the patient

2.2.1. Categorization of the exposure

Main categories of exposure

- Major exposure – Category III
- Minor exposure – Category II
- No exposure – Category I

Major exposures: Category III

- Single or multiple bite/s or scratch/es with bleeding on any part of the body
- Contamination of mucous membranes with animal saliva
- Contamination of an open fresh wound/broken skin with animal saliva
- Wild animal bites or scratches

Minor exposures: Category II

- (i) Bites or scratches without bleeding on any part of the body
- (ii) Nibbling of uncovered skin

No exposure: Category I

- a) Contamination of intact skin with saliva of any mammal (even that of a proven rabid, suspicious, stray or wild animal)
- b) Petting, bathing or coming in contact with utensils of any mammal (even of a proven rabid, suspicious, stray or wild animal)
- c) Eating of leftovers which were previously eaten by an animal
- d) Drinking water from a water source (well / tank / sump) where a mammal had fallen / died
- e) Drinking raw milk of a rabid cow or goat
- f) Bites from cold blooded animals (reptiles, amphibians, fish) and pecks by birds
- g) Bites by House rats identified with confidence

2.2.2. Medical history

It is essential to inquire about the patient's medical history prior to starting PEP. Immunocompromised patients should be evaluated individually as the treatment regimen will be different. For patients with confirmed drug allergy a prior history of anaphylaxis, PEP and with confirmed drug allergy should be given where emergency management facilities are available.

2.2.3. History of previous PEP / PrEP

Before deciding on PEP, patient's previous ARV /RIG treatment records should be reviewed

2.3 Screening the animal

The health status of the animal at the time of exposure is a crucial factor to consider. If the animal is apparently ill or shows any change in behaviour, post-exposure prophylaxis (PEP) should be initiated based on a risk assessment, irrespective of its vaccination status.

History of animal vaccination is another important factor in deciding the PEP.

Appropriately immunized animals - Appropriately immunized animal is considered having had 2 consecutive booster doses of vaccines given within the last 2 years and the last booster dose given within one year and before one month of the exposure.

For Newborn Puppies / kittens – First dose should be given as soon as they open their eyes. A second dose should be given in one to two months and annually thereafter. Puppy is considered appropriately immunized six weeks after the 2nd dose (booster dose).

Animal (applied only for dogs and cats) observation period is 14 days from the day of the exposure. Patient must be clearly advised to closely monitor the animal for healthiness and behavioural changes during the observation period. Animal should be observed in their natural / habitual environment.

During the observation period if the animal becomes sick, develops any suspicious / deviation from its normal behaviour, goes missing or dies, the patient should be advised to report to the hospital immediately. In case of death of the animal, the patient should be encouraged to send the head of the animal for laboratory confirmation/exclusion of rabies (Refer Chapter 3.2. on Transport of specimen).

2.4 Incident /situation/encounter analysis

An unprovoked animal bite is highly suspicious but a provoked bite does not exclude rabies risk. It is important to have a reliable history, especially in an encounter involving a child. The decision to start PEP or not should not solely depend on the incident.

When PEP is indicated

- Patients in the major category should be given rabies immunoglobulin (RIG) followed by a course of anti-rabies vaccine (ARV)
- Patients in the minor category should be given only a course of ARV

2.5 Management of patients with a minor exposure, without a history of previous PEP/PrEP

Only Anti-rabies vaccine (ARV) is indicated for management of minor exposures

If the animal is apparently healthy at the time of the incident, observable by a responsible person, with a reliable history and has documented proof of being properly vaccinated, PEP can be delayed while observing the animal for healthiness / deviation from its normal behaviour for 14 days from the day of the exposure.

2.5.1 If the animal becomes apparently sick, develops any behavioural changes, goes missing or dies, during the observation period, the patient should be advised to report to the hospital immediately to commence PEP.

2.5.2 If the animal is sick at the time of exposure, irrespective of vaccination status, start PEP.

2.5.3 If the animal develops behavioural changes or become sick but observable (irrespective of vaccination status) initiate PEP while observing the animal. Discontinue PEP if the animal is healthy after 14 days.

- 2.5.4 If the animal is confirmed rabid by laboratory diagnosis or unobservable (stray animal, animal dead, killed, missing) irrespective of the vaccination status, initiate PEP and continue the full course.
- 2.5.5 In a situation where the patient presented late to the hospital, PEP should commence as a modified 4 site ID, ARV schedule after the risk assessment.

2.6 Management of patients with a major exposure, without a history of previous PEP/PrEP

Management of major exposures Category III – Both rabies immunoglobulin (RIG) and ARV are indicated

- 2.6.1 If the animal concerned is identified with confidence, apparently healthy, and observable with a reliable history and has documented proof of being appropriately immunized, PEP could be delayed while observing the animal for healthiness / deviation from its normal behavior for 14 days from the day of the exposure
- 2.6.2 In situations, with a reliable history where the animal is apparently healthy, and observable, but not appropriately immunized,
- If wounds are not in the head, neck and face region, tips of fingers and toes and genitalia If wound/s do not need major surgical manipulations
 - If bite was due to a provoked situation
 - If the patient/ parent of a child is responsible and reliable If patient is not immunocompromised the patient could be managed with a modified ID 4 site schedule (4-2-2-0-2) in place of RIG, while observing the animal for 14 days for healthiness / behavioral changes.

Clear instructions should be given to the patient to report back to hospital immediately, if the animal becomes sick, deviates from its normal behaviour, goes missing or dies during the observation period.

If the patient reports back within 7 days of initiation of modified ARV ID 4 site schedule, wound/s should be infiltrated with RIG and a fresh course of 2 site ID ARV schedule should be initiated.

If a dose of ARV had been given within 24 hours prior to the infiltration of RIG, that dose of ARV could be considered as the D 0 of the fresh schedule.

If the patient reports back after the day 7 of initiation of ARV, modified 4 site ID ARV schedule should be continued with an additional dose of ARV on day 14. In such situations RIG is not recommended.

2.6.3 In following situations, PEP should be initiated immediately with infiltration of rabies immunoglobulin (RIG) in and around the wound/s and followed by a full course of anti-rabies vaccine (ARV).

- Animal is sick / showing behavioural changes (irrespective of the vaccination status)
- Animal diagnosed as rabid (confirmed by laboratory diagnosis)
- Animal is unobservable (animal dead, killed, missing or stray animal)

2.6.4 In case of mucous membrane exposures, in a site where it does not permit washing with soap and water, irrigate the area with copious amounts of normal saline/clean water.

2.6.5 In the case of eye involvement, seek urgent ophthalmology opinion to assess intraocular injuries. If RIG is indicated, advise ophthalmology team to infiltrate into the site. If it is not possible, calculate the full RIG amount according to the body weight of the patient and give it as intramuscular injection.

2.6.6 In other mucous membrane involvement, such as genitalia, lips, nasal and oral cavity, irrigate the wound with RIG or administer RIG to nearest anatomically feasible site.

Both RIG and ARV should not be administered at the same site.

2.7 Management of patients with a previous history of rabies PEP/PrEP

2.7.1 Patients presenting with a reliable history and documented evidence of full or a partial course of ARV (3 doses of ID /IM ARV), irrespective of the time duration, for both major and minor exposures to healthy, observable animals (irrespective of the vaccination status), PEP could be delayed while observing the animal for 14 days.

2.7.2 The patient should be advised to report to the hospital immediately to commence PEP if the animal:

- **becomes sick,**
- **deviates from its normal behaviour, goes missing or**
- **dies during the observation period,**

2.7.3 Patient with a documented evidence of a full course of ARV presenting with an exposure to a proven rabid, suspicious, sick, dead or unobservable animal,

- a) where the exposure occurs within 90 days, neither RIG nor ARV is needed. Only wound treatment is required.
- b) where the exposure occurs after 90 days of the previous course of PEP (irrespective of the time duration), RIG is not indicated

ID ARV 2 sites or IM ARV one site, should be given on D0 and D3 as boosters.

2.7.4 As an alternative to this, the patient may be offered with a single visit 4 site intradermal doses (0.1ml ID at each site) over deltoids and anterolateral thighs areas. Patient with a documented evidence of a partial course of ARV (3 doses) presenting with an exposure to a proven rabid, suspicious, sick, dead or unobservable animal,

- RIG is not indicated irrespective of the time duration from the previous course of ARV.
- If the patient presents with an exposure occurring within one month from the initiation of the previous course, it could be completed with the D30 ARV dose.
- If the patient presents within 10years - ID ARV 2 doses each or IM ARV one dose each should be given on D0 and D3 as boosters.
- If the patient presents after 10years – ID / IM ARV full course is recommended.

Table : 1 - Summary of Post Exposure Prophylaxis depending on the category of exposure

Immunization Status exposure Category	Non-immunized	Partially immunized (3 doses of ARV taken)	Fully immunized	Pre-exposure prophylaxis taken	Immuno-compromised patient
No exposure Category I	None	None	None	None	None
Minor exposure Category II	ARV 2 site ID schedule	ARS not indicated	ARS not indicated	ARV 2 site ID boosters -2 doses	ARS+ARV IM 4 doses schedule
Minor exposure Late presentation	ARV modified 4 site ID schedule	≤ 10 years of PEP - ARV 2 site ID boosters -2 doses > 10 years of PEP ARV 2 site ID schedule	ARV 2 site ID boosters -2 doses		
Major exposure Category III	ARS+ARV 2 site ID schedule				ARS+ARV IM 5 doses schedule

2.8 Anti rabies PEP for immunocompromised patients

This category includes:

- patients on chemotherapy,
- on cytotoxic drugs,
- on long-term steroids,
- on long-term anti-malarials,
- positive for HIV/AIDS,

- organ transplant recipients and stem cell transplant patients on immunosuppressive therapy etc.
- Intradermal schedules of ARV are not recommended for immunocompromised patients and IM-ARV schedule is recommended.
- These patients may require RIG even for minor exposures.
- In high risk situations, after obtaining expert advice, rabies antibody assessment could be offered for these patients.

