



# WEEKLY EPIDEMIOLOGICAL REPORT

A publication of the Epidemiology Unit  
Ministry of Health, Nutrition & Indigenous Medicine

231, de Saram Place, Colombo 01000, Sri Lanka  
Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@sltnet.lk  
Epidemiologist: +94 11 2681548, E mail: chepid@sltnet.lk  
Web: <http://www.epid.gov.lk>

Vol. 45 No. 43

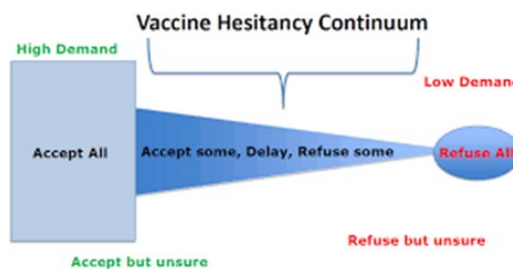
20<sup>th</sup> – 26<sup>th</sup> October 2018

## Vaccine Hesitancy

WHO defines vaccine hesitancy as the “delay in acceptance or refusal of vaccines, despite availability of vaccination services . Vaccine hesitancy is complex and context specific varying across time, place and types of vaccines. It includes factors such as complacency, convenience and confidence”. Therefore, it is a global problem which requires monitoring and evolution.

tion, a diagnosis of the underlying reasons for hesitancy should adequately differentiate between barriers related to acceptance and access

Figure 1.0 Vaccine Hesitancy Continuum



The vaccine hesitancy continuum describes, that vaccine hesitancy occurs between two poles. When the demand for vaccines are present all the vaccines will be accepted. In the opposite pole it is a complete refusal of vaccine. Therefore, vaccine hesitancy occurs in-between the two poles causing the recipient not to accept the vaccines at the expected rate causing the demand to be lower. When vaccine hesitancy occurs, it is at individual and community level which affects the effectiveness of personal and community responsibility of immunization. Therefore, to overcome vaccine hesitancy, the root cause needs to be identified and its magnitude needs to be assessed to design custom made solutions to supersede the problem. Evidence-based strategies to address the causes, monitoring and evaluation to determine the impact and sustainability of the intervention is essential.

When understanding vaccine hesitancy, it must be noted that there can be many inter-related determinants. These should be assessed in a systematic manner to comprehend the individual, group, and contextual influences, as well as any vaccine/vaccination specific issues. In addition,

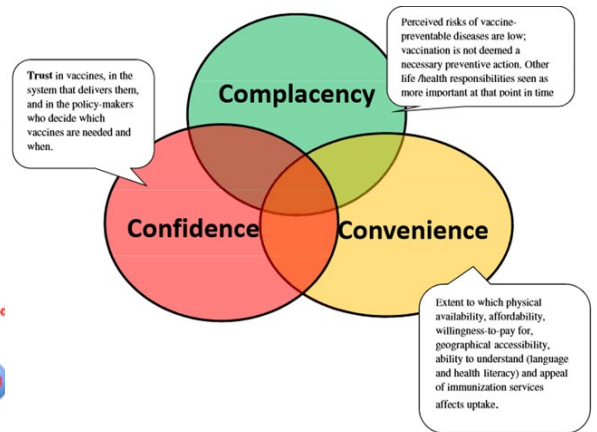


Figure 2.0 Vaccine Hesitancy Matrix

The 3 key determinants are known as the working group determinants which are demonstrated in the vaccine hesitancy matrix. On the individual basis, beliefs and attitudes about health, knowledge and awareness has to be considered. With relation to the context, influence by media communication, influential leaders, politics, religion, culture and socio economy will cause the impact according to the working group determinants of vaccine group matrix. Vaccine hesitancy had been prevalent since the 18th century with the emergence of the small pox vaccination. Vaccine hesitancy has increased in the recent past owing to different factors. It is reported in the world and in isolated pockets of Sri Lanka that certain groups/cultures induce vaccine hesitancy.

There is no single intervention that addresses all instances of vaccine hesitancy. Based on the systematic review of strategies to address vaccine hesitancy conducted by the SAGE (Strategic Advisory Group of Experts) working group the most effective interventions are multi-component versus single-

WEB SRI LANKA 2018

### Contents

	Page
1. Leading Article – Vaccine Hesitancy	1
2. Summary of selected notifiable diseases reported (13 <sup>th</sup> – 19 <sup>th</sup> October 2018)	3
3. Surveillance of vaccine preventable diseases & AFP (13 <sup>th</sup> – 19 <sup>th</sup> October 2018)	4

component. In most cases, interventions should be dialogue based and directly targeted to a specific under-vaccinated population group.

By engaging collaboratively with health workers, service-users, and their families and communities, national authorities can generate the insights to develop better quality health services, systems, policies, and communication strategies that support and enable recommended vaccination behaviours.

