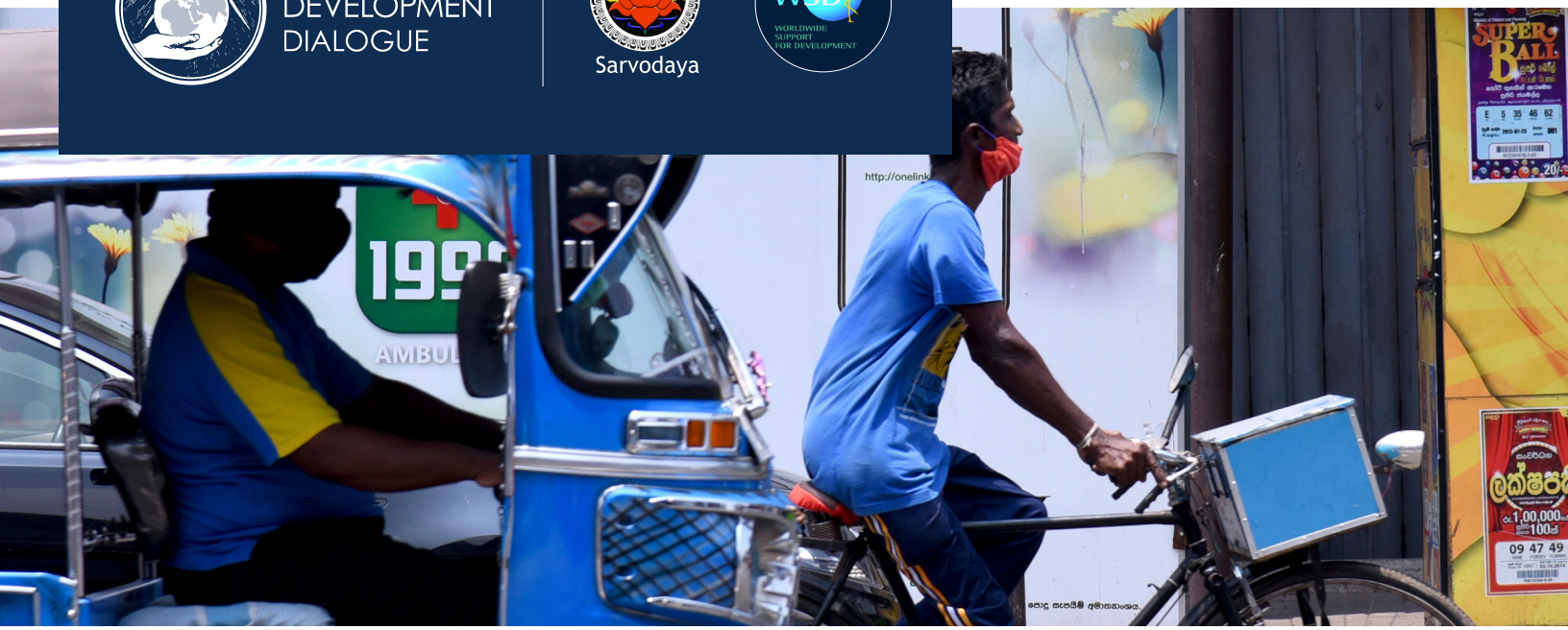

Sri Lanka's Intersecting COVID-19 Emergencies: Highlights and Lessons

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CHALLENGES GALORE

The COVID-19 pandemic caught global institutions and health systems off guard, despite repeated warnings that pandemics were inevitable, and notwithstanding significant efforts after prior health emergencies to recommend specific, crucially-needed preparations. National and international public health responses varied widely, influenced by, *inter alia*, existing public health system structures, levels of trust of citizens, and religious beliefs and culture. The wide array of weaknesses identified in public health responses included ineffective or missing transnational cooperation, poorly-defined inter-institutional arrangements, crucial funding shortfalls, and failures to engage effectively with communities. The devastating global consequences of the COVID-19 pandemic, and its continuing and often shifting character, include layers of effects that extend well beyond public health. Job losses, truncated education provision, and supply chain disruptions, for example, overwhelmed the global governance mechanisms that were, in principle, mandated to respond to crises. The public health crisis combined with and exacerbated conflicts, so that a public health emergency led to and fed tumultuous global economic, social, financial, and, by some counts political upheavals.

Sri Lanka exemplifies the compounding crises, at a national level. Often exemplary initial technical public health responses unraveled as layers of crisis unfolded. These in turn involved complex relationships between public health and broader social and governance features. Some effects were driven by specific circumstances of the covid crises, while others resulted from long years of conflict and fragility, including largely unhealed social and political divisions. Both the public health and

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the broader responses, including reforms to social safety nets aimed at cushioning vulnerable citizens, failed to involve deliberate and meaningful engagement of communities, including the religious communities that are a deeply embedded part of Sri Lanka's society.

Sri Lanka's experience highlights challenges echoed everywhere around the world (decisions on shutdowns, supply issues, risk assessment, vaccination rollouts). It also shows how a country and society's distinctive features colored immediate responses and the sequels in disruptions and transformations.

This paper explores Sri Lanka's experience in responding to the COVID-19 Pandemic. It draws on a study of the COVID-19 response launched in mid 2022, with support from the World Faiths Development Dialogue (WFDD). The study reviewed public health responses from public documents and undertook surveys, focus groups, and targeted interviews aimed at understanding community responses and engagement through the crisis, in order to set the specific experience in a broad national setting. Sri Lanka's experience has particular relevance for situations of state and social fragility, but the challenges of community and especially religious engagement, rarely addressed in a strategic manner, have especially broad relevance.

The paper poses many questions for dialogue and reflection. What conclusions and lessons should public health and other policy makers draw from Sri Lanka's experience as they address "preparedness" for future pandemics? What "bright spots", and what dark experiences – at both the national and international levels – offer the most learning? With significant evidence of widely different local experiences, are there significant lessons from differences as well as common experience?

THE SRI LANKA STORY

Sri Lanka had important assets as the COVID-19 pandemic began. Apart from its island status which offered some protection, Sri Lanka's health system (Box 1), with over 95% of the population relying on free public healthcare services, stands out for its broad and equitable nature. The relatively well educated and connected population was another asset. However, the economic, social, and political crisis that developed with the crisis revealed deep-rooted governance failures that affected health care delivery and also exacerbated the country's economic and social fragility. The interplay of public health and economic policies, along with the impact of inter-group tensions, demands a broad perspective in assessing the pandemic response and health system performance. A historical investigation and rigorous survey data can help in assessing experience, making it possible to understand communal responses and lasting impacts beyond biological and sociological factors.