2.9 Rabies Immunoglobulin (RIG)

- If the patient reports late, RIG could be given up to 3 months after exposure, if the patient has not taken the anti rabies vaccine.

2.9.1 Types of RIG available in Sri Lanka at present

- Equine rabies immunoglobulin (ERIG)
- Human rabies immunoglobulin (HRIG)

2.9.2 Dosage of RIG

- Maximum dose of Equine rabies immunoglobulin (ERIG) 40IU/Kg body weight
- Maximum dose of Human rabies immunoglobulin(HRIG) 20IU/Kg body weight

There is no minimum dose

2.9.3 Administration of equine rabies immunoglobulin (ERIG)

- The present WHO guideline does not recommend skin testing (ST) before administration of Equine Rabies Immunoglobulin (ERIG), as such tests poorly predict severe adverse events and their results should not be the basis for non-administration of ERIG when indicated.
- However the treating medical officers should be prepared to manage anaphylaxis, which although rare, could occur during the administration of ERIG which is heterologous serum.
- The entire immunoglobulin dose or as much as anatomically feasible should be infiltrated carefully into or as close as possible to all wounds.
- WHO no longer recommends injecting the remainder of the calculated RIG dose IM at a distance from the wound/s, as evidence suggest that there is no or little additional protection against rabies as compared with infiltration of the wound/s alone.
- In situations with multiple bites, where the volume of RIG is insufficient for infiltration in and around all wounds (especially in children), RIG could be diluted with sterile N. Saline up to twice or a maximum of 3 times.
- Administration of ERIG could be done in a centre where emergency care facilities are available. i.e. PCU, ETU, A&E, ICU etc.

(PCU-Primary care unit, ETU- Emergency treatment unit, A&E- Accident and Emergency, ICU- Intensive care unit)

- Drug of choice for management of anaphylaxis is 1:1000 adrenaline, 0.5ml in adults and 0.01ml/kg with a maximum of 0.3ml in children given intramuscularly (IM) into the mid antero lateral thigh immediately. This dose can be repeated in 5 to 15 minutes or even earlier if necessary. Mild sensitivity reactions could be managed with antihistamine therapy. Oral or parenteral steroids should be best avoided.
- ARV should be administered preferably on the same day after RIG, but at a different site.

2.9.4 Administration of human rabies immunoglobulin (HRIG)

HRIG is a very costly biologic with limited availability. Hence this product should be used strictly for the following indications, if / when available.

1. History of severe allergic reaction/anaphylaxis to red meat or cow's milk
2. Patients who developed severe allergic reaction/anaphylaxis while infiltrating wounds with ERIG, before completing the wound infiltration
3. Patients who report back later with a missed wound/s, after infiltration of wound/s with ERIG

2.10 Anti Rabies Vaccines (ARV)

Following anti rabies vaccines are registered in Sri Lanka.

- a) Purified Vero cell rabies vaccine (PVRV)
- b) Purified chick embryo cell culture vaccine (PCEC)

2.10.1 Intradermal (ID) schedules of ARV

- WHO recommends the use of ID schedules as there is a global shortage of ARV and for developing countries, where cost of vaccines is a major limiting factor. Intradermal route is safe and immunogenic in equivalent to intramuscular route.
- The recommended ID dose is 0.1ml per site for both PCEC and PVRV.
- For all age groups, ID injection sites are the deltoid region, anterolateral thigh or suprascapular regions.
- It is recommended to use fixed needle 1ml disposable syringes for intradermal administration of ARV to minimize vaccine wastage.

2.10.2 The 2 site ID schedule (2-2-2-0-2 schedule)

The standard schedule used in government hospitals: One dose each (0.1ml) is given at 2 sites (deltoids) on D0, D3, D7 and D30.

2.10.3 The modified 4 site ID schedule (4-2-2-0-2 schedule)

- One dose each (0.1ml) is given at 4 sites on day D0 (deltoids and lateral thighs)
- One dose each (0.1ml) given at 2 sites (deltoids) on D3, D7 and D30.

This schedule could be recommended for patients with minor exposures with late presentation, borderline exposures and major exposures from healthy observable domestic animals as stated in 2.6

2.10.4 Precautions that should be taken when using ID- ARV schedules.

All injections should be administered only by trained staff under supervision of a medical officer.

- Once the vaccine is reconstituted, the contents should be used as soon as possible (preferably within 6 hours, stored at 2 - 8°C).
- Separate disposable syringes and needles should be used for each patient.
- If a dose of ARV has gone subcutaneously (where the bleb is not observed), an extra dose of ID ARV is recommended.

2.10.5 Intramuscular (IM) schedules of ARV

- For major exposures: 5 dose regimen with RIG

IM-ARV one dose* each on D0, D3, D7, D14, & D30

This schedule is recommended for patients who are immunocompromised and for international travelers.

- For minor exposures: 4 dose (2-1-1) regimen

2 doses * of IM-ARV one in each deltoid on D0, followed by 1 dose* each on D7 & D21.

*1 dose - PCEC 1ml (1 vial) / PVRV 0.5ml (1vial)

- IM injections should be given into the deltoid muscle or into the anterolateral aspect of the thigh in small children.
- Administration of ARV on the buttocks is not recommended as absorption is poor

2.11 Management of patients with delayed presentation for ARV doses

Getting delayed for ARV vaccination should be discouraged. However, depending on the urgency of treatment, recommendations will be as follows.

Table 2 : - Rabies Post Exposure Prophylaxis for different delays in presentations

ARV dose	Recommendation
D3 dose	When patient delays up to one week give ARV on that day as D3. Reschedule D7 and D30 to match the delay. When patient delays more than one week take that day as D0 and reschedule the rest of the ARV doses
D7 dose	When patient delays up to one week give ARV on that day as D7. Give D30 as scheduled. When patient delays more than one week give 4 site ARV on that day as D7 and reschedule D30 to match the delay
D30 dose	Give D30 dose on the day he presents.

2.12 Important points to be noted

- Ideally RIG should be administered before starting on ARV.
- Pregnancy/breast feeding is not a contraindication for RIG (ERIG/HRIG) and ARV therapy when indicated.
- All patients who receive rabies PEP should be given a document/card, clearly stating the date, month & the year of vaccination, the type of vaccine used and RIG given or not.
- In situations where the animal is not vaccinated, encourage the owner to vaccinate the animal concerned after the observation period.
- Laboratory confirmation of rabies should always be encouraged.
- Human to human transmission of rabies has not been reported (except through corneal or organ grafts)
- In a case of suspected human death due to rabies, it is mandatory to order a postmortem and fresh brain (without preservatives) sent to MRI for laboratory confirmation.
- For any person who has had direct or indirect contact with a rabies patient, PEP is not recommended except in special situations. Please refer to General Circular No: DGHS/Circular/2016-127(MRI-Gu-HR) Guidelines to be followed in a case of human rabies/death and disposal of the body.
- Any allergic reactions following RIG/ARV should be documented on the patient's immunization card for future reference.

Please note that all health care staff managing anti rabies PEP patients should strictly adhere to the guidelines given in this protocol. For any clarification, contact Dept of Rabies and Vaccine QC, MRI. Telephone numbers: 011-2693532-4. It is essential that all institutions using RIG and ARV should send a monthly return (Annexure 1) in 03 copies and sent to the following officers before 5th of the following month.

1. Consultant Virologist, Dept. of Rabies and Vaccine QC, MRI
2. Director, Public Health Veterinary Services, 6th Floor, 555/5, Elvitigala Mw, Colombo 05
3. Chief Epidemiologist, Epidemiology unit
4. Regional Epidemiologist

Any serious adverse reactions following rabies PEP should be informed in writing to Chairman/ NMRA, Virologist/Dept. of Rabies and Vaccine QC, MRI, Director/MSD and Chief Epidemiologist, Epidemiology Unit.

Adverse reactions also should be reported under the AEFI section of the monthly return on mammal bites from hospital PEP units.

Summery

In an animal bite/scratch or mucous membrane exposure to saliva, perform a risk assessment of the animal, patient and the situation based on the risk assessment decide the appropriate rabies post exposure therapy regimen.

Adequate wound washing for 15 minutes is essential with proper wound management

Start PEP accordingly

No exposure (Category I) - Reassure

Minor exposure (Category II)- ARV

Major exposure (Category III) -RIG +ARV

Patient education on,

Importance of follow up vaccination as schedule

Animal observation period

When to seek medical advice if animal sick,died or missing

Follow up

Inquire on animal's wellness

03 Laboratory diagnosis of rabies

Laboratory diagnosis is performed to confirm/exclude rabies in both humans and animals suspected of rabies. At present in Sri Lanka both antemortem and postmortem diagnosis is performed for humans, while only postmortem diagnosis is performed for animals.

3.1 Laboratory diagnosis

Purpose of Laboratory Diagnosis

To;

- (i) Confirm/exclude rabies in suspected animals (dogs, cats, wildlife, livestock)/ human
- (ii) Guide post-exposure prophylaxis (PEP) decisions in exposed humans
- (iii) Support rabies surveillance and control programmes

3.2 Sample collection & transport

Type of specimen:

For animal rabies testing - postmortem brain tissue. Send the entire head, or the whole carcass for small animals (E.g. squirrels, house rats, bandicoots).

