Updates

Enhancing the Sri Lankan response to COVID-19

- A Communique from the College of Community Physicians of Sri Lanka

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Background

With the identification of the first local case of COVID-19 on 11th March 2020, Sri Lanka responded urgently and aggressively via a multitude of health and non-health sector measures to control its spread. Sri Lanka being a middle-income country was commended for its timely and pro-active "whole-of-government and whole-of-society" epidemic response. However, COVID-19 epidemic is dynamic, demanding the control strategies to be responsive to its dynamic nature. While continuing the key control measures such as, tracing, testing detecting, isolating and treating, there is a need to modify our approach of conducting those to the changing context.

While commending the successful efforts undertaken by the Government of Sri Lanka (GoSL) and other entities partnering to contain the epidemic, CCPSL urges all parties to review the preventive and control strategies undertaken, considering the current realities.

This communique presents essential recommendations on changes to be made to the priority steps documented in the *Sri Lanka Preparedness & Response Plan COVID-19 (April 2020)* to improve the pandemic response.

1. Country-level planning, coordination and monitoring

- In all technical decisions regarding the control of this epidemic, the health input should be given the priority.
- A Director General of Health Services should be appointed immediately to lead the professionals.
- The Inter Collegiate Committee, epidemiologists, microbiologists, internal medicine and public health professionals, sociologists and behavioural scientists need to be included in the national and regional level decision making process. This group should include experts from direct implementing bodies as well as outside the

implementation institutions (E.g., professional colleges) for critical assessment of the process.

- To avoid the current lapses in coordination on national strategy and regional implementation, appointing a technical authority at national and regional level for control of COVID-19 should be done to lessen administrative barriers.

2. Risk communication and community engagement

Implementation of risk communication plan executed by technically competent, trained persons is urgently needed. Currently, behaviour assessment, use of trusted community groups and already available channels for risk communication remains suboptimal. Risk communication strategies should adapt to the dynamic nature of the epidemic monitoring the ongoing situation.

Key areas to focus attention:

- Fast, clear and accurate delivery of information to the public, specially about new cases and clusters is required.
- Bring in regulations to urgently control the illegal media exposure of COVID -19 patients and their contacts. Serious regulations should be introduced to prevent stigmatizing populations, geographical areas, ethnic groups, professions or industry connected to identified clusters.
- Prevent unlawful access to media for confidential information till those are officially confirmed.
- Mental and behavioural preparation of the public for escalation of epidemic should be done with clear communication on the country's policy.
- Avoid giving false assurances that harm the primary prevention strategies and reduce adherence to optimal health practices.

3. Surveillance, case investigation and rapid response

Surveillance:

Active and passive surveillance of COVID-19 needs to be streamlined.

- A case definition based on Sri Lanka's reported cases is not yet defined. A symptom profile of Sri Lankan patients needs to be developed using the available data.
- Available data indicate that around 50% of outpatients care is done in the private sector and hence the surveillance of Influenza like Illness (ILI) and Severe Acute Respiratory Infections (SARI) to be extended to this sector. All those who are engaged in private general practice (GP practice) should be instructed to refer suspected ILI/ SARI patients to get PCR at designated places.
- Active surveillance among high-risk individuals and clusters should be initiated. This includes any place with increase intensity and duration of exposure for large number of people (E.g., factories, schools) and people with high mobility and possible exposure.

Case investigation:

To optimize the efficiency of rapidly increasing workload in case investigations, delegation of work is required.

- Individual case investigations and contact tracing should be done by a team led by medical officer of health (MOH) at divisional level.
- For cluster investigations, a deployment team should be established headed by CCP with regional epidemiologists.
- The epidemiology unit should provide the technical support and guidance, but not the direct case or cluster investigation.
- Case investigation should ensure that the investigation procedure is standard and not stigmatizing the patients.

Rapid response:

The rapidly increasing number of infections will quickly exceed the hospital capacity. To minimize this and to optimize resource utilization and in

preparation for the long-term battle against COVID-19, following change of strategy is proposed. Rapid response with individual and mass isolation, quarantine and lockdown needs to continue, adhering to the instructions stipulated in the gazette No.2197/25.

- Contacts: home/self-isolation as in the Gazette No.2197/25
- Asymptomatic positives: Risk assessment and self -isolation/isolation in intermediate centers with additionally trained staff
- Mild symptomatic cases: Dedicated hospitals /quarantine centers (should not be a part of secondary or tertiary care hospitals)
- Moderate to severe cases: Dedicated hospitals /wards with intensive care unit (ICU) facilities

Decision of isolation and quarantine should be done by a competent health professional to do the risk assessment.

4. Immigration at points of entry

The current process is effective. However, if a person is quarantined immediately upon repatriation and stays in quarantine for 14 days, entry PCR would be adequate. However, this will not be valid if the individual isolation is not done. Individuals or third-party organizations should not be allowed to violate the laid down rules of quarantine.

5. Capacity of national laboratories

The number of cases and close contacts is already exceeding the national laboratory capacity. The move to include all places with PCR facilities outside the health ministry is commendable. A technical committee is needed to assess the new diagnostic tests and to update recommendations based on new evidence.

6. Infection prevention and control (IPC)

IPC capacity is not equitably distributed even across healthcare institutions. Heads of institutions in health and other public and private sector institutions should be made accountable for the IPC capacity development and implementation. Implementations of the published guidelines needs to be monitored by the MoH, as the implementation process is sub optimal in many places.

Triage in hospitals should be strictly monitored and be headed by a trained health professional.

A national plan of supply of PPE for health staff is required.

7. Case management

Case management strategy should be developed with relevant technical bodies.

Selfcare guidelines should be developed for mild/ asymptomatic cases, to make sure healthcare professionals are not overburdened and the focus is not deviated from moderate to severe cases (COVID-19 and non-COVID-19).

COVID-19 case management plan should not jeopardize the accessibility and availability of healthcare for other illnesses, especially with restricted movements and lockdown. Prevention of non-COVID-19 related deaths should remain a priority.

An ongoing capacity assessment and future projection of requirement is required especially for ICU care facilities.

8. Operational support and logistics

Mapping future requirements based on epidemiological predictions should be optimized.