BOX 1

Sri Lanka's Health System

Sri Lanka's public sector provides some 95% of inpatient care and 50% of outpatient care; for decades health care is clearly set as a human right. Though private health services are growing, they are accessible to a small fraction of the population. Preventive healthcare is provided through geographically defined areas, each served by a medical officer of health, with strong supportive supervision. Separate service facilities are available for the armed forces, police, and prisons. The state health services function under a cabinet minister. With the Thirteenth amendment to the Constitution, health is partially devolved; the Ministry of Health (MoH) is responsible for stewardship functions such as policy formulation and health legislation, program monitoring, and technical oversight, management of health technologies, human resources, and tertiary and other selected hospitals, and the primary and secondary levels of curative care and preventive services function under the nine provincial ministries.

Government spending on health care as a share of GDP was around 1.7% in the 2013 to 2016 period. Household contribution to current health expenditure is significant, though catastrophic health expenditure is relatively low as the government remains a key provider of inpatient care. Medication and investigations are provided free of charge.

A first comprehensive national health policy based on primary health care was drafted in 1992, then revised with a focus on universal health coverage (2014–2016). The current policy (2016–2025) addresses emerging health issues, quality and safety, and people's expectations. Recent reforms aim to re-organize primary care services and include the launch of a policy on health-care delivery for UHC along with other supporting policies such as the National Authority on Tobacco and Alcohol, National Policy and Strategic Framework for Prevention and Control of Chronic Non-communicable Diseases, National Policy on Health Information, and Policy on Health Service delivery for UHC.

Sri Lanka has achieved strong health outcomes over and above what is commensurate with its income level. Health indicators include life expectancy of 82 for women, 78 for men, and an infant mortality rate (IMR) rate of 5 per 1000 live births, akin to much richer countries. Sri Lanka has eliminated malaria, filariasis, polio, and neonatal tetanus. Health system challenges include a rapidly ageing population, and the need to address the burden of non-communicable diseases which currently contributes to nearly 75% of deaths.

Rajapaksa L, De Silva P, Abeykoon A, Somatunga L, Sathasivam S, Perera S et al. Sri Lanka health system review. New Delhi: World Health Organization Regional Office for South-East Asia; 2021.

STUDY OBJECTIVES, METHODOLOGY, AND HIGHLIGHTS OF FINDINGS

The Sri Lanka case review was led by Dr. Vinya Ariyaratne, with support from the World Faiths Development Dialogue. It aimed to highlight lessons in a Sri Lankan context and to contribute to the many efforts underway to assess the COVID-19 pandemic experience. Specific study objectives were:

1. To review the multisectoral COVID-19 pandemic response in Sri Lanka as a foundation for policy analysis and recommendations.

2. To develop a multi-stakeholder learning review on pandemic preparedness in Sri Lanka as a learning case study for multiple audiences.

3. To identify features of the community responses and their impact due to the COVID-19 pandemic as a basis for further research and analysis, with inter alia attention to religious dimensions. A first component relied on desk reviews, followed by quantitative and qualitative surveys focused on community response.

The study was completed as planned, albeit with delays notably due to review by Sri Lanka's Ethics Review Committee (approval received May 25, 2023).

The desk reviews entailed collecting, organizing, and synthesizing available information from a variety of sources. A stakeholder analysis was first conducted to identify the key sectors that were involved in pandemic preparedness and responses. In-depth reviews identified documents related to pandemic preparedness in Sri Lanka to trace and specify the COVID-19 pandemic response. The desk review documented the chronological actions of government and private actors, including efforts to identify the pandemic's different socio-economic challenges and its impact on society. Working papers on the three components of the review are available on request.

The Sri Lankan government's public health response was prompt and generally appropriate. Soon after the COVID-19 emergency was recognized, a National Action Committee for COVID-19 was appointed, with representatives from various sectors. Drawing on a first National Influenza Pandemic Preparedness Plan from 2005, the initial response to the COVID-19 pandemic focused on revisions to and implementation of an interim Strategic Preparedness and Response Plan. This involved collaboration with the Ministry of Health, Nutrition, and Indigenous Medicine and the World Health Organization (WHO). Recognizing the need for a comprehensive multisectoral response,

BOX 2

Sri Lanka: COVID-19

First reported case: January 27, 2020
Three COVID-19 waves were identified.

- 1st wave – 11th March 2020 to 2nd October 2020
- 2nd wave – 3rd October 2020 to 14th April 2021
- 3rd wave – 15th April 2021 to 31st December 2021

Total cases reported: 672,039

Reported fatalities: 16, 830

Vaccinations: All doses: 40,116,590

% of Population receiving at least 1 dose: 80.06%

https://coronavirus.jhu.edu/region/sri-lanka

actions included stringent measures such as banning public gatherings, travel restrictions, school closures, mandatory quarantining, work-from-home adaptations, and curfews. The national response was structured around four lines of operations: (i) the Military, Police, Intelligence; (ii) Medical and Healthcare, Psychological; (iii) Economic,; and (iv) Community well-being.

The health sector response was multifaceted, centered notably on quarantine and isolation measures. Sri Lanka established a comprehensive set of guidelines, gazettes, and circulars under "The Quarantine and Prevention of Disease Ordinance" to regulate quarantine and isolation, adapting these measures as circumstances evolved. Home quarantine was utilized for individuals and close contacts without severe symptoms, monitored by Public Health Inspectors (PHI) and village committees. The process underwent revisions, initially allowing home quarantine, then mandating institutional quarantining due to breaches, and subsequently restoring home quarantining with enhanced supervision. Geographic areas with high case detection were isolated for 2-4 weeks. The government's strategy involved strict measures at ports of entry, including screening, mandatory quarantine, and travel restrictions.

Sri Lanka's COVID-19 response was marked by a comprehensive surveillance system and strategic testing protocols. The Epidemiology Unit under the Ministry of Health played a pivotal role in overseeing surveillance activities, conducted at district levels by regional epidemiologists and at the community level by Ministry of Health and Public Health Inspectors. The establishment of a National COVID-19 surveillance system, integration with existing platforms, and mandatory reporting of laboratory-confirmed cases facilitated the monitoring of disease dynamics. A notable aspect was the selective testing strategy during the early stages, prioritizing vulnerable populations in high-risk areas over mass testing. Contact tracing, coordinated by the Epidemiology Unit and involving Public Health Inspectors and the armed forces, played a crucial role. Ports, the main entry points to the island nation, implemented screening and surveillance, with returnees initially placed in institutional quarantine.

The testing strategy involved a combination of RT-PCR, antigen-detecting rapid diagnostic tests (Ag-RDT), and antibody testing. The Virology Department of Medical Research Institute initiated RT-PCR molecular testing in January 2020; Sri Lanka received external support for strengthening testing capacity. The introduction of Rapid Antigen Tests in November 2020, with support from WHO, aimed to enhance testing accessibility. Circulars and guidelines were issued to regulate testing criteria, testing facilities, and reporting protocols. The testing strategy evolved based on disease progression and resource availability. The use of digital mapping and GIS technology gave decision-makers data-driven tools for effective response. Despite challenges like limited testing capacity during certain periods, Sri Lanka's approach demonstrated adaptability and a multifaceted strategy involving surveillance, contact tracing, and testing for managing the impact of COVID-19.