For human rabies testing-

- Antemortem specimens
 - Pooled saliva
 - CSF sample
- Postmortem specimens
 - Whole human brain without any preservatives

Procedure of collecting pooled saliva sample

Wear appropriate PPE (Gloves, Mask, eye protector/face shield). Collect the patient's saliva using a needleless syringe and stored in a VTM tube at 4°C temperature. Repeat 2 more times of this procedure in 2-4 hours intervals and collect the saliva into the same VTM tube. Send the pooled saliva sample to the testing laboratory (MRI- Department of Rabies) as soon as possible.

Collection and transport of human brain specimens:

Submit whole brain tissue (without preservatives) with the patient's clinical history to the Medical Research Institute (MRI) for laboratory diagnosis. Transport the specimen in a leak-proof container packed in ice.

Do not send blood or cerebrospinal fluid collected post-mortem for rabies diagnosis.

Transport of animal brain specimens:

Send specimen as soon as possible preferably within 24 hours of death.

Place the head in a primary leak-proof bag / container, then in a secondary container with ice-ensuring the specimen itself does not directly come into contact with ice. If the sample could reach the testing laboratory within 6 - 8 hours of death packing in ice is not mandatory.

Precautions in handling:

Decapitation should be carried out with appropriate PPE (apron, eye protection, heavy-duty gloves, mask/cloth, boots) to minimize exposure to blood and body fluids.

Avoid transporting specimens in formalin or sending live animals.

At present the testing laboratories are:

Medical Research Institute (MRI) Colombo

Rabies Laboratory, National Hospital Galle

Faculty of Veterinary Medicine and Animal Sciences, University of Peradeniya

3.3 Diagnosis

A. Specimen

Brain smears from at least two locations:

- Brain stem
- Cerebellum
- hippocampus (Ammon's horn)

B. Biosafety

- BSL-2/3 for sample handling
- PPE: gloves, gown, eye protection, mask
- Minimize aerosol generation

C. Diagnostic Methods

- i. Direct smear test for Negri bodies (histopathology)
 - Negri bodies in neurons (Seller's stain)
 - Found in hippocampus, Purkinje cells, medulla
 - Not as sensitive as dFAT, so no longer recommended as a sole diagnostic tool
- ii. Direct Detection of Rabies Virus Antigen (dFAT / DFA)
 - Gold standard recommended by WHO & WOA

- Detects rabies virus nucleoprotein antigen in brain smears
- Requires fluorescence microscope
- High sensitivity and specificity

Lateral-Flow Immunochromatography, and RT-PCR, as necessary or in special cases and available at MRI.

- iii. Lateral flow immunoassays (LFA)
 - Variable accuracy
 - Not a replacement for dFAT in official confirmation
- iv. Molecular Detection RT-PCR
 - Detects rabies virus RNA from brain tissue/ CSF/pooled saliva
 - Useful for confirmation or degraded samples
 - Sequencing- For strain typing and epidemiological studies

D. Interpretation

Positive: Immediate public health response (PEP for exposed humans)

Negative: If good-quality samples tested by dFAT, rabies unlikely

3.4 Data reporting

Upon a positive result, the following actions are mandatory:

- Inform the sender of the sample.
- Notify the area Medical Officer of Health (MOH) and Public Health Inspector (PHI).
- Alert the institution providing post-exposure prophylaxis (PEP).
- Inform any other persons exposed.
- Exposed animals: If unvaccinated should be placed under strict isolation and monitored for six months. If vaccinated, revaccinate and observe for 45 days, under guidance from MOH/ PHI

04 Advice to the patients on observation of suspected rabid animals

4.1 Introduction

This chapter provides medical officers with clear guidance to advise patients regarding observation of animals suspected of rabies following a human exposure and outlines how animals should be confined, monitored and assessed.

4.2 Animals eligible for observation

- Dogs or cats are apparently healthy and having normal behaviour at the time of the exposure and reliably observable on a daily basis by the patient or guardian.

Observation is not applicable to:

- Animals that are already showing signs of any illness or behavioural changes.
- Animals with a history of contact with a rabid/suspected animal where secure confinement is not possible.
- Species other than dogs or cats (e.g., wild mammals, livestock).

4.3 Observation criteria

- The standard period is 14 days on a daily basis, starting from the day of the exposure.
- If the animal shows signs of any illness, deviation from its usual behaviour, goes missing or dies during this period, advise the patient to report back to the hospital immediately.
- Dog / cat should be observed in its usual habitat.
- Unnecessary handling should be avoided and not be vaccinated during the observation period.

4.4 Common signs suggestive of rabies

- Refusal of food / water.
- Change of gait - ataxia, paresis, or paralysis.
- Behavioural changes: unexplained aggression, fear, unusually docile
- Excessive salivation and difficulty in swallowing (E.g resembles a bone stuck in throat)

- Change in vocalization: pitch, persistent barking/howling.
- Neurological signs: tremors, seizures, or disorientation.

Initial signs in the animal may include,

- Any behavioural change
- Lethargy
- Fever
- Refusal of food and water
- Difficulty in swallowing
- Vomiting, diarrhoea
- Excessive salivation
- Frequent straining to urinate and/or defecate
- Changes in sound of the bark
- Dropped jaw

There are two clinical forms of rabies in carnivores such as dogs and cats; the furious form and the dumb form.

Animals with furious rabies can exhibit signs such as,

- Increased aggressiveness and barking
- Fearfulness
- Restlessness
- Aimless wandering
- Biting anything encountered
- Convulsions/fits in the body

Animals with dumb rabies would show,

- Confused like clinical signs such as withdrawal from the society.
- Partial or complete paralysis of different parts of the body including the limbs, resulting in inability to walk.

Both forms eventually end up in death.

If any suspicious signs are observed in a dog / cat under observation it should be restrained. This is to observe any progression of the condition and to avoid risk of further exposures.

05 Management of suspected rabies patients

Providing compassionate support during advanced rabies infection.

5.1 Introduction to palliative care

Rabies is a viral disease that affects the central nervous system, leading to progressive and fatal encephalitis. Once clinical symptoms appear, rabies is invariably fatal. As such, the focus for patients with confirmed symptomatic rabies is essentially palliative, aiming to provide comfort, dignity, and support to both patients and their families.

Palliative care for rabies patients is centered on compassion, symptom relief, and holistic support. By focusing on comfort and dignity, healthcare providers can help patients and their families navigate the final stages of this tragic disease with respect and empathy.

5.2 Principles of palliative care in rabies

Palliative care for rabies patients centers on relieving distressing symptoms, supporting emotional and psychological needs, and assisting families through this stressful situation.

These patients could be managed in any medical facility with inward care. (It is not necessary to transfer these patients to any higher level / specialized healthcare facility)

Patients should be managed in a quiet and dimly lit environment to minimize external stimuli which could trigger spasms and distress.

Clinical staff should take adequate precautions which includes PPE to minimize the risk of exposure.

5.3 Management of symptoms

- **Pain Relief:** Rabies patients often experience severe pain, muscle spasms, and discomfort. Opioids and other analgesics are administered to alleviate pain and suffering.
- **Hydrophobia** (difficulty in swallowing /fear of water) and **aerophobia** (fear of air) are hallmark symptoms that will cause distress, confusion and delirium. Sedatives and anxiolytics help in managing distress, agitation and hallucinations.
- **Seizure control:** anticonvulsants may be used to control seizures and involuntary movements.
- **Respiratory support:** as respiratory failure is common in late-stage rabies, supportive measures such as oxygen therapy may be provided.

- Nutritional and hydration needs: while swallowing is impaired, intravenous fluids may be considered for hydration, however, the focus remains on comfort rather than prolonging life.

5.4 Psychosocial and emotional support

The diagnosis of rabies is devastating for patients and families. Palliative care addresses psychological distress, fear, and grief. Counselling, clear communication about the disease trajectory, and emotional support are essential. Cultural and spiritual needs should be respected and incorporated into care planning.

5.5 Family involvement and support

Families play a crucial role in the care and emotional well-being of rabies patients. Healthcare staff should provide guidance on caring for the patient, coping strategies, and bereavement support. Education about infection control is important to protect caregivers.

5.6 Ethical considerations

Since rabies is universally fatal once symptoms develop, aggressive interventions should be avoided. Decisions about hydration, nutrition, and sedation should be made collaboratively, respecting the patient's and family's wishes and sociocultural values.

5.7 Differential diagnosis for paralytic rabies

Characterized by progressive, ascending flaccid paralysis that can resemble other neuromuscular disorders.

Guillain-Barré Syndrome (GBS):

This autoimmune disorder is a major mimic of paralytic rabies, especially when an animal exposure history is absent. Both cause ascending paralysis, but GBS often lacks the fever and bladder dysfunction seen in paralytic rabies.

Botulism

This rare condition, caused by the toxin, leads to descending paralysis.

Autoimmune encephalitis, brain tumors, and strokes can present with neurological deficits that may overlap with paralytic rabies.

Metabolic causes

Disorders such as severe hypoglycemia or thiamine deficiency can cause altered mental status and neurological deficits.

History is paramount: Clinicians should pursue a detailed history, including any potential animal exposure, no matter how remote. A high degree of suspicion is crucial.

Judicial postmortem is mandatory for rabies suspected deaths.

06 Rabies pre-exposure prophylaxis

Rabies pre-exposure prophylaxis (PrEP) is a series of rabies vaccine doses given before exposure to the rabies virus to a certain group of people.

People who are in higher risk of exposure to rabies virus, like laboratory staff handling live rabies virus, veterinarians and support staff, rabies control staff (vaccinators), wild life officers, employees in animal quarantine premises and zoological establishments etc. and those who travel to parts of the world where rabies is common and access to medical care is limited also may consider pre-exposure prophylaxis.