### Tailoring Immunization Programmes

It is imperative to diagnose the factors influencing vaccination intentions, decisions and behaviours, WHO/Europe developed the guide to Tailoring Immunization Programmes (TIP). It consists of proven methods and tools to:

- Identify populations susceptible to vaccine-preventable diseases
- Diagnose supply and demand side barriers and enablers to vaccination
- Recommend evidence-informed responses to build and sustain vaccination uptake
- Global guidance on TIP

Given the potential for hesitancy to rapidly undermine vaccination coverage in specific settings, it is important that all countries take steps to understand both the extent and nature of hesitancy at a local level, on a continuing basis. Accordingly, each country should develop a strategy to increase acceptance and demand for vaccination, which should include ongoing community engagement and trust-building, active hesitancy prevention, regular national assessments of concerns, and crisis response planning.

It should be noted that in low vaccine uptake situations, where lack of available services is the major factor impairing adequate coverage, vaccine hesitancy can be present but is not the priority and should not be the focus of investments.

### The critical role of health workers

In the face of emerging hesitancy, health workers remain the most trusted advisor and influencer of vaccination decisions. The capacity and confidence of health workers are often stretched, though, as they are faced with time constraints, limited resources, and inadequate information and/or training to respond to any questions and discuss the risks and benefits. For health workers to be prepared for the different types of interactions they might face, a number of actions are required.

- Explore existing knowledge, attitudes and practices, as a basis for the design and evaluation of trainings and tools
- A guide for exploring health worker/caregiver inter-

actions on immunization is needed

- Two specific and adaptable training programmes in the following areas
  - To build capacity in managing pain during vaccination and
  - in engaging in difficult conversations with hesitant caregivers

### Community engagement

Communities also need to be at the centre of driving to improve the quality of immunization and health services, access and equity. The linkages between health systems and communities are inter-dependent and thus systems should engage directly with communities via face-to-face interactions. This participatory process can play a major role in improving the quality of services in such a way that builds trust and demonstrates respect, with broader benefits for immunization coverage.

#### Compiled by-

Dr.T.D.Haputhanthri -Epidemiology unit

#### Sources-

World Health Organization- Addressing Vaccine Hesitancy [https://www.who.int/immunization/programmes\\_systems/vaccine\\_hesitancy/en/](https://www.who.int/immunization/programmes_systems/vaccine_hesitancy/en/)

**Table 1 : Water Quality Surveillance— Number of microbiological water samples September 2018**

District	MOH areas	No: Expected *	No: Received
Colombo	15	90	90
Gampaha	15	90	NR
Kalutara	12	72	NR
Kalutara NIHS	2	12	9
Kandy	23	138	93
Matale	13	78	23
Nuwara Eliya	13	78	54
Galle	20	120	51
Matara	17	102	19
Hambantota	12	72	37
Jaffna	12	72	118
Kilinochchi	4	24	22
Manner	5	30	NR
Vavuniya	4	24	31
Mullatvu	5	30	NR
Batticaloa	14	84	87
Ampara	7	42	42
Trincomalee	11	66	48
Kurunegala	29	174	65
Puttalam	13	78	40
Anuradhapura	19	114	15
Polonnaruwa	7	42	NR
Badulla	16	96	121
Moneragala	11	66	114
Rathnapura	18	108	74
Kegalle	11	66	0
Kalmunai	13	78	78

\* No of samples expected (6 / MOH area / Month)  
NR = Return not received

Table 1: Selected notifiable diseases reported by Medical Officers of Health 13<sup>th</sup>-19<sup>th</sup> October 2018(42<sup>nd</sup> Week)