Extensive guidance documents were issued, circulated, and revised especially during the first months of the Pandemic. The Director General of Health Services (DGHS) issued in January 2020 a circular outlining interim guidelines for the clinical management of COVID-19 patients, later revised in February 2020. WHO further updated the surveillance case definition in March 2020. Subsequently, the Epidemiology Unit collaborated with the Ceylon College of Physicians to develop detailed clinical practice guidelines published in March 2020, which were revised multiple times. An Expert Advisory Committee was formed in March 2020 to advise the Ministry of Health on diagnosis and clinical management, leading to the issuance of circulars and gazettes with recommendations. A

hospital preparedness and response plan for COVID-19 was also developed, emphasizing key elements, functional areas, and procedures for managing patients, including those in home-based isolation.

As the outbreak progressed, concerns arose about the potential collapse of the health system during the third wave. In response, guidelines for integrated home-based isolation and management of asymptomatic and mild symptomatic COVID-19 patients were issued in August 2021. The guidelines outlined a system where positive individuals were triaged by area Medical Officers of Health (MOH) for either home or institutional care. The Ministry of Health expanded the number of treatment centers from 14 during the first wave to 278 by the third wave. Various circulars and guidelines issued by the Ministry of Health in collaboration with expert committees and colleges addressed specific aspects of COVID-19 patient care, including guidelines for children, newborns, pregnant women, and primary care physicians. Initial guidelines primarily focused on hospital-based care, but as cases increased, attention was directed towards primary care, resulting in the development of guidelines suitable for primary care settings by a team of physicians, later accepted by the Ministry of Health.

The COVID-19 vaccination campaign in Sri Lanka began on January 29, 2021, with the Ministry of Health coordinating a comprehensive plan outlined in the National Vaccination and Deployment Plan (NVDP). A National Coordination Committee and three technical subcommittees were established to oversee various aspects of the vaccination program, such as deployment planning, safety monitoring, and expert recommendations. The vaccine procurement process was managed through the State Pharmaceutical Corporation. Global organizations like GAVI, WHO, UNICEF, ADB, and the World Bank supported the deployment, and regulatory approvals were expedited for seven vaccines.

To finance vaccination COVID-19 vaccine procurement, Sri Lanka, like many other countries, utilized a combination of domestic resources, international aid, and partnerships. The key mechanisms through which Sri Lanka financed its COVID-19 vaccination campaign were:

1. Domestic funding - The Sri Lankan government allocated funds from its national budget to procure COVID-19 vaccines. This involved diverting resources from various sectors to prioritize vaccine procurement and distribution as a critical public health measure.

2. Multilateral and Bilateral Assistance - Sri Lanka received financial and technical assistance from multilateral organizations such as the World Bank, Asian Development Bank (ADB), and the United Nations (UN), as well as bilateral partners. These entities provided grants, loans, and technical support to help finance vaccine procurement and strengthen the country's healthcare infrastructure.

3. COVAX Facility - Sri Lanka participated in the COVAX initiative, a global vaccine distribution program co-led by WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations (CEPI). Through COVAX, Sri Lanka received a portion of its COVID-19 vaccine doses free of charge or at a reduced cost, primarily targeting vulnerable populations.

4. Direct Purchase Agreements - The Sri Lankan government negotiated direct purchase agreements with various vaccine manufacturers to secure additional doses beyond those obtained through COVAX. These agreements involved negotiations on pricing, delivery schedules, and logistical arrangements to ensure timely access to vaccines.

5. Public-Private Partnerships - Sri Lanka leveraged partnerships with private sector entities, philanthropic organizations, and civil society groups to mobilize additional resources and support for its

COVID-19 vaccination campaign. This involved corporate donations, fundraising initiatives, and community engagement efforts to supplement government-led efforts

6. Donations and Grants - Several countries and organizations provided donations and grants to support Sri Lanka's COVID-19 response, including vaccine procurement. These donations included both financial contributions and in-kind assistance, such as vaccine doses, medical supplies, and technical expertise.

By utilizing a combination of these financing mechanisms, Sri Lanka was able to procure and distribute COVID-19 vaccines to its population, contributing to efforts to contain the spread of the virus, protect public health, and mitigate the socio-economic impact of the pandemic. However, challenges such as vaccine supply constraints, logistical hurdles, and vaccine hesitancy necessitated ongoing efforts to ensure equitable access to vaccines and achieve widespread vaccination coverage.

Vaccination prioritization aligned with global guidelines, starting with healthcare staff and frontline workers. The Ministry issued a series of circulars and guidelines to manage vaccine campaigns for different vaccines, detailing stock management, storage, dosage, and administration procedures. The deployment faced challenges, including a mismatch in demand and supply due to changing priority groups, delayed second doses, and a shortage of healthcare staff during the third wave. External support, including from the military, helped address logistical challenges, and an appointment-based system was developed with WHO and ICTA assistance. Despite overall low vaccine hesitancy, certain groups showed reluctance, influenced by misconceptions and preferences for specific vaccines. The government spent 0.4% of the GDP on vaccine procurement in 2021, achieving a vaccination coverage of 60% of the population by year-end.

EMERGING TOPICS OF FOCUS

The following sections focus on specific issues that emerged from the review, highlighting those related to public health policies.

Concerns were raised about *transparency in vaccine selection and deployment plans*. Actual vaccine roll-out in Sri Lanka did not strictly follow the road map laid out in the NDVP. The vaccination drive started with health care workers on 29th of January 2021. What followed was a chaotic period with problems associated with changes of priority groups initially selected for vaccination, shortage of stocks, approval process, irregularities in the procurement process, public concerns on vaccine safety etc. The NDVP priority list for vaccination was based on the quantity of vaccine available - with health workers, front line security forces personnel, and persons with co-morbidities and the elderly in the order of priority (page 13, NDVP). However, around February/March 2020, a decision was made to vaccinate working population (ages above 20 years) in the Western Province, deviating from the original priority framework. Although this group was important from an economic perspective, this decision denied, albeit temporarily, giving the vaccines to the elderly and the persons with comorbidities. However, with vaccine supply being significantly increased in the following months, the vaccination program was put back on track and followed the original priority framework.