At present, in Sri Lanka the recommended schedules are ID 0.1ml single dose on D0, D7 & D28 or IM-ARV- single dose (1 vial) on D0, D7 & D28.

A single booster dose is given 1 year after the primary course. Additional booster doses are given once every 5 years.

Administration of RIG is not indicated in persons on pre-exposure therapy following an exposure.

Exposed patients should only be given additional doses of ID 2 sites or IM- ARV 1 dose each on D0 and D3 as boosters even in a case of a major exposure to a confirmed rabid animal.

07 Management of adverse events following rabies vaccines and immunoglobulin therapy

Rabies is a disease that is almost universally fatal in the absence of adequate post-exposure prophylaxis (PEP). Therefore, unlike other vaccines, the rabies vaccine does not have absolute contraindications for PEP. However, it is imperative that all medical officers are aware of adverse events following anti-rabies vaccine (ARV) and rabies immunoglobulin (RIG) to improve vaccine safety.

The cell culture anti-rabies vaccines currently used in Sri Lanka are generally safe and well tolerated. The available vaccines are purified chick embryo cell vaccine (PCEC) and purified Vero cell rabies vaccine (PVRV).

Rarely, recipients may develop adverse effects depending on the type of vaccine used and the route. Most adverse events occur within 3 days of vaccination and often resolve spontaneously within 1-3 days of onset.

7.1 Mild adverse events following ARV

Local reactions such as pain, redness, itching or induration at the injection site are more frequent following intradermal vaccination compared to intramuscular.

Systemic mild adverse reactions include headache, fever, lymphadenopathy, allergic reactions and flu-like illness. In addition, gastrointestinal symptoms such as nausea, vomiting, diarrhoea, abdominal pain and musculoskeletal symptoms such as myalgia or arthralgia have also been reported. Incidence is less frequent compared to local reactions. Adverse reactions may occur during both primary and booster immunizations with no observed difference in frequency.

7.2 Severe adverse events

Severe adverse events, including anaphylaxis are rare. PVRV is preferred in patients with severe hens' egg allergy, as trace amounts of residual protein (ovalbumin) may be present in the PCEC vaccine. However, as the amount is only trace, the PCEC vaccine is not contraindicated in such persons and vaccine may be administered under close observation. Other residual ingredients in rabies vaccines include neomycin, amphotericin, polygeline and gelatin. Specific reports of vaccine-induced anaphylaxis due to antimicrobials in rabies vaccines are absent. However, the rare patients who have experienced anaphylaxis confirmed to be due to these antimicrobials may require close observation during vaccination. Conversely, those who experienced contact dermatitis alone with these agents do not require any precautionary measures.

Patients with primary mammalian meat allergy or alpha-gal syndrome (AGS) may develop allergic reactions including anaphylaxis, due to gelatin in vaccine preparations. AGS is due to IgE to galactose-alpha-1,3-galactose (alpha-gal), which is an oligosaccharide characterised by delayed allergy to red meat. Gelatin and bovine serum albumin-free vaccines are recommended for patients with these allergies. In the absence of such products, specialist advice should be sought promptly since vaccination should not be delayed.

Anaphylaxis must be recognised early and treated promptly with adrenaline (refer management protocol - Annexure I). All units that administer rabies vaccines should therefore be equipped with facilities to manage anaphylaxis. Anaphylaxis should be reported promptly to the Epidemiology Unit, NMRA, MRI and MSD as postexposure prophylaxis cannot be interrupted and safe alternatives should be sought. For further management purposes the Department of Immunology, and Department of Rabies and Vaccine QC, MRI should be contacted.

Serum sickness-like reactions are uncommon following both PCEC and PVRV vaccines. Concomitantly administered rabies immunoglobulin may be the reason for the reported cases that occur 7- 10 days after the initial dose. In such instances, it is important to reassure patients and provide symptomatic treatment (avoiding steroids). The continuation of the course of ARV should not be interrupted where indicated.

Although a few case reports of temporally associated Guillain-Barré syndrome or acute disseminated encephalomyelitis exist, causality has not been established to date.

7.3 Adverse reactions to rabies immunoglobulins

Human rabies immunoglobulin (HRIG) may cause local reactions, such as pain, tenderness, erythema and induration at the injection site. The commonest systemic reaction reported is headache.

Equine rabies immunoglobulin (ERIG) may also cause local and systemic reactions. There are reported cases of hypersensitivity to equine rabies immunoglobulin and anaphylaxis could occur at any stage of ERIG administration. Therefore, ERIG should be administered under close supervision at a place such as the ETU or the PCU, especially in patients with a history of an allergy to mammalian meat. Skin testing before administration is not recommended currently. Serum sickness-like reactions following rabies immunoglobulin have been reported. The incidence appears to be less in children younger than 10 years of age.

Mild fever, headache and malaise could be due to the rabies vaccine rather than the immunoglobulin since both are administered concomitantly to these patients.

All serious adverse events following either ARV or RIG should be reported to the NMRA for investigation.

08 Counselling, health education and the public health response

This chapter provides practical guidance for frontline health staff on patient counseling, health education, surveillance, notification, and the coordinated public health response.

Counselling begins at first contact and continues through follow-up to ensure correct initial wound management, timely post-exposure prophylaxis, correct animal observation, and completion of vaccination.

8.1 Counselling and health education

A) Goals of counselling

- Provide reassurance, ensure understanding of risk, and initiate post-exposure prophylaxis immediately.
- Ensure proper initial wound management and completion of the full course of all recommended anti-rabies vaccine doses and, when indicated, administration of rabies immunoglobulin.
- Provide clear instructions on observation of the biting animal where relevant with clear advice on when to report to the treatment hospital.

B) Counselling checklist (ask, verify, guide)

Table 3 : - Counselling Check List

No	Topic	Key prompts and actions
1	Event details	“Please tell me exactly what happened.” Confirm bite, scratch, or lick on broken skin or exposure of intact mucosa, and time since exposure. If uncertain, manage as an exposure.
2	Animal identity	Dog, cat, or other; domestic or free-roaming. If domestic, reconfirm identity (colour, size, collar, owner name and address).
3	Initial wound management	Wound should be properly cleaned in the hospital even if the patient had cleaned the wound before coming to the hospital. Demonstrate and explain: wash with running water and soap for at least 15 minutes, then clean with povidone-iodine or 70% alcohol (surgical spirit). No lime, chilli, ash, herbal pastes, oil, powders or any other home remedies.
4	Post-exposure prophylaxis plan	Explain the vaccination schedule and the importance of retaining the vaccination card. Write dates clearly on the patient’s card. When RIG is indicated, explain how it will be given.

5	Advice on completion of the course	Please do not miss any dose. If you miss one, come as soon as possible, we will continue the course of vaccine. Treatment can continue at any hospital providing PEP. Please bring the vaccination card. Please come for the due dose even if you misplace the card.
6	Animal vaccination history and observation	Ask vaccination history of the animal and request any vaccination record (make sure the record belongs to the biting animal). Ask whether the animal was apparently healthy at the time of exposure. Instruct to report to the treatment hospital without delay if the animal becomes ill, dies, or goes missing. Do not vaccinate the animal during the observation period.
7	Any exposed household members and neighbours	If anyone else was bitten or scratched by the same animal, please ask them to come for treatment immediately."Promote responsible dog ownership (annual vaccination, registration, restraint, consider sterilization).
8	Sending the head of the animal for testing if the animal dies during the observation period.	Instruct how decapitation should be carried out with appropriate PPE (apron, eye protection, heavy-duty gloves, mask, boots) to minimize exposure to blood and body fluids. Instruct how to pack the specimen and transport to the laboratory as per chapter 3.
9	What not to do	Do not frighten the person with features of human rabies at the clinic visit. Do not vilify the dog or owner; keep the conversation factual and respectful.

8.2 Surveillance and public health response

8.2.1 Situation and Legal Context

In Sri Lanka Rabies remains predominantly dog-mediated. Despite free access to post-exposure prophylaxis (PEP), occasional human deaths occur. The National policy aims to prevent all human deaths from rabies and to eliminate canine rabies through coordinated One Health approach.

Public-health interventions are supported mainly by the Rabies Ordinance of 1894, the Quarantine and Prevention of Diseases Ordinance No. 03 of 1897, and other ordinances and subsequent amendments. Subsequently local-authority may adopt by-laws within the provisions of ordinances.

8.2.2 Reporting, Notification and Surveillance

A. Human rabies surveillance

ICD 10 Classification for human rabies – A 82 (for further details refer ICD 10, Volume 1, WHO, 1992)

Surveillance case definition

An acute neurological syndrome (encephalomyelitis) characterized by forms of hyperactivity in the majority of subjects (furious rabies) or paralytic syndromes seen less often (dumb rabies) which progresses towards coma and death usually by respiratory failure, within 10 to 14 days after

developing the first symptom, if no intensive care is instituted. An exposure could be bites, scratches, contamination of mucous membranes or contamination of an open wound with saliva from a suspected rabid animal which usually should be obtained from the patient's medical history. The incubation period may vary from less than 1 week to more than 1 year, but usually falls between 30-90 days.

Case Classification

- Suspected: A case that is compatible with the surveillance case definition.
- Probable: A suspected case with a history of contact with suspected rabid animal.
- Confirmed: A suspected case that is laboratory-confirmed.

Notification of a suspected case of human rabies

- Inform immediately: Every medical practitioner who treats or encounters a suspected human rabies case must inform the Medical Officer of Health, Regional Epidemiologist and the Epidemiology Unit by telephone immediately.
- Notification: All such cases should be notified using the national Notifiable Disease Notification Card (Form H-544).
- Field confirmation: Field confirmation should be carried out for all notified cases using the 411 and 411a forms and reported through the EPINET system.
- Special field investigation by MOH: A special field investigation must be performed for all notified cases by the MOH and the duly filled special investigation form should be sent to the Epidemiology Unit and the PHVS with a copy to the Regional Epidemiologist.
- The Regional Epidemiologist along with their District Rabies PHI should visit all confirmed human rabies cases.
- A team from the PHVS will also join this field investigation.

