

## Updates



## Need to ensure voluntary compliance of the public towards public health and social measures to contain COVID-19

*- A Position Paper from the College of Community Physicians of Sri Lanka*

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### Background

Currently into the 13<sup>th</sup> month of the battle against the COVID-19 pandemic, the world has witnessed a multitude of legislations, guidelines and recommendations intended to empower the public to face this battle. The Public Health and Social Measures (PHSM) (1) included in such documents have enabled Sri Lanka to contain the pandemic to a level not exceeding the health system response capacity. Successful containment of COVID-19 critically relies on people's voluntary compliance with the recommended PHSM guidelines, which in turn is influenced by a large number of personal and societal factors. Until now, Sri Lanka's public health response has been quite satisfactory in many aspects. Arrival of some stocks of vaccines has given new hope for mitigation of this disaster, however the

pandemic will have its toll on this island for a longer period due to many issues such as the vaccine supply in the global context, effectiveness of the vaccine, emergence of vaccine resistance strains, duration of the immunity provided and issues related to the development of herd immunity. Also, it is clear that Sri Lanka, at this stage, is on the brink of experiencing a widespread community spread, where health system capacity will be overwhelmed by the surge of caseload. It is clear that people's precise risk perception could be compromised by many behavioural biases including unwarranted optimism and overconfidence (2). The College of Community Physicians of Sri Lanka (CCPSL) takes the stand that the vaccine arrival should not be allowed to create a false sense of security which could lead people to dropping their guards down as the pandemic continues. This position paper discusses the barriers

in ensuring compliance among the public at this decisive juncture with a view to facilitate implementation of/or adhering to current COVID-19 control strategies in Sri Lanka.

The PHSM include personal protective measures (such as hand hygiene, respiratory etiquette, mask wearing); environmental measures (such as cleaning, disinfection, ventilation); surveillance and response measures (including contact tracing, isolation and quarantine); physical distancing measures (e.g., limiting the size of gatherings, maintaining distance in public or workplaces, domestic movement restrictions); and international travel-related measures (1). However, it has been observed that there are substantial regional differences in intent to comply with public health recommendations to reduce the spread of COVID-19 (3). Research in Sri Lanka in this regard is few and far between. However, it is observed that practical application of these recommendations into daily routines has not been optimal in Sri Lanka thus far, even with law enforcement. This issue has been identified as a common threat to outbreak response strategies in many other countries as well as discussed below.

Researchers have looked into various factors (5-33) influencing the compliance to PHSM and the barriers (4) in implementing these. The factors which affect the compliance include: perceived severity (5) and the mortality status of the country (5), socio-economic status (6-7), age (older ages being more compliant) (8-12), gender (females being more compliant) (13-16), occupation (5,17-18), self-efficacy (19-20), perceived effectiveness of the recommended measures (13), perceived reliability of the media (13), personality (21-22), moral principles such as caring, fairness, loyalty, sanctity, equality and respecting authority (23-25), perceived benefits (26-27) and trust in the government (5, 28). Based on this evidence and the experience of local public health teams who face the ground reality while engaging in their field work with different communities in Sri Lanka, we propose the need for urgently addressing the following major barriers in adopting the PHSM by the public with a view to facilitate the current COVID-19 response strategies in Sri Lanka.

### **Poor ownership, community engagement and empowerment leading to poor safety commitment from public**

Commitment is a force that binds an individual to a course of action of relevance to one or more targets (29). In the present context, the safety commitment from the public could be considered as voluntary adoption of the PHSM in order to protect self, family and community until the risk of COVID-19 is eliminated. It is known from past research (30-32) that such commitment occurs in a situation where people feel the ownership, are engaged in the decision making and empowered or efficacious to undertake the course of action to achieve some positive targets.

There have been a number of innovative programmes in Sri Lanka intended to inculcate this ownership, engagement and commitment among the public, especially at the start of the pandemic, however, it is clear that the thrust could not be maintained throughout. In addition, these approaches have not been scientifically assessed yet in Sri Lanka. Most of the policy making happened with a top-down social engineering process with minimal representation of the general public. Thus, there is a need to communicate the ultimate outcomes of this present pandemic in Sri Lanka to the public soon, clearly and positively and attempts should be taken to get the general public involved in decision making at all levels with their fullest participation.

The COVID-19 pandemic has brought within a short time period many novel instructions, behaviours and legal obligations in the day-to-day lives of people. The use of correct health promotional (empowerment) strategies that have been proven scientifically in designing COVID-19 responses would be useful in improving the public engagement. With the ownership of the interventions, the community will be driven by 'voluntary compliance', rather than by 'enforced compliance' and thereby act more responsibly and with better motivation. Such community empowerment and participatory interventions could be initiated at the lowest village / community level with a bottom-up approach as well as at the national level. The World Health Organization identifies community empowerment

and participation as a key strategy in an outbreak response with the lessons learnt from the West Africa Ebola Outbreak in 2013-2016 (33).