Sri Lanka, like many countries, implemented strict measures to contain the spread of COVID-19, including *protocols for the disposal of deceased individuals*. Initially, the government mandated cremation for all COVID-19 victims, citing concerns over public health and the potential risk of groundwater contamination if bodies were buried. However, this policy directly contradicted Islamic beliefs, which require deceased Muslims to be buried according to religious rites; it also the WHO Guidelines on the management of dead bodies of persons who

have died of suspected or confirmed COVID-19. (WHO, 2020). Guidelines for disposal of patients who had died of COVID-19 were initially outlined in a provisional clinical practice guideline issued by the Ministry of Health in March 2020. Bodies of confirmed COVID-19 cases were to be cremated within 24 hours, with a preference for 12 hours, without autopsy or embalming.[1] The government's mandatory cremation policy faced significant backlash, particularly from the Muslim community. The policy was criticized by human rights groups, the United Nations, and international communities, leading to protests and condemnation. The government's stance on mandatory cremation persisted despite an expert panel's recommendations and WHO guidelines allowing both burial and cremation. In March 2021, a circular was issued, reversing the policy and allowing the choice of cremation or burial, but concerns persisted, particularly regarding the designated burial site on a remote island in the Gulf of Mannar, causing hardship for the Muslim community (Box:3). Muslims argued that the policy infringed upon their religious rights and cultural practices. Burial is a fundamental tenet of Islam and denying this rite to Muslim COVID-19 victims was perceived as a violation of their dignity and religious freedom.[2] Human rights groups, religious leaders, and diplomatic missions raised concerns about the discriminatory nature of the policy and its impact on religious minorities. The United Nations and other international bodies urged the Sri Lankan government to respect the religious rights of its citizens and adhere to global human rights standards.

Despite initial resistance, the Sri Lankan government eventually bowed to pressure and reversed its policy on forced cremation. In early 2021, authorities announced that Muslim COVID-19 victims would be allowed to be buried, albeit under strict health guidelines to mitigate any potential risks of transmission. This decision was hailed as a victory for religious freedom and a testament to the power of collective advocacy. It demonstrated the importance of dialogue, engagement, and international pressure in addressing human rights violations. If communities had been effectively engaged earlier, the problems might well have been avoided.

BOX 3

Muslims in Sri Lanka and the COVID-19 Pandemic

Muslims in Sri Lanka form a significant minority group, constituting around 9.3% of the country's population (Census of Population & Housing 2021). They have a rich and diverse history that spans centuries, deeply rooted in trade, culture, and religion. The earliest Muslim arrivals are believed to have been Arab traders who settled along the island's coastal regions. Over time, these traders intermarried with local communities, leading to the emergence of a distinct Sri Lankan Muslim identity. Additionally, there were migrations of Muslims from various parts of the Indian subcontinent, particularly during the colonial era, further enriching the community's cultural tapestry.

Sri Lankan Muslims have a unique cultural heritage influenced by both Arab and South Asian traditions. Their cultural practices encompass a blend of language, cuisine, attire, and social customs. Sri Lankan Muslims are known as "Moors", and Tamil-speaking Muslims predominantly reside in

1 https://iris.who.int/bitstream/handle/10665/331538/WHO-COVID-19-lPC_DBMgmt-2020.1-eng.pdf

2 https://groundviews.org/2021/01/04/civil-society-calls-on-government-to-enable-burials-of-covid-19-dead/

the northern and eastern regions of the country, while the Sinhala-speaking Muslims are dispersed across other parts of Sri Lanka.

Islam is the predominant religion among Sri Lankan Muslims, with the majority adhering to Sunni Islam. The community follows various Islamic traditions and rituals, including daily prayers, fasting during Ramadan, and the celebration of Islamic festivals such as Eid al-Fitr and Eid al-Adha. Mosques serve as central hubs for religious activities and community gatherings, fostering social cohesion and spiritual guidance.

Sri Lankan Muslims have historically been active participants in trade, commerce, and industry, playing a vital role in the country's economy. Many are engaged in businesses ranging from retail and textiles to gemstones and hospitality. Muslims have made significant contributions to various fields such as education, healthcare, and politics, shaping the socio-economic landscape of Sri Lanka.

Despite their contributions to Sri Lankan society, Muslims have faced challenges and discrimination, particularly in the realms of politics and inter-ethnic relations. Tensions have periodically arisen between Muslims and other ethnic communities, fueled by socio-political factors and historical grievances. In recent years, there have been instances of communal violence and religious extremism, further exacerbating inter-ethnic tensions and posing challenges to the harmonious coexistence of diverse communities.

Muslims in Sri Lanka are represented in parliament and hold positions of political influence at both national and local levels. Political parties representing Muslim interests advocate for the community's rights and welfare, addressing issues such as religious freedom, education, and economic empowerment. Additionally, civil society organizations and religious leaders play crucial roles in promoting interfaith dialogue, social cohesion, and peacebuilding initiatives.

The Easter Sunday terrorist attacks in Sri Lanka in April 2019 had a profound impact on the country, including its Muslim community. These attacks, carried out by a local Islamist extremist group, targeted churches and hotels, resulting in hundreds of deaths and injuries. In the aftermath of the attacks, the Muslim community in Sri Lanka faced a myriad of challenges, including security concerns, stigmatization and discrimination, and economic impact. The attacks strained social cohesion and interfaith relations in Sri Lanka. Trust between religious communities eroded, and tensions escalated, leading to divisions and polarization within society. Efforts to foster dialogue and understanding between Muslims and other religious groups faced challenges amid heightened emotions and suspicion. The Easter Sunday attacks underscored the presence of radical elements within Sri Lanka's Muslim community and raised concerns about the recruitment and radicalization of young Muslims by extremist groups. The government intensified efforts to counter radicalization and extremism, but these measures also risked alienating innocent individuals and fueling grievances.

The trajectory of COVID-19 unfolded against this background.

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The resolution of the forced cremation issue in Sri Lanka had far-reaching implications beyond the country's borders. It underscored the significance of upholding religious rights and respecting cultural diversity, especially in times of crisis. The episode served as a reminder to governments worldwide to prioritize inclusivity and consult affected communities when formulating public health policies. Furthermore, it highlighted the critical role of civil society, media, and international institutions in holding governments accountable and safeguarding human rights. This offers hope for religious minorities facing similar challenges globally and emphasizes the importance of upholding fundamental rights and freedoms, even in the midst of a pandemic.

Risk communication and community engagement. The Sri Lanka Preparedness & Response Plans for COVID-19 in April 2020 and 2021 included a focus on risk. The Health Promotion Bureau (HPB) of the Ministry of Health played a key role in carrying out risk communication, involving measures such as regular meetings with stakeholders, the activation of a communication network with support from WHO and UNICEF, active rumor monitoring, daily press briefings, website updates, and the dissemination of information through various channels. The 2021 plan introduced the DReAM campaign (Distancing, Respiratory etiquette, Aseptic techniques, Mask), a hotline for public queries, media campaigns targeting different festive seasons, and a social-media initiative. As this initiative was an official government campaign and importantly, passionately driven by committed community physicians from the Ministry of Health, it was effective to a considerable extent, particularly in getting 3-Wheeler drivers and private buses to display stickers with the key messages.