Laboratory surveillance - human

Autopsy and Brain sample: In the event of a clinically confirmed or suspected human death and an inquest and a judicial postmortem examination should be essential. Whole brain sample should be sent to the MRI packed in ice without any preservatives.

B. Animal rabies surveillance

Animal Rabies is a notifiable disease (Animal Disease Act No.59 of 1992)

- The Veterinary Surgeon or Veterinary Investigation Officer should report suspected or confirmed animal rabies cases to the Department of Animal Production and Health (DAPH).
- Reporting should be performed using the Department of Animal Production and Health Disease Outbreak Report (Form FO/AH/32).

Laboratory surveillance - animal

All animal heads tested at the rabies testing laboratories both in the health sector and the animal health sector should be entered into the National Animal Rabies surveillance system (RabSys) immediately upon testing.

The relevant REs and MOHs will be able to know results of the samples tested through the system for field level preventive actions without delay.

C. Record maintenance and returns form hospitals

All hospitals should maintain a Register for Patients Exposed to Mammal Bite as per the format provided (Annexure VII).

PEP providing hospitals should issue a vaccination card with the details of immunization and due dates for next doses of ARV (Annexure II).

PEP providing hospitals should maintain registers pertaining to PEP including a Daily Summary of the Patients Exposed to Mammal Bites (Annexure VIII).

A monthly return on rabies post exposure prophylaxis that also includes vaccine stock levels and AEFI data should be sent to the Epidemiology Unit, MRI, PHVS, and the Regional Epidemiologist as per the provided format (Annexure IX).

8.3 Public-health response

Ring vaccination: : For every clinically suspected or laboratory-confirmed case of human rabies, as well as any laboratory-confirmed case of animal rabies, ring vaccination should be implemented for within a minimum radius of one-kilometer of the index case without delay, preferably within 24 hours of notification.

Public awareness:

A public awareness campaign should be conducted in the area around the index case using public address systems and other communication channels. Individuals who were bitten by or exposed to the suspected rabid animal, or to other animals in the area, should be identified and referred for appropriate post-exposure prophylaxis (PEP).

The public should also be advised to restrain and closely observe any animals bitten by the same dog for a minimum period of 14 days. However, it should be noted that in some reported cases, signs of rabies have developed in the exposed animal several months following exposure.

09 Management of human rabies deaths and disposal of the dead body

- Human-to-human transmission of rabies has not been documented, however there is a theoretical risk of exposure to infectious materials, particularly brain tissue and saliva, during the handling of a deceased person.
- Standard infection prevention and control precautions should be followed when handling the body of a suspected or confirmed rabies patient to minimize the risk of contamination and ensure the safety of healthcare workers, mortuary staff, and others involved.

9.1 Death occurring in a medical institution

- Regional Epidemiologist and the Epidemiology Unit should be informed immediately.
- Notify the relevant Medical Officer of Health (MOH) immediately, as human rabies is a notifiable disease.
- An inquest and post-mortem examination is essential for all suspected rabies deaths.
- Submit whole brain tissue (without preservatives) with the patient's clinical history to the Medical Research Institute (MRI) for laboratory diagnosis.
- Transport the specimen in a leak-proof container packed in ice.
- Do not send blood or cerebrospinal fluid collected post-mortem for rabies diagnosis.
- All staff handling the dead body and the soiled articles should wear gloves. In addition the use of standard precautions are recommended to be adopted during a post-mortem by wearing masks, gloves, boots, and apron, and preferably eye protection.
- The body should be released to the relatives without undue delay.

9.2 Death occurring outside a medical institution

- Should be informed to the relevant MOH and range PHI immediately.
- The medical officer certifying the death should inform the coroner and request a post-mortem examination.

9.3 Safe handling and disposal of the body

- Unnecessary handling of the body should be avoided.
- Relatives should be advised to arranged early disposal, preferably by cremation.
- Embalming is not recommended. If it is essential undertakers should be advised to wear protective clothing, mask, gloves and boots during preparation of the body to prevent contamination.

- Sealing the coffin is not required, but a closed coffin is encouraged to prevent relatives hugging and embracing the body.
- Contaminated surfaces should be cleaned with freshly prepared 10% sodium hypochlorite.
- The deceased persons clothing, bed linen, and reusable personal items should be boiled and washed with soap and water before reuse.

9.4 Post-exposure prophylaxis (PEP)

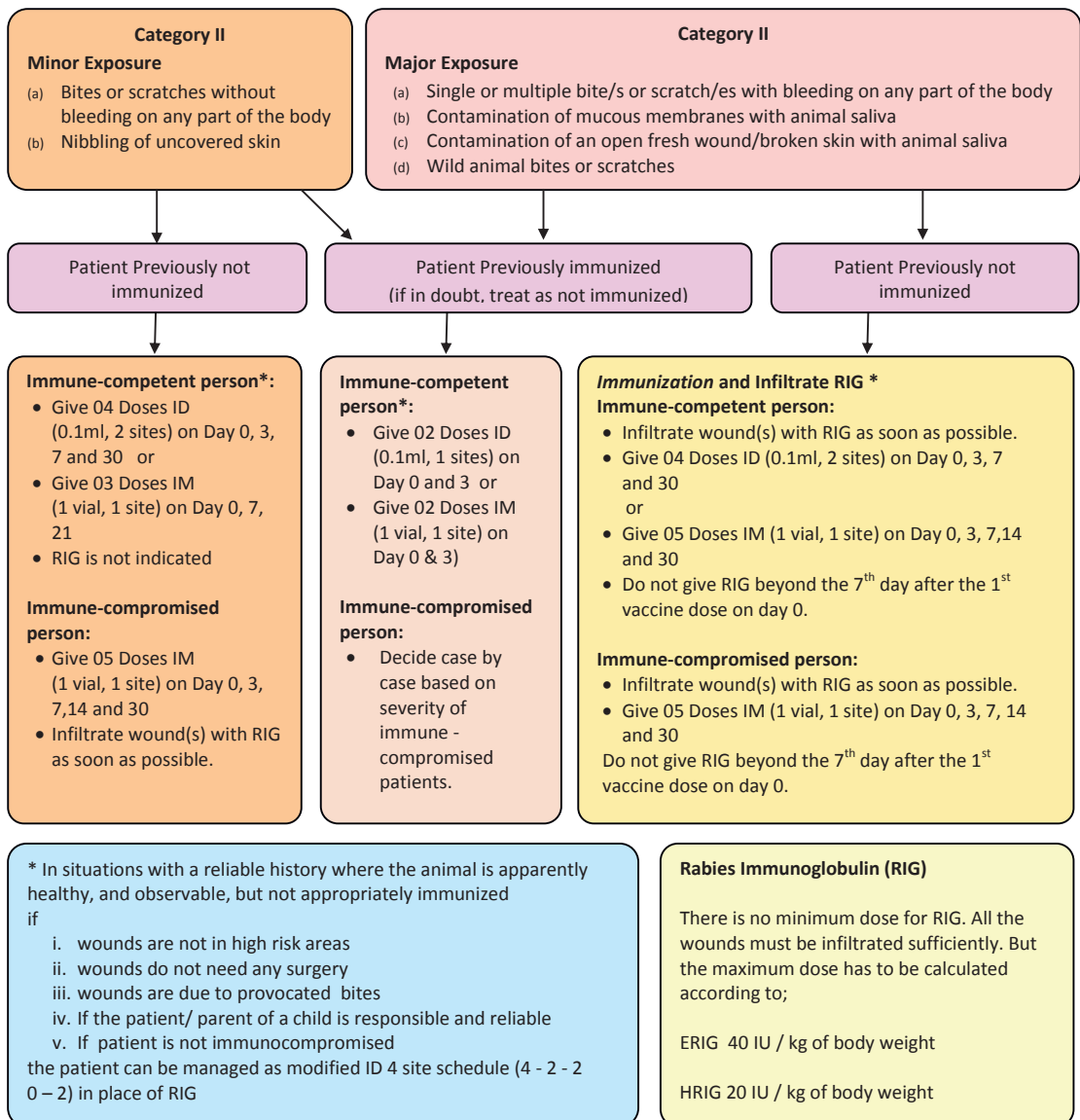
- PEP is recommended only for bystanders with significant exposure, and persons who had sexual contact with the patient within 14 days before the onset of clinical symptoms.

Annexure i

Protocol for rabies PEP - Decision to treat

Category I No exposure	Wash with soap and water for at least 15 minutes. Clean with 70% alcohol or povidone iodine	Anti Rabies Vaccine (ARV) and Rabies Immunoglobulin (RIG) not indicated
Category II Minor exposure	Wash with soap and water for at least 15 minutes. Clean with 70% alcohol or povidone iodine	If the dog is healthy, observable and appropriately vaccinated , rabies vaccination can be delayed while observing the dog for 14 days
Category III Major exposure	Wash with soap and water for at least 15 minutes. Clean with 70% alcohol or povidone iodine	Rabies vaccination + RIG infiltration

PEP Protocol



This algorithm is only for quick reference. Please refer the guideline for further clarification.