RDHS Division	Dengue Fever		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmaniasis		WRCD											
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**										
Colombo	92	7821	2	75	0	9	1	38	1	32	9	187	0	12	1	8	0	0	11	594	5	60	0	4	62	100
paha	53	4462	1	59	0	8	1	22	0	168	2	194	1	6	1	13	0	0	9	638	0	40	0	45	65	100
Kalutara	16	2555	1	76	0	5	0	12	0	54	19	537	0	6	1	13	0	0	26	577	6	88	0	9	54	100
Kandy	52	3081	2	100	0	5	1	4	1	22	7	79	2	89	1	20	0	1	9	286	3	37	2	29	59	100
Matale	7	796	1	22	0	1	0	4	1	39	0	82	1	3	1	8	0	0	2	42	0	13	5	127	60	100
NuwaraEliya	5	177	0	50	0	4	0	12	0	47	0	41	4	124	0	24	0	0	5	195	1	38	0	0	25	100
Galle	8	816	1	48	0	12	0	6	1	15	7	342	0	57	0	3	0	1	16	313	2	54	0	5	27	100
Hambantota	5	758	0	14	0	4	0	3	0	5	1	63	2	70	0	3	0	1	4	230	2	15	22	677	72	100
Matara	7	912	0	36	0	6	1	8	0	23	5	202	4	46	1	16	0	0	4	247	0	12	18	411	55	100
Jaffna	58	2548	5	145	0	5	1	44	0	217	0	10	1	258	0	1	0	2	1	254	0	9	0	3	37	93
Kilinochchi	1	278	1	27	0	1	0	17	0	5	0	5	0	16	0	0	0	1	0	31	0	2	0	1	50	100
Mannar	3	196	0	18	0	0	0	3	0	2	0	1	0	1	0	0	0	0	1	28	0	4	0	3	37	100
Vavuniya	6	504	0	15	0	4	0	41	0	12	1	34	0	7	0	0	0	1	0	45	0	5	0	12	58	100
Mullaitivu	5	100	0	7	0	0	0	10	0	11	0	8	1	7	0	0	0	1	1	10	0	1	0	2	25	100
Batticaloa	40	4365	1	148	0	5	0	7	3	29	1	41	1	2	0	3	0	3	3	163	1	19	0	0	65	100
Ampara	2	207	9	66	0	3	1	3	0	9	0	34	0	0	0	7	0	1	6	271	1	23	0	3	66	100
Trincormalee	1	940	0	36	0	2	0	5	0	13	1	49	0	22	0	2	0	0	1	181	0	9	0	18	28	100
Kurunegala	12	2028	1	116	1	17	0	13	1	5	4	123	0	21	2	22	0	2	16	477	0	82	13	353	62	100
Puttalam	40	1498	5	45	0	6	0	4	0	10	0	41	0	11	0	2	0	0	2	129	3	72	0	2	62	100
Anuradhapura	6	752	3	54	0	7	0	4	5	44	1	113	1	18	1	13	0	2	7	364	1	44	11	419	44	95
Polonnaruwa	3	263	1	34	1	3	0	0	1	19	4	99	0	0	0	4	0	1	10	242	2	20	6	212	56	88
Badulla	8	471	6	110	0	8	0	13	0	15	3	145	1	81	4	64	0	0	10	407	2	102	0	9	47	100
Monaragala	6	759	2	68	0	2	0	1	0	4	1	243	1	123	3	38	0	0	4	162	5	130	2	43	66	100
Ratnapura	21	1904	7	164	1	39	1	22	0	5	13	592	0	26	0	25	0	2	14	277	3	105	7	191	47	100
Kegalle	19	1220	1	50	3	12	0	8	1	86	16	249	1	69	0	15	0	0	10	338	1	43	1	14	64	100
Kalmune	6	1578	0	41	0	3	0	3	1	32	1	8	0	1	0	1	0	0	6	183	0	14	0	1	51	100
<b>SRI LANKA</b>	<b>482</b>	<b>40989</b>	<b>50</b>	<b>1624</b>	<b>6</b>	<b>171</b>	<b>7</b>	<b>307</b>	<b>16</b>	<b>923</b>	<b>96</b>	<b>3522</b>	<b>21</b>	<b>1076</b>	<b>16</b>	<b>305</b>	<b>0</b>	<b>19</b>	<b>178</b>	<b>6684</b>	<b>38</b>	<b>1041</b>	<b>87</b>	<b>259</b>	<b>53</b>	<b>99</b>

Source: Weekly Returns of Communicable Diseases (WRCD).  
 \*T=Timeliness refers to returns received on or before 19<sup>th</sup> October, 2018 Total number of reporting units 353 Number of reporting units data provided for the current week: 351 C\*\*=Completeness  
 A = Cases reported during the current week. B = Cumulative cases for the year.

**Table 2: Vaccine-Preventable Diseases & AFP**

**13<sup>th</sup>- 19<sup>th</sup> October 2018(42<sup>nd</sup> Week)**

Disease	No. of Cases by Province									Number of cases during current week in 2018	Number of cases during same week in 2017	Total number of cases to date in 2018	Total number of cases to date in 2017	Difference between the number of cases to date in 2018 & 2017
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	01	00	00	01	00	00	00	00	02	03	54	59	- 8.4 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	04	02	00	00	00	01	00	01	01	09	06	286	256	11.7 %
Measles	00	01	00	01	00	00	00	00	01	03	02	105	177	- 40.6 %
Rubella	00	00	00	00	00	00	00	00	00	00	00	05	10	- 50 %
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	01	0%
Tetanus	01	00	00	00	00	00	00	00	00	01	00	18	16	12.5 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	25	21	19.0 %
Whooping Cough	01	00	00	00	00	00	00	00	00	01	01	42	19	121 %
Tuberculosis	157	29	42	19	48	18	15	09	17	282	174	6987	6877	1.5 %

**Key to Table 1 & 2**

**Provinces:** W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.  
**RDHS Divisions:** CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.

**Data Sources:**

**Weekly Return of Communicable Diseases:** Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

**Special Surveillance:** AFP\* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS\*\* =Congenital Rubella Syndrome

NA = Not Available

Influenza Surveillance in Sentinel Hospitals - ILI & SARI							
Month	Human				Animal		
	No Total	No Positive	Infl A	Infl B	Pooled samples	Serum Samples	Positives
October	77	22	03	19	1449	10000	0

Source: Medical Research Institute & Veterinary Research Institute

**PRINTING OF THIS PUBLICATION IS FUNDED BY THE WORLD HEALTH ORGANIZATION (WHO).**

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, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to [chepid@slt.net.lk](mailto:chepid@slt.net.lk). **Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

**ON STATE SERVICE**

**Dr. S.A.R. Dissanayake**  
 CHIEF EPIDEMIOLOGIST  
 EPIDEMIOLOGY UNIT  
 231, DE SARAM PLACE  
 COLOMBO 10