RESPONSE FROM STAKEHOLDER PARTIES

Sri Lanka Medical Association: The Sri Lanka Medical Association (SLMA) played a significant role during the COVID-19 pandemic, providing expert advice and guidelines on managing and controlling the spread of COVID-19. It also played a crucial role in opposing the compulsory cremation policy by advocating for evidence-based practices, communicating with the government, educating the public, supporting religious and cultural sensitivities, and collaborating with other organizations. Their efforts were part of the broader discourse that eventually led to the reconsideration of the policy.

The College of Community physicinas of Sri Lanka (CCPSL): The College of Community Physicians of Sri Lanka (CCPSL) played a vital role in responding to the COVID-19 pandemic by publishing various position papers aimed at mitigating its effects. One notable document emphasized the need for continual assessment of community transmission levels to inform appropriate actions. Another provided a comprehensive scientific directive, advocating for increased vaccination coverage, strict adherence to preventive measures, and coordinated efforts among

different sectors. Additionally, the CCPSL engaged in debates on topics such as the compulsory cremation of COVID-19 victims and proposed strategic planning to expand testing capacity and promote vaccination. Their recommendations also included guidelines for an exit strategy, emphasizing the importance of surveillance and antibody testing.

Defense & Security: The Defense and Security sector in Sri Lanka responded to the COVID-19 pandemic, working in collaboration with various stakeholders such as the Ministry of Health, Sri Lanka Police, and other responsible authorities. The establishment of the National Operations Centre for Prevention of COVID-19 Outbreak (NOCPCO) under the leadership of the Chief of Defense and Army Commander was a significant step towards coordinating pandemic-related operations. Numerous quarantine centers were set up across the country, providing essential facilities and care to returning citizens and those in quarantine through the efforts of the Sri Lankan Army, Navy, and Air Force. Additionally, the military contributed to the construction and management of Intermediate Care Centers to accommodate COVID-19 patients. The Defense sector also assisted in contact tracing efforts, enforcement of curfew measures, and deployment of vaccination campaigns, including mobile vaccination drives to reach vulnerable populations. Furthermore, initiatives such as musical entertainment programs and distribution of essential supplies aimed to support the mental and physical well-being of affected communities.

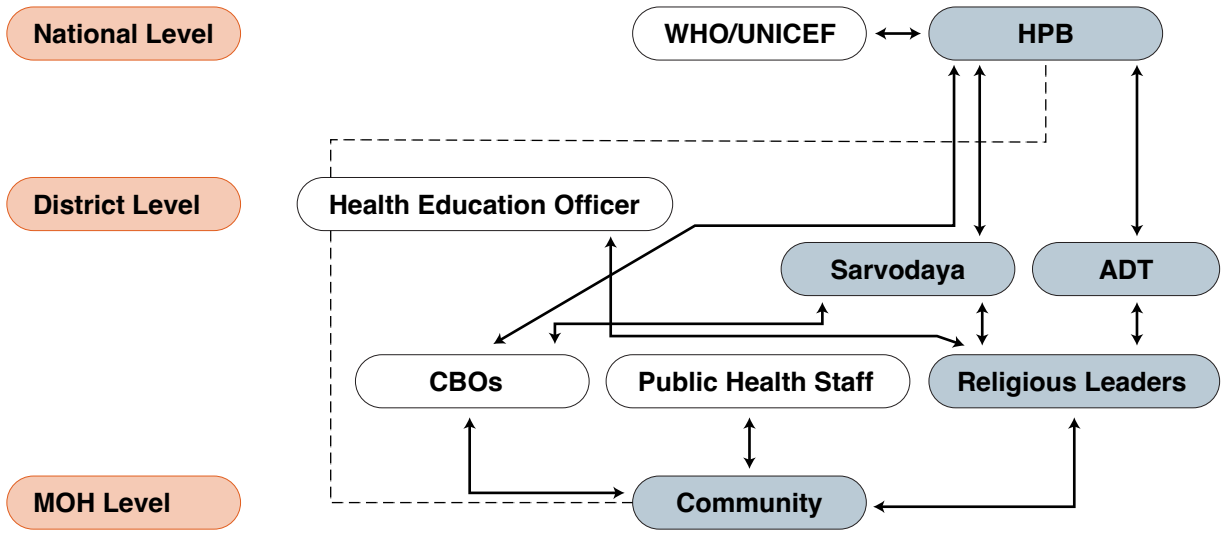
International Partners and NGOs: International partners and non-governmental organizations (NGOs) played important roles in supporting Sri Lanka's response to the COVID-19 pandemic, collaborating closely with the government. The WHO facilitated various initiatives, including genomic sequencing of the virus, donation of Rapid Antigen Kits for surveillance, dissemination of infection prevention control information, and development of an IT-based data system for monitoring COVID-19 testing. WHO provided essential supplies such as PPE for frontline workers and medical equipment, conducted awareness programs, and supported mental health activities. Funding from organizations like the World Bank and Asian Development Bank (ADB) supported Sri Lanka's emergency response and health system preparedness, including procurement of vaccines and financial aid for vulnerable populations and small businesses affected by the pandemic.

Clergy, Faith Organisations and public ethnic and religious response: The response of clergy, faith organizations, and public ethnic and religious groups to the COVID-19 pandemic in Sri Lanka underwent significant adaptations and challenges. With religious services interrupted and gatherings restricted, communities had to find alternative ways to practice their faith while prioritizing public safety. The government's controversial mandatory cremation policy for COVID-19 victims faced opposition from religious leaders, leading to calls for a review to respect minority religious beliefs. Despite restrictions on mass gatherings, some religious events saw defiance, leading to protests and health concerns.

Various faith communities adapted their practices, utilizing digital platforms to continue religious activities and disseminate health guidelines. Special prayers and rituals were conducted to seek protection from the pandemic, demonstrating a blend of spiritual and public health initiatives. Religious leaders played a crucial role in promoting health behaviors and vaccine uptake, addressing vaccine hesitancy within their communities through education and advocacy efforts. Initiatives such as the Health-Interfaith-CBO COVID-19 prevention model engaged religious leaders in promoting health behaviors and disseminating accurate information. Training sessions and collaboration with religious organizations helped raise awareness and encourage vaccine acceptance among communities.