Simplified format for rabies PEP

PATIENT'S COPY

REGISTERED NO :

Name :

Age :

Sex :

Address :

DATE OF LAST VACCINATION

FULL COURSE OF VACCINATION

PARTIAL TREATMENT

PATIENT'S WEIGHT :

1. Rabies Immunoglobulin - category III
ERIC 40 IU/kg ☐ HRIG 20 IU/kg ☐
(as the maximum dose within 72 hours or upto 3 months if no vaccine has been given) Infuse all wounds.
Anti Rabies Vaccine (ARV)

2. I.D. Treatment Schedule & Dosage for

2. a. Category III (minor exposure Without RIG } 3 site schedule Vero cell
Category III (major exposure) With RIG } PCCE 0.1ml per cell

2. b. Category III (minor exposure) Modified 4 site ID
Category III (major exposure) Modified 4 site ID
Vero cell 0.5ml PCCE 1ml
vaccinated animal has pet Rabies PET protocol

Batch No

Date/Year

2 Site ID

Modified 4 Site ID

Date/Year

Signature

D10

D11

D12

D13

D14

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Any Other Information :

[illegible]

Annexure iii

Animal immunization schedule

Recommended rabies vaccination schedule for owned and stray dogs

As dogs are the principal reservoir responsible for transmission of rabies to humans, maintaining adequate vaccination coverage among both owned and stray dog populations is essential to interrupt transmission and support the national goal of rabies elimination.

To strengthen field-level rabies prevention and control activities, the Public Health Veterinary Services (PHVS) Directorate recommends the following vaccination schedule for owned and stray dogs, based on national programme experience and available epidemiological evidence.

Dog rabies vaccination schedule

Category of Dog	First Inoculation	First Booster	Follow-up / Revaccination
Pet Dogs – Dam Immunised	At 06 weeks of age	At 14 weeks of age	Annually (1 year after the last booster)
Pet Dogs – Dam Not Immunised	At the time of presentation (after opening eyes)	At 14 weeks of age	Annually (1 year after the last booster)
Stray / Community Dogs	At the time of presentation (after opening eyes)	In 10 weeks	Annually (1 year after the last booster)

Additional recommendation

Annual mass dog vaccination campaigns should aim to achieve at least 70% vaccination coverage of the dog population, which is considered the minimum threshold necessary to interrupt rabies transmission in endemic settings.

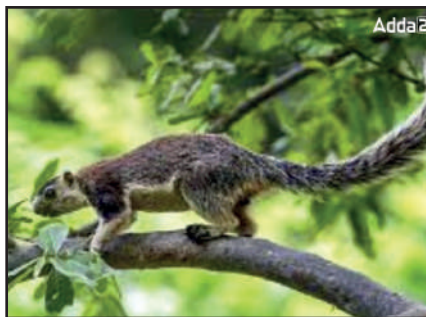
Source: Public Health Veterinary Services Directorate, Ministry of Health, Sri Lanka.

Reference: Veterinary Epidemiological Bulletin, DAPH, Sri Lanka, Volume 6, No. 02 (ISSN 1800-4881)

Annexure iv
Photo gallery – misidentified wild animals



Mongoose
(*Herpestes ichneumon*)



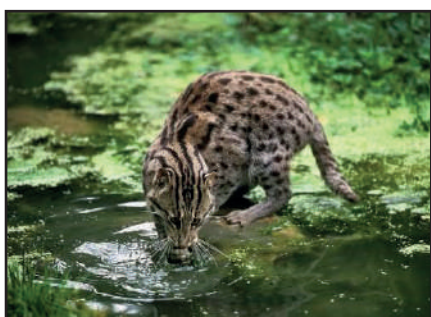
Giant squirrel
(*Ratufa macroura*)



Bandicoot
(*Bandicota indica*)



Three striped palm squirrel
(*Funambulus palmarum*)



Fishing Cat
(*Prionailurus viverrinus*)



Civet Cat
(*Paradoxurus hermaphroditus*)



Golden jackal
(*Canis aureus*)

Annexure v

Algorithm for the treatment of anaphylaxis



Ministry of Health

December 2023

Anaphylaxis

Anaphylaxis Is a serious systemic hypersensitivity reaction usually rapid in onset and may cause death

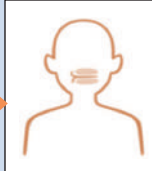
Anaphylaxis is a **MEDICAL EMERGENCY**

RAPID IDENTIFICATION and **EARLY TREATMENT** will **SAVE LIVES**

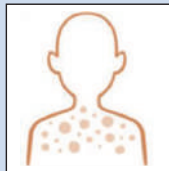
ADRENALINE IS THE FIRST-LINE TREATMENT FOR ANAPHYLAXIS

MILD TO MODERATE ANAPHYLAXIS

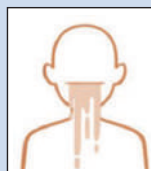
Mild to moderate allergic reactions may not always occur before anaphylaxis



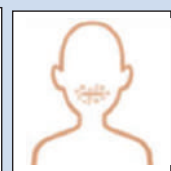
Swelling of lips, face,



Hives or welts



Vomiting
Abdominal pain



Tingling mouth

ANAPHYLAXIS - Severe Allergic Reaction

Is highly likely
When any **ONE** of the following criteria are present



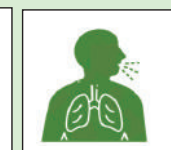
Difficult or noisy breathing



Swelling of tongue



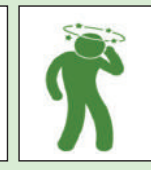
Swelling or tightness in throat



Wheeze or persistent cough



Difficulty in talking or hoarse voice



Persistent dizziness or collapse



Pale and floppy
(young children)



Abdominal pain, vomiting
(signs of anaphylaxis for insect allergy)

Adrenaline injector doses are:

- 150 mcg for children 7.5-20 kg
- 300 mcg for children **OVER** 20 kg & adults
- 300 mcg or 500 mcg for children and adults over 50kg



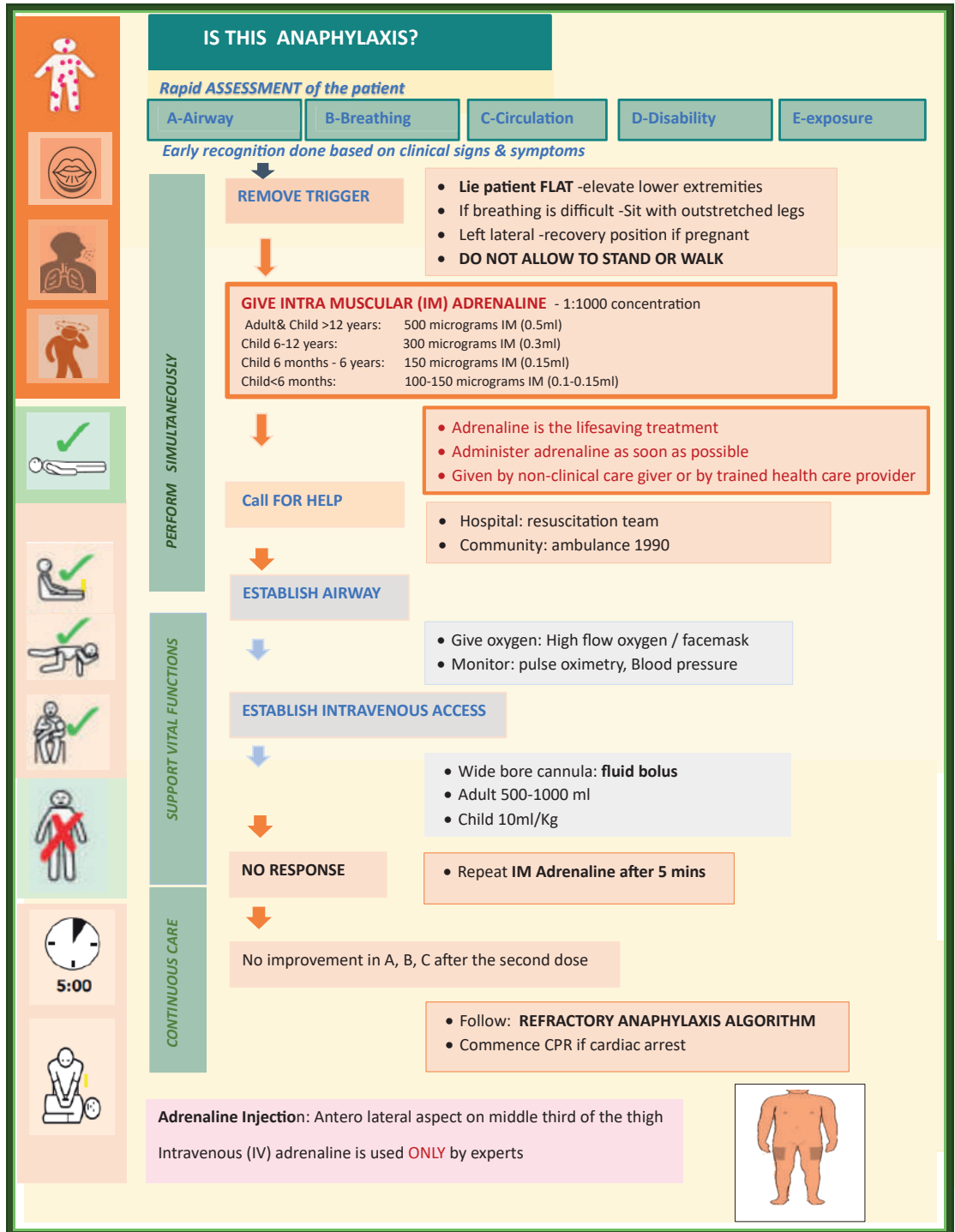
COAISL

AICBU



Sri Lanka College of
Emergency Physicians





- Lie patient **FLAT** -elevate lower extremities
- If breathing is difficult -Sit with outstretched legs
- Left lateral -recovery position if pregnant
- **DO NOT ALLOW TO STAND OR WALK**