### **Conducive environments, disadvantaged, high risk and vulnerable groups**

Lockdowns and social isolation measures affect some populations more than the others, and the effects extend well beyond mortality (34). The harder toll of the pandemic is on the poor and disadvantaged communities such as urban slum dwellers and daily wage earners. It is well known that socio-economically disadvantaged groups are at a higher risk of COVID-19, as they generally are more undernourished, less immune to the disease and tend to be more affected by poorly controlled chronic diseases and respiratory diseases (35). It is evident that poverty and economic dislocation reduce compliance with COVID-19 shelter-in-place protocols in other countries (36). This requires more steps to be taken to ensure the well-being of poor and vulnerable groups in the COVID-19 era by reducing the socio-economic inequalities. It is noteworthy that the Sri Lankan Government has taken some positive steps to look after the disadvantaged groups. We feel a well-planned strategy to fulfil basic life essentials could be successfully implemented using the existing social services structure in the country. It is very important that these services should not be limited to food and other basic essentials, but extended to include psycho-social support for vulnerable groups including children and women.

In some public settings and also among some disadvantaged groups, a conducive environment to practise PHSM recommendations does not exist. For example, there have been instances where one-meter distance is not practised in public transport. In a workplace where basic hygienic facilities are not provided for workers, employees cannot practise regular hand washing as expected of them. These are the areas that should be monitored by the health and other regulatory authors. It is not clear whether there are monitoring mechanisms existing, especially with regard to social measures, in order to keep the implementation of PHSM in check.

### **Lack of proper communication between health advisors and public, misinformation and disinformation**

When well-conceived, carefully implemented and sustained over time, public health communication programs have the capacity to elicit change among individuals and populations by raising awareness, increasing knowledge, shaping attitudes and changing behaviours (36-37). Compliance with government-mandated health directives among democratic systems requires that the public embrace a set of pro-health social norms that can withstand the spread of scientifically unsupported information and/or lack of trust in national health leaders (38). At the start of the pandemic, there have been some innovative public communication efforts and risk communication systems in Sri Lanka (39) to instigate some social norms in relation to COVID-19. However, from the Government side, there have been unscientific messages propagated and disseminated to the public later on. Once it was about scientifically unproven COVID-19 treatment options and then about insisting on compulsory cremation despite not having any solid evidence to recommend so. Moreover, there have been contrasting messages regarding PHSM from different sectors of the medical fraternity. There have been some instances when some of the key personnel in the hierarchy have themselves violated the PHSM as reported in media. This trend has been observed in other countries too (40). All these could contribute to the weakening of the risk perception among the public and poor public engagement.

The media communications by some of the key officials have often been based on creating emotional, i.e., fear or threat, responses among the public. It was noted that there have been only some instances where efforts were taken to improve self-efficacy in adopting PHSM among the public. Building trust in the efficacy of health-promoting behaviour could increase willingness to engage in such practices, thus reducing the need for more intrusive government interventions, which might impel protest and backlash, particularly in democratic societies (41). This should be coupled with addressing the key issues related to adopting PHSM among the lay public. For

example, some studies indicate that people have been reluctant to wear face-masks due to reasons such as discomfort and for feeling trapped or suffocated (42). In Sri Lanka, there seems to be lack of research evidence on the difficulties the public face in adhering to PHSM. Having a higher trust in scientists has been associated with lower susceptibility to coronavirus-related misinformation among the public (42). Also, it has been highlighted that in order to increase voluntary compliance with COVID-19 measures, public health campaigns should implement strategies that foster moral obligation and trust in authorities or leverage trustworthy individuals in the community to disseminate information (17). Some other challenges to be addressed in risk communication in the pandemic would be as follows: tailoring message to account for foundational belief systems; acknowledging uncertainty; aiming to earn the public's trust; and prioritizing communicating risk well (43).

### **Apathetic whole-of-government and whole-of-society approach**

The COVID-19 pandemic is a stark reminder of the need to elevate the role of science in public and political decision-making (43). The success in fighting against COVID-19 in China has been mainly attributed to adaptable governance to changing situations, culture of moral compliance with rules, trusted collaboration between government and people and an advanced technical framework (44). It is noted in some instances that the approach had not been mainly geared for an all-inclusive one in Sri Lanka. Different government agencies were functioning in isolation at times and some groups of the society were rendered marginalised due to some controversial decisions. It is pathetic that the whole country was baffled by a few controversial personalities during the pandemic, especially with regard to many 'herbal tonics' ('peniya') some of which have been supposedly revealed to the persons concerned, by unforeseen powers. Pseudoscience, or a collection of beliefs or practices mistakenly regarded as being based on scientific methods, has emerged as a powerful destructive force during the current pandemic (45-47). Government intervention,

or lack thereof, can drastically change the impact of the outbreak on society (48) and there is no better approach for a government than following the lead of science to take the most appropriate actions. Degraded trust and cohesion within a country are often shown to have large socio-economic impacts, they can also have dramatic consequences when compliance is required for collective survival (49). Public health blind spotting by senior elected political executives has become a serious problem during the COVID-19 pandemic (50).

### **Conclusions**

It is mandatory that in our optimism about vaccines, we do not lose the focus of the dangers of this virus, the situation of the country that we are in at the moment and the simple actions we all need to take to protect ourselves and each other. PHSM as practised today need to be strengthened in order to prevent a possible community transmission in Sri Lanka. Risk communication has to be continued at a faster phase in order to empower the public. Not pseudoscience but science should provide the key to all those concerned to see the end of this pandemic while the initiatives need to be backed by proper research. The public needs not only be the recipients but also a stakeholder to all decisions taken at all levels.

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