FIGURE 1

Health-Interfaith-CBO COVID-19 Prevention Model



Source: Role of religious leaders in covid-19 prevention: A community-level prevention model in Sri Lanka

In 2020, as part of their national and regional community engagement network with WHO and UNICEF, the Health Promotion Bureau (HPB) took proactive measures to establish a community-level preventative model for COVID-19 which involved religious leaders. Other than the HPB, this initiative was supported by the Sarvodaya movement, Alliance Development Trust, and other community organizations. As shown in Figure.2, this model has been effectively utilized for mobilizing religious leaders of all faiths in promoting nine identified health behaviours, namely to develop model community settings in religious places, to involve vulnerable groups in discussions, strengthen community leadership, distribute IEC materials via community networks, and to monitor and evaluate the community engagement activities. Routine training sessions for religious leaders were conducted by HPB and Sarvodaya, with the assistance of WHO, through online platforms. This helped religious leaders to stay in contact with local health authorities as well as to stay informed about latest health policies.

ORGANIZATIONS WITH FAITH LINKS AND OTHER NGOS

Various organizations made distinctive contributions during the pandemic emergency. World Vision Lanka, with support from the EU Humanitarian Aid, focused on relief efforts and healthcare support, distributing dry rations, providing nutritional meals for children, and strengthening rural healthcare facilities. They also facilitated COVID-19 PCR testing and supported the national vaccination program, particularly targeting vulnerable groups.

The Salvation Army contributed ventilators, hygiene packs, and emergency feeding programs to support marginalized communities. They distributed dry ration parcels and conducted social media campaigns to raise awareness about disease prevention measures.

The National Christian Evangelical Alliance of Sri Lanka (NCEASL) and their Alliance Development Trust (ADT) conducted relief programs, distributing dry rations, medical equipment, and educational materials. They also addressed mental well-being and produced guidelines for faith communities and civil society groups.

The National Peace Council Sri Lanka, supported by funding from organizations like Misereor, the German Embassy, and the European Union, conducted a relief program distributing essential items like dry rations, sanitary items, and PPE kits. Through their District Inter Religious Committee (DIRC) network, they reached out to diverse communities, providing assistance to low-income families, orphanages, and medical institutions. They also engaged in awareness programs and disaster management planning, aiming to promote community cohesion and resilience.

Indigenous medical practices gained attention during the pandemic, with the controversy surrounding Dhammika Paniya, an indigenous herbal syrup claimed to prevent and cure COVID-19. Despite government skepticism, the syrup gained popularity, reflecting the trust in traditional remedies among local communities. However, the pandemic also exacerbated social tensions, with reports of hate speech targeting ethnic minorities, particularly the Muslim community. Anti-Muslim sentiments were fueled by incidents of non-compliance with disease control measures and controversies surrounding burial practices.

Civil Society Organizations (CSO) supported children's homes, elder's homes, Centres for people with special needs rehabilitation centres, Safe houses for women, Rehabilitation centres, Probation centres around the country, to provide food security, hygiene, and medical care.

Sarvodaya Shramadana Movement, the largest national NGO with the widest community outreach, played a pivotal role in engaging civil society in COVID-19 prevention and control efforts. Sarvodaya's work was driven by their belief that community engagement should be focused on the smallest geographical unit, the village; this was reflected in the concept of "COVID ready village" which was initially implemented in 30 selected villages across the country. The village-level coordination was led through a village committee named "Suwodaya" *(Awakening of Health)*. Sarvodaya acted as the main mediator in coordinating among CSOs. They also mobilized and engaged community leaders/volunteers and community based organizations (CBOs) in the prevention and control of COVID-19 and in addressing its health and social impact, to implement community engagement programs and strengthen the leadership and meaningful participation of women and girls in all decision-making in addressing the COVID-19 outbreak.

SOCIO-ECONOMIC CHALLENGES OF THE PANDEMIC AND ITS IMPACT ON SOCIETY

The Sri Lanka review also included a cross-sectional survey and a qualitative component (study objective 3). Mixed methods research (MMR) allowed for rigor in the research, based on both inductive and deductive approaches to the research question. Through systematic and integrated interrogation of the qualitative and quantitative data, MMR also provided the opportunity to triangulate answers from quantitative inputs, thereby increasing the depth of the information received. The work made it possible to situate the public health responses in the broader context of the unfolding and broadening crisis.

Prior to early 2020 and the outbreak of the pandemic, Sri Lanka faced economic vulnerability with fiscal problems and high external debt. The outbreak worsened this situation, leading to a health crisis that quickly transformed into a social and economic crisis. Strict measures, including lockdowns, curfews, and travel restrictions, disrupted the economy, particularly affecting tourism, exports, and remittances. The unemployment rate surpassed 5%, reaching an 11-year high, leading to income losses and psychological distress. The government responded with social protection measures, including cash transfers and ration packages. However, there were continuing challenges in identifying vulnerable populations. The disruption in the education sector was notable, with schools and higher education institutions closing, forcing a shift to online learning (Box 4).

The government of Sri Lanka implemented a range of social protection measures during the COVID-19 pandemic to mitigate the economic and social impact on its citizens. These measures aimed to support vulnerable populations, maintain economic stability, and ensure access to essential services. The government provided one-time cash transfers (of Rs.5000/-) to low-income families, daily wage earners, elderly individuals, and persons with disabilities. This financial assistance aimed to alleviate the immediate economic hardships caused by lockdowns and reduced economic activity. These measures, however, were not sufficient to mitigate the significant social impact on the poor and the vulnerable. This situation was further aggravated by the economic crisis which was unfolding towards the end of 2022.

In 2022, according to the World Food Programme (WFP), 6.3 million people, or over 30% of Sri Lanka's population, were "food insecure" and required humanitarian assistance. Of these, around 5.3 million people were either reducing meals or skipping meals, and at least 65,600 people are severely food insecure.

Phase I of the mixed method study identified the community responses and lasting impacts attributable to the COVID-19 pandemic in Sri Lanka. The study design was a descriptive cross-sectional survey. The target population of the quantitative study comprised the general population of Sri Lanka who are 18 years old or above. A total of 1100 households were included. Ten households (i.e., study units) for each cluster resulted in 110 clusters in the final sample from urban, rural, and estate sectors. The selection of the number of clusters was based on the population proportions in each district. The households that are ultimately included in the study were selected randomly from the GNs division.

A majority of the study participants were male (N=560, 54.96%), between the age of 41 to 50 years (N=267, 26.20 %), Sinhalese by ethnicity (N=786, 77.13%), Buddhist by religion (N=773, 75.86%), Married (N=847, 83.12%), and had an education level up to grade 6-11 (N=401, 39.35%).

A summary of conclusions follows:

- Significant numbers of participants saw changes in their main employment. Most were urban dwellers. The pandemic resulted in the loss of income among households. The median (IQR) household food expenditure was Rs. 30,000 (20,000); the pandemic increased monthly food expenditures.

- Households reported that they faced difficulties in accessing healthcare during the pandemic especially non-urban communities. Disruptions to healthcare services delivered led to decreased healthcare seeking.