- Adrenaline is the lifesaving treatment
- Administer adrenaline as soon as possible
- Given by non-clinical care giver or by trained health care provider

- Hospital: resuscitation team
- Community: ambulance 1990

- Give oxygen: High flow oxygen / facemask
- Monitor: pulse oximetry, Blood pressure

- Wide bore cannula: **fluid bolus**
- Adult 500-1000 ml
- Child 10ml/Kg

- Repeat **IM Adrenaline** after 5 mins

- Follow: **REFRACTORY ANAPHYLAXIS ALGORITHM**
- Commence CPR if cardiac arrest

Annexure vi

Case scenarios

1. A 12 year old girl presented with laceration on leg. Her pant was blood stained according to father But says clothes were not torn. Child says she was bitten by an unidentified animal while trying to close the gate late evening.
RIG + full course of ARV
2. 46 year old woman presented with severe asthma which got worse following a dog bite last night. According to her it was a free roaming dog in the neighborhood. She says she accidentally trampled the dog. Dog is not vaccinated but can be observed for 2 weeks. Wound had appeared blood Patient is on inhaler for asthma for several years.
RIG + ARV IM
3. An elderly woman noticed two puncture marks on the hand in the morning. A dead small bat was lying on the floor . She believes her cat may have killed the bat. She is on metformin for DM.
RIG + full course of ARV
4. 58 year old patient presented following a stray dog bite on foot with severe bleeding. He is on aspirin. The towel around the wound is soaked in blood. Patient says he was given a course of injections following a dog bite at Negombo hospital 5 years ago. No records available.
RIG + full course of ARV
5. A doctor brought her 30 year old sister following a cat bite. No bite marks are visible. She says cat was sick a week ago but recovered since yesterday.
Observation of cat for 14 from incident And vaccinate cat against rabies
6. Police brought a 28 year old man with a deep dog bite on his leg. He was caught following a burglary. Man says he was bitten by a friend's dog. Police say he is awaiting to be presented to courts tomorrow.
RIG + full course of ARV
7. A 67 year old woman presented for her ARV on Day 5. She was bitten by a healthy unvaccinated puppy with no bleeding. She had missed the D 3 ARV as she was affected by floods. Animal is healthy.
Give missed ARV on day 5 and reschedule day 7 dose to two days later.
8. A 54 year old man received ARV for a wound with minimal bleeding. He had received D0 and D3 only. Dog fell ill on day 4 and died and he managed to take the animal head to MRI. He has brought a MRI report positive for Rabies.
RIG + Restart ARV from the beginning and continue full course

Annexure vii

Register for patients exposed to mammal bite

Register for Patients Exposed to Mammal Bite

Date	Monthly Number	Daily Number	Personal Details of the Patients					Date of exposure	Detail of the Animal			Details of exposure			Details of the Treatment							AEFI (Local/CNS/Other severe/Non Severe/Death	Not given PEP as per guideline	Referred to another hospital	Remarks																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
			Name	Age (Yrs)	Sex (M/F)	Address	Tele: No.		Animal involved	Domestic (C) Stray (S)	Valid documented vaccination (Y/N)	Only for dogs and cats	Site of wound	Type of exposure (Bite/Scratch/Mucous membrane)	Category of exposure (Major/Minor)	Rabies Immunoglobulin ERIG/HRIG/Not given	ID/IM	D0	D3	D7	D14					D21	D28	Anti rabies vaccine (ARV)																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																												

Annexure viii

Monthly Return on Mammal Bite Patients to Epidemiology Unit / MRI / PHVS

Year		Month	
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1. Name of the Hospital
2. Type of mammal involved - **1st visit patients**

Type of mammal involved	Male	Female	Total	Animal vaccinated		
				Yes	No	Not Known
Domestic dog						
Community/stray dog						
Domestic Cat						
Community/stray cat						
Wild animal						
Other						
Total						

3. Category of Exposure

Category of Exposure	No of patients
Major (Category III)	
Minor(Category II)	
No exposure (Category I)	

4. No of patients not initiated PEP (according to guidelines) ☐

5. No of patients referred to other hospitals ☐

6. Treatment with Rabies Immunoglobulin (RIG) and Anti Rabies Vaccine (ARV)

Type of immunization	No of patients treated				
Rabies Immunoglobulin (RIG)					
ERIG					
HRIG					
Anti Rabies Vaccine					
Schedule and doses of ARV	1 st dose	2 nd dose	3 rd dose	4 th dose	5 th dose
1. Intradermal					
a. 2 side schedule (2-2-2-0-2)					

b. 4 side schedule (4-2-2-0-2)					
2. Intramuscular					
c. 5 dose schedule (1-1-1-1-1)					
d. Minor exposure schedule (2-1-1)					

7. Adverse Events following Immunization (AEFI) with ARV/RIG

Type of AEFI	ARV	ERIG	HRIG
Local Adverse Events (E.g. Injection site abscess, Severe local reactions)			
CNS related Adverse Events (E.g. Guillen-Barre syndrome / Encephalopathy /Encephalitis / Seizures)			
Other sever adverse events (E.g. Anaphylactic shock)			
NON-SEVER adverse events E.g. Headache, pain, urticaria/rash /arthralgia / myalgia/ high fever - >39 C ⁰ / 102 ⁰ F- / dizziness, nausea / vomiting/ paresthesia / fatigue /chills)			
Death			

8. Movement of ARV and RIG:

	ARV	RIG		
		ERIG	HRIG 300 unit	HRIG 750 unit
a) No of doses available at the beginning of the month				
b) No of doses received during the month				
c) No of doses issued during the month				
d) No of doses used during the month				
e) No of doses sent to RMSD/ Other hospital during the month				
f) No of doses damaged / expired / discarded during the month				
g) No of doses available at the end of the month				

.....
Signature of the nursing officer in charge

Name :

Designation :

Date :

.....
Signature of the medical officer in

Name :

Designation :

Date :

Please return to within first 10 days of the following month in to the

1. Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10
2. Medical Research Institute (MRI)
3. Public health veterinary services (PHVS)

Annexure ix

Daily summary of the patients exposed to mammal bites

Daily Summary of the Patients Exposed to Mammal Bites

Name of the institution: _____
 Year: _____ Month: _____

[illegible]

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விசாரணை

2 யிரக்கொல்லி நோய் ஆகும்

தாமதமின்றி முறையான நடவடிக்கைகளை எடுத்தால் தடுவீரக்கொல்லை கிடுகனப் பற்றி நீங்கள் தெரிவிக்க வேண்டும். மற்றவர்களுக்கும் தீவிரத்திற்குள் தடுவீரக்கொல்லை கிடுகனப் பற்றி நீங்கள் தெரிவிக்க வேண்டும்.

விவங்கு கடித்தால்

1

காயத்தின் 2-டாடியாக சலிக்காரும் தண்ணீரும் கொண்டு குறைந்தது 15 விநாடிகள் நன்றாக கழிவு வேண்டும். கிடுகனப் பற்றி நீங்கள் தெரிவிக்க வேண்டும்.

2

2-டாடியாக அருகிலுள்ள மருத்துவமனைக்குச் செல்லுங்கள். மருக்காயம் நுயிர் தடுப்பி அடையுமே எடுத்துச் செல்லுங்கள்.

3

கடித்த நாயை 14 நாட்கள் கண்காணிக்க வேண்டும்.

கடித்த விவங்கை கண்காணிக்கவும்

- நோயுடைய ஒருவரால் தினமும் கண்காணிக்கப்பட வேண்டும்
- கண்காணிப்பு காலத்தில் விலங்கைத் தொடுவதை தவிர்க்க வேண்டும்
- விலங்கு வழக்கமான வாயும் கும்பிலேயே வைத்துக் கண்காணிக்க வேண்டும்

கவனிக்க வேண்டிய அருகத்தினங்கள்

- வழக்கமான நடத்தை அல்லது செயற்பாடுகளில் மாற்றம்
- எதேனும் நோய் அறிகுறிகள்
- சோர்வு அல்லது அசாதாரண மந்தநிலை
- உணவு அல்லது தண்ணீர் குடிப்பதை மறுத்தல்
- அதிக உமிழ்வு வெளியேறுவது
- விழுங்குவதில் சிரமம்
- வாந்தி, வாயிற்போக்கு, சிறுநீர் அல்லது மலம் கழிப்பதில் சிரமம்
- குரலில் மாற்றம்
- நடுக்கம், வலிப்பு, பைத்தியத்தனமான நடத்தை
- திடீர் தாக்குதல், அதிக ஆத்திரம், அசாதாரண அமைதி அல்லது பயம்
- காபச்சல்

கிடுகன கண்காணிப்பு காலத்தில் விவங்கில் மேற்கூறிய அறிகுறிகள் தோன்றினால், விவங்கு கிடுகனத்தில் சம்பவம் காரணமாக போனால், 2-டாடியாக அருகிலுள்ள மருத்துவமனையில் தடுவீரக்கொல்லை கிடுகனப் பற்றி நீங்கள் தெரிவிக்க வேண்டும்.

கடித்த விவங்கிற்கு விசாரணை (டிபி) தடுப்பி செலுத்தப்படவில்லை என்றால், கண்காணிப்பு காலம் முடிந்ததும் அவசியமாக தடுப்பி செலுத்த வேண்டும்

விவங்கிற்கு நிரணிக்கப்பட்ட முறையில் விசாரணைக்கு (டிபி) தடுப்பி செலுத்த வேண்டும்

- சிறுகுடிகள் கண் திறந்தவுடன் முதல் தடுப்பியை கொடுங்கள்.
- முறை மாதங்களில் இரண்டாவது தடுப்பியையும்
- பின்னர் ஆண்டுதோறும் ஒருமுறை தடுப்பி.
- அசாங்கத்தால், வருடத்திற்கு ஒருமுறை தடுப்பி இலவசமாகவே வழங்கப்படுகிறது
- உங்கள் பகுதியில் உள்ள கன்தார மருத்துவ அதிகாரி அல்லது பொது கன்தார பரிசோதகரிடம் ஆலோசனை பெறலாம்.
- தெருவோரக் குட்டிகளை வீட்டிற்கு எடுத்து வருவதாயின், அன்றை தடுப்பி ஏற்றிப் பின்னர் அழைத்து வாரங்கள்

சுறுத்தில் வரும் நுயிகள் தொடர்ந்து தடுப்பி திட்டம் சமூக நுயிகளுக்கு தடுப்பி செலுத்தும் திட்டத்தில் உங்கள் ஒத்துழைப்பை வழங்க வேண்டும்

உங்கள் செல்வப்பிராணியை பொறுப்புடன் மற்றும் அன்புடன் பராமரிக்கவும்

- நாயை உங்கள் வீட்டு கும்பில் வைத்து வளருங்கள். வெளியே சுதந்திரமாக சுற்றி விடக்கூடாது
- தயவுசெய்து, அது மற்றவர்களைக் கடிக்கக்கூடிய விதத்தில் வளர்க்காதீர்கள்.
- அது வெளியே சுதந்திரமும் அனுமதிக்காதீர்கள்.
- அவர்களின் தேவைகளை சந்திப்பதற்கு முறையில் பூத்தி செய்ய முயற்சிக்கவும்
- உங்கள் குழந்தைகளுக்கு சிறுவயதில் இருந்து விலங்குகளை பராமரிக்கக் கற்பிப்பீர்கள்.
- அவர்கள் தேவைக்கு ஏற்ப உணவும் தண்ணீரும் வழங்குங்கள்.
- நாய்க்குட்டிகளை லைட் இடங்களிலும் விட்டுச்செல்ல வேண்டாம்.
- மேலும், வேண்டாத நாய்க்குட்டிகள் பிறப்பதைத் தடுக்க கருத்தடை செய்து வைத்துக் கொள்ளுங்கள்.
- உங்கள் பகுதியில் உள்ள கால்நடை மருத்துவரிடம் ஆலோசனை பெற வேண்டும்.

விவங்கு உட்கணைக் கடித்தால் கிடுகனப் பற்றி விவங்குகளுக்கு, அவை அருகிலுள்ள மருத்துவமனை (கன்தார) தடுப்பி திட்டம்

0112 693 532 - 4



செலித சுகாதார அமைச்சு
Ministry of Health



தமிழ்நாடு அரசு
Tamil Nadu Government



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Annexure xi
Surveillance of human rabies - case investigation form

30. Type of biting animal ☐ 1. fully ☐ 1. household pet ☐ 2. neighbour's pet ☐ 3. stray ☐ 4. not known	34. Number of days animal was alive after the bite 1. ☐ days 2. not known 35. Was the brain sent for virological examination? ☐ 1. yes → 36. findings: ☐ 1. positive ☐ 2. no ☐ 2. negative ☐ 3. not known ☐ 3. not known																				
31. Was the biting animal suspected of rabies? ☐ 1. yes ☐ 2. no ☐ 3. not known 32. Was the animal observed for 14 days? ☐ 1. yes ☐ 2. no ☐ 3. not known 33. Is the animal dead? ☐ 1. yes → O 34 ☐ 2. no ☐ 3. not known } to Q. 37	36. If 'yes', when was it done? ☐ 1. immediately ☐ 2. not immediately ☐ 3. not known 37. For patients who received post exposure treatment (PET): 38. Treatment: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>TT</td> <td>1. completed</td> <td>2. not completed</td> <td>3. not given</td> <td>4. not known</td> </tr> <tr> <td>ARV (anti-rabies vaccine)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ARS (anti-rabies serum (horse))</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RIG (rabies immunoglobulin (human))</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	TT	1. completed	2. not completed	3. not given	4. not known	ARV (anti-rabies vaccine)					ARS (anti-rabies serum (horse))					RIG (rabies immunoglobulin (human))				
TT	1. completed	2. not completed	3. not given	4. not known																	
ARV (anti-rabies vaccine)																					
ARS (anti-rabies serum (horse))																					
RIG (rabies immunoglobulin (human))																					
39. Date of commencement of anti-rabies treatment: d m y	40. Schedule* of anti-rabies treatment ☐ 1. RIG followed by IM ARV 5 dose regimen [D0-1, D3-1, D7-1, D14-1, D30-1] ☐ 2. IM-ARV 4 dose regimen [D0-2, D7-1, D21-1] ☐ 3. 2 site ID schedule [D0-2, D3-2, D7-2, D30-1, D90-1] ☐ 4. 4 site ID schedule [D0-4, D7-4, D30-1, D90-1] * For example: [D0-2, D7-1, D21-1] denotes: 2 doses on day 0, 1 dose on day 7, 1 dose on day 21																				
41. PET was not completed or not given, reasons: 14. Was post-mortem performed? ☐ 1. yes ☐ 2. no 15. If yes, human brain sent for histopathology? ☐ 1. yes ☐ 2. no 16. If yes, results:	42. Results: 17. Remarks:																				

Annexure xii

Guideline to be followed in a case of human rabies deaths and disposal of the body

My No: DGHS/Circular/2016-127(MRI-Gu-HR)
Office of the Director General of Health Services,
Ministry of Health,
"Suwasiripaya"
Colombo 10.
16th March, 2016

Provincial Directors of Health Services,
Deputy Provincial Director of Health Services,
All Heads of Decentralized Units,
Directors of Teaching Hospitals,
All MSS/DMOs/MOICs,
All Heads of Institutions.

GUIDELINES TO BE FOLLOWED IN A CASE OF HUMAN RABIES/ DEATH AND DISPOSAL OF THE BODY

Human to human transmission of rabies has not been reported even though there is a theoretical possibility for such transmission. Duration of virus survival in a dead body is unknown, but most likely may be for a few hours. However, it is necessary to take all precautions when handling a dead body due to the risk of contamination with infected material, such as brain and saliva.

- When a rabies suspected patient is admitted to a medical institution, the Department of Rabies, MRI should be contacted before sending specimens for anti-mortem diagnosis.

Please follow the instructions given below in a case of death due to human rabies and disposal of the body.

Death occurring in a medical institution

1. Human rabies is a notifiable disease in Sri Lanka and therefore all cases should be notified immediately to the relevant medical officer of health (MOH).
2. An inquest and a post-mortem is essential in all suspected cases of human rabies in order to confirm by laboratory diagnosis. A specimen of the whole brain without any preservatives should be sent to the Medical Research Institute (MRI) with a clinical history of the patient. The specimen should be transported in a leak proof container packed in ice. Blood or cerebrospinal fluid collected at post-mortem are not suitable specimens and should not be sent to MRI for rabies diagnosis.
3. All staff handling the dead body and the soiled linen should wear gloves. In addition the use of standard precautions are recommended to be adopted during a post-mortem, by wearing masks, gloves, boots, an apron and preferably goggles.
4. The body should be handed over to the relatives without any delay.

Death occurring outside a medical institution

1. Notify the case to the relevant medical officer of health (MOH) and the range public health inspector (PHI) immediately.
2. Medical officer certifying the death should inform the coroner and request for a post-mortem.

The general measures to be followed:

1. The body should not be handled unnecessarily. Inform the relatives to dispose the body (preferably by cremation) as early as possible.
2. Embalming of body is not recommended. However, if it is essential, the undertaker should be advised to wear protective clothing, mask, gloves and boots during preparation of the body to prevent contamination.
3. Sealing the coffin is not required.
4. A closed coffin should be encouraged to prevent relatives from embracing or hugging the body.
5. Any place or item which is contaminated with body secretions, should be disinfected with freshly prepared 10% Sodium Hypochlorite solution.
6. The patient's clothing, bed linen and other personal items should be boiled and washed with soap & water before reuse.
7. Post exposure treatment (PET) is recommended only for the bystander(s) who nursed the patient and those who had sexual contact with the deceased within 14 days prior to the onset of clinical signs and symptoms
8. No PET is required forward and judicial medical officer's staff and unnecessary PET should always be avoided. However, specialized advice could be sought for any accidental exposure to body secretions.

(Please follow the instructions given on rabies PET in protocol for anti rabies post exposure therapy - circular No 2016-127(MRI-AR-PET))

Any clarification could be obtained from the Consultant Virologist, Dept of Rabies, Medical Research Institute, Colombo 08. (Tel: 011-2693532-4, 011-2698660) or Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10. (Tel: 011-2695112, 2681548)
Dr. P.G. Mahipala
Director General of Health Services

Notes

Summary of the Guideline

The Revised and Expanded Edition of the National Guideline on Prevention, Control and Management of Human Rabies provides a framework for rabies prevention, clinical management, surveillance, and public health response in Sri Lanka. It guides healthcare workers on the assessment and management of animal exposures, including wound management, exposure classification, rabies post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) with rabies vaccines and immunoglobulins, and management of adverse events.

The guideline also covers laboratory diagnosis, animal observation, management of suspected human rabies cases, counselling, health education, surveillance, vaccination of animals, field response activities and management of human rabies deaths and disposal of the dead body.

Supported by practical annexures and tools, this guideline serves as a national reference for healthcare workers to strengthen rabies prevention and control activities and support the goal of achieving zero human deaths from dog-mediated rabies by 2030 in Sri Lanka.

This guideline is available on the Epidemiology unit website, www.epid.gov.lk