- Mental wellbeing was affected during the pandemic. Anxiety, feeling depressed, stressed, and hopeless were the common psychological symptoms experienced by the majority of participants during the pandemic. However, only a few obtained treatment and the majority

knew whom to approach. Social isolation and uncertainty were the main reasons for these symptoms.

- The majority responded that the government's approach and the services delivered to mitigate the pandemic were commendable. Respondents perceived that the community leaders had an important role to play during the pandemic.

- Television, friends and family, and social media were the main sources of information. The information disseminated during the pandemic was adequate. However, the estate sector participants didn't have enough information.

Overall, the pandemic disrupted life in unprecedented ways. Socioeconomic conditions deteriorated as businesses shuttered, and employment status was affected. Health services were affected which hindered respondents' access to care. Mental well-being suffered due to isolation, anxiety, and grief, leaving a lasting impact on individuals. Religious leaders provided solace, disseminated guidance, and promoted safety measures, fostering hope during the challenging pandemic which was essential for all individuals.

The study's most important finding is that there were sector-wide variations of all the above factors studied.

The qualitative study conducted as part of the mixed method study identified the community responses and lasting impacts of the COVID-19 pandemic in Sri Lanka. The target population for focus group discussions was considered the general population of Sri Lanka who are above 18 years old. In contrast, key informant interviews were conducted among selected representatives from identified stakeholders who were involved in the pandemic preparedness and response. Results were analyzed distinguishing the urban, rural, and estate sectors. The review focused on key aspects of the community response to the COVID-19 pandemic. Five topics (also tested by the quantitative study) were the economic Impact, Health Seeking Behavior, Psychological Impact, Community Response, and Sources of Information. Four key findings were of particular interest: the impact on families, shortcomings and challenges faced, response to the COVID-19 vaccination program, and Recovery from the pandemic.

Economic Impact: The majority of people representing Urban, Rural, and estate sectors faced financial hardships resulting in challenges such as job losses, income disruptions, business closures, and increased debt burdens. People with daily wage-earning jobs were the largest portion who lost their jobs during the pandemic. A distressing account reflects the economic struggles faced by individuals: "I owned a shop, and it was permanently closed during the pandemic. I had loans to pay, but I couldn't imagine a way to pay those as I lost my business."

Health Seeking Behavior: Changes in health-seeking behavior, such as clinic discontinuation and challenges in accessing doctors, have been observed, and patient behavior has shifted towards avoiding hospitals and self-purchasing medication.

Psychological Impact: Mental wellbeing was affected during the pandemic. Psychological impacts have been significant, with anxiety and stress stemming from home confinement, social isolation, mental discomfort, and loss of income and jobs.

Community Response: The community's response to the government approach was marked by dissatisfaction, including discontent with decision-making, vaccination programs, and the lack of welfare programs for affected families. Challenges during lockdowns, political influences, and transparency issues have also been notable, as expressed through statements like, "During the lockdown, we encountered a shortage of drinking water. The government didn't focus on this issue."

The health sector's response has been met with dissatisfaction, particularly concerning health staff's responsiveness, diagnosis and examination discrepancies, and inadequate guidance. Community self-reliance emerged as individuals sought alternative methods for protection, stating, *"I observed that both vaccinated and non-vaccinated people in our village got the disease. So, I started following my own ways to protect myself and my family using natural home remedies."*

Sources of Information: The majority of respondents have expressed dissatisfaction with the reliability of information received through the mass media, citing contradictions in reporting. The influence of social media emerges as a significant factor, with misleading information leading the public to trust and follow these sources over official health authorities. Mass media channels promoting scientifically unproven herbal tonics contributed to the spread of misinformation. The impact on mental health also was evident, with fear and depression curtailing from the information received, particularly concerning rising death tolls.

Impact on families: The impact on families during the COVID-19 pandemic was multifaceted. A key impact on the families was children's education.. Prolonged school closures led to disruptions in the academic calendar and delays in examinations and academic activities. With schools closed, there was a rapid shift to online learning. However, this transition was challenging due to inadequate digital infrastructure, lack of access to devices, and limited internet connectivity, especially in rural areas. The shift to online education highlighted and exacerbated the existing digital divide. Students from low-income families and remote areas faced significant barriers in accessing online education, leading to increased educational inequalities. Teachers had to adapt quickly to new teaching methods and technologies, often without sufficient training or resources. This transition was challenging for many educators.

The economic downturn caused by the pandemic affected many families' ability to support their children's education. Loss of income led to difficulties in affording school fees, transportation, and learning materials. This economic strain and the shift to online learning led to an increase in school dropouts, particularly among vulnerable groups. In the interviews this was highlighted by families in quotes such as, *"Most of the children in our village left the school because they couldn't participate in online classes during the pandemic due to financial hardships.*

The pandemic response and the subsequent changes in the learning environment had adverse effects on the mental health of students and teachers. Increased stress, anxiety, and feelings of isolation were reported. The Sri Lankan government and educational institutions took several measures to mitigate the impact, such as providing online resources, broadcasting educational programs on television, and distributing printed materials for students without internet access. The CSOs also provided substantial support in providing facilities for online learning, and once the schools were reopened, by providing school supplies to underprivileged students.

The changes made to the examination schedules and assessment methods to accommodate the disruptions caused by the pandemic had long term implications. Some exams were postponed, while others were conducted with alternative arrangements.

The pandemic, which was followed by the economic crisis in 2022, underscored the need for policy reforms to build a more resilient and inclusive educational system. There is an increased focus on integrating technology into education and improving digital infrastructure. While the COVID-19 pandemic posed numerous challenges to the education sector in Sri Lanka, it also highlighted opportunities for innovation and the need for systemic changes to ensure equitable access to education for all students.

BOX 4

Impact of COVID-19 on Sri Lanka's Education Sector

Most Sri Lankan schools and piriven closed (by government order) for approximately 18 months during the COVID-19 pandemic. This severely disrupted the education of all children, with both immediate and long-range impacts. Those most marginalized were worst affected. Among other lasting challenges the closures exacerbated inequalities that were already large.

The government initially closed schools in March 2020, two days after the first official COVID-19 death. There were plans for several reopenings, but these were delayed as case numbers rose. Schools were also closed during periods of acute fuel shortages.

During school closures, the Ministry of Education (MoE) and Provincial Departments of Education (PDE) in Sri Lanka implemented several measures to ensure continuous education. They partnered with internet service providers to activate the web-based learning platform e-thaksalawa, offering free access to a wide range of educational content for grades 1 to 13 in Sinhala, Tamil, and English. Special e-learning data packages were provided by private internet companies, and two public television channels aired educational programs for key exam grades The MoE, in collaboration with UNICEF, also provided study packs for early-primary students in grades 1 and 2 to address their specific educational needs.

Only about 4% of children could access lessons via online platforms, while others relied on WhatsApp and some accessed educational content through television programs. Only 22.2% of households owned a computer or laptop in 2020. Teachers faced significant difficulties in delivering the curriculum through distance learning modalities, lacking training in information and communications technology (ICT). Many adapted by using mobile apps and recording teaching videos. Thus wide differences in access to computers and internet limited the effectiveness of remote learning. Learning losses were wide but also unequal. The Ministry of Education introduced the Essential Learning Content curriculum to address learning loss but has not measured or mitigated dropout rates and learning gaps.

The closure of schools had effects well beyond learning loss. Midday meals, crucial for many children's nutrition, could not be delivered. Family income lost (urban households saw a 37% decrease in income) affected children's education as parents struggled to prioritize schooling over economic survival. Rising costs of fuel and essential food items pushed parents to send their children to work, hindering their education. High food prices and undernutrition affect nearly 43% of children under five, contributing both to learning loss and dropouts.

Most or all schools reopened in June 2022. Attendance has not yet returned to pre-pandemic levels, The long-term impacts threaten to perpetuate generational poverty, with marginalized children experiencing 57% more learning loss than their wealthier peers. The government's reduced budget for school meal programs exacerbates the situation.

Substantial, immediate interventions are needed. The crisis highlighted the need for comprehensive reforms.

Changes in family dynamics weakened bonds, altered family roles, and led to increased family disputes and the loss of family members, as illustrated by personal stories like, *"My brother died at the hospital from Covid, and his body was immediately cremated without the opportunity for a proper funeral."*

Shortcomings and emergency challenges included shortages of essential goods and services, including medicinal drugs, food, drinking water, and disruptions in healthcare access. The inadequate government response is evident in the lack of support for families in quarantine, poor management of quarantine centers, and poorly scheduled curfews; as stated by one respondent: *"My entire family contracted the virus, and during this period, my mother got severely sick. We were unable to contact an ambulance because both hospital ambulances and the 1990 ambulance service were fully occupied."*

Response to the COVID-19 vaccination: Some degree of vaccine dissatisfaction was expressed by some individuals who attributed side effects like body aches and fatigue to vaccination. The mandatory nature of vaccination, enforced by the government, led to compliance without personal willingness. At one-point, a declining trend was noted in vaccination of young people owing to misconceptions about side effects of COVID-19 vaccines. Young people also showed a preference for vaccines such as Pfizer-BionTech over the Chinese Sinopharm jab, Sri Lanka's most widely used COVID-19 vaccine. Communication gaps, fueled by contradictory information from the media and social media's influence, contributed to misconceptions and distrust in certain vaccine types. Delays and inefficiencies in vaccine administration further complicated the process, with concerns about potential side effects from receiving different vaccine types for three doses. Responding to emerging vaccination hesitancy, in September 2021, UNICEF and Sarvodaya published a communication and information guide for community leaders titled "Community Engagement During COVID-19 Vaccine Rollout" that was widely disseminated.

Recovery from the pandemic: As communities looked toward recovery from the pandemic, ongoing financial disruptions and struggles for daily wage workers persisted. The education system is in the process of recovery, with challenges for children's education and the higher education sector. Coping and moving forward involves various challenges, particularly for those who have been infected or bereaved, highlighting the profound and lasting impact of the COVID-19 pandemic on individuals and families.

TOWARDS CONCLUSIONS

A central study objective was to identify lessons from Sri Lanka's distinctive challenges and responses to the COVID-19 pandemic. An initial striking difficulty is the complexity of disentangling specific public health lessons that are essential in looking to pandemic preparedness from the broader impact and implications of the interlinked crises that Sri Lanka still confronts. Thus in many respects the public health responses, both those led by the government, drawing on the strengths of public health systems and policies and external support, are positively assessed. Public health measures were carefully designed and generally well implemented. Vaccination programs were designed and implemented in a timely manner. An exception was the cremation policy which was not well conceived and had the effect of exacerbating inter-communal and inter-religious tensions. However, as economic and social problems multiplied, weaknesses in systems and resource constraints emerged, leading to compounding problems and waves of social discontent.

The community responses reflected in focus group discussions point to considerable dissatisfaction with the government approach, focused on decision-making, vaccination programs, and inadequate welfare programs for affected families.

Challenges during lockdowns, political influence, and transparency issues were cited, expressed through statements like, "During the lockdown, we encountered a shortage of drinking water. The government didn't focus on this issue." Despite its overall strengths, health sector responses saw critiques, notably on health staff responsiveness, diagnosis and examination discrepancies, and inadequate guidance.

A central premise for the study and clear conclusion that emerged from surveys, focus groups, and interviews was that weaknesses in engaging communities at different times and places often impaired the effectiveness of COVID-19 responses, and reflect significant gaps that need to be addressed. This applies generally to Sri Lanka's diverse communities and types of community organizations and more specifically to religious communities. Engaging in purposeful ways with communities and religious leaders at an early stage and at every level of pandemic response would have surfaced problems and assured stronger popular support for difficult measures.

The robust public health care system which existed prior to the onset of the pandemic, played a crucial role in mitigating the health impact on the Sri Lankan people. However, the pandemic response exposed several weaknesses of the system and highlighted the need for more collaborative approaches in addressing a public health emergency and, more generally, public health policies. The community response and the multisectoral engagement demonstrated the opportunities that existed to mobilize additional resources—material, financial and technical/intellectual—in pandemic response. The study also confirmed the relevance and feasibility of working with religious teachings and traditions in building trust in health information disseminated to the communities and gaining acceptance of vaccination by different religious and ethnic groups. The critical importance of recognizing religious and cultural

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dimensions of public health control measures was highlighted. Reflection on how to engage and build on these community level links is a priority.

The study highlights the vital importance of community trust. The focus group and informant interviews in particular highlight that efforts exerted to sustain and expand such trust were inadequate, in ways that other methodologies failed to capture fully, underscoring the crucial importance of these methodologies. These problems were exacerbated by conflicting messages to the public from various sources, and a lack of disclosure of data, recommended by the WHO for a "whole-of-society approach." The absence of representation of CSOs, NGOs, and community-based organizations at national-level decision-making bodies hindered effective community engagement.

A finding that can be seen as a strength offering positive areas for future action was the emergence of community self-reliance, as individuals sought alternative methods for protection. A comment reflects this spirit: *"I observed that both vaccinated and non-vaccinated people in our village got the disease. So, I started following my own ways to protect myself and my family…."*

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The World Faiths Development Dialogue (WFDD) is a not-for-profit organization working at the intersection of religion and global development. Housed within the Berkley Center in Washington, D.C., WFDD documents the work of faith inspired organizations and explores the importance of religious ideas and actors in development contexts. WFDD supports dialogue between religious and development communities and promotes innovative partnerships, at national and international levels, with the goal of contributing to positive and inclusive development outcomes.

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