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COVID 19: Impact, Mitigation, Opportunities and Building Resilience

From Adversity to Serendipity

*Perspectives of global relevance based on
research, experience and successes in
combating COVID-19 in Sri Lanka*

Volume 01

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(edited by)

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A more decentralized governance framework for pandemic response: A multi-stakeholder approach for COVID-19 preparedness and planning in Sri Lanka

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ABSTRACT

The entire world is in an unprecedented dysfunction since 11th March 2020 when the WHO declared a global pandemic as unprecedented health and socio-economic issues emerged with the outbreak of the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and its associated 53 coronavirus diseases (COVID-19). This challenging pandemic has created a greater shock on regular activities of every social strata resulting in a significant decline in economic growth and health sector progression. A serious wearing down of infrastructure, human resources and emergency response in the public health sector was visible in many countries, irrespective of the level of economic and social development. In this backdrop, many scholars are exploring appropriate and effective resilient systems to govern pandemic risks in varied settings. It is observed that Sri Lanka's pandemic response is not properly embedded with the country's Disaster Risk Reduction (DRR) framework and in many aspects, it is heavily reliant on the public health sector authority. In further elaborating the identified gap, this study explored many possible policy amalgamations that can be considered to improve the effectiveness of pandemic response activities at sub-national levels in Sri Lanka. Many government authorities, universities, volunteer agencies including NGOs, private sector organisations and the community can be efficiently integrated into pandemic response activities, vesting necessary responsibilities and authority for contingency and financial decision making at sub-national level. This system further ensures the unique and contextual approach in pandemic response at Divisional Secretariat level of each sub-region, which consists of diverse cultures. A large number of public officers are employed at District Secretary (DS) level in different areas of work such as finance, statistic and information, development, public health, livelihood, legal, police, child protection and probation, social welfare, elderly care, poverty alleviation, etc. within the public administration protocol adopted in Sri Lanka. These official positions can also be effectively integrated with the pandemic preparedness and response mechanisms at sub-national level.

Key words: COVID-19, Pandemic response, Disaster risk reduction, Public health emergencies in Sri Lanka

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1. INTRODUCTION

The COVID-19 pandemic is the most devastating health concern which has significantly impacted the global community in the recent past. By the first week of February 2021, a total of 2,312,278 deaths have been reported all over the world, while 105,805,951 people have been identified as confirmed cases since the first incident reported in 2019 (WHO, 2021c). Therefore, the COVID-19 pandemic can be considered as the most severe biological hazard of its kind, which happened during recent times in terms of the systemic nature of the cascading risks of this infectious disease around the world. The Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and its associated 53 coronavirus diseases, commonly known as COVID-19 was initially found in China, in December 2019 and spread across other regions rapidly within a short time span (Quigley et al., 2020; WHO, 2020). Considering the alarming outbreak of this virus and its greater repercussions impacting the social, economic and political spheres and in particular the public health sector, the World Health Organization (WHO) declared the epidemic as a global pandemic on 11th March 2020 (WHO, 2020).

The severity of the pandemic outbreak is significant and alarming due to the sudden emergence of two variants of SARS-COV-2 known as the VOC-202012/01 variant, which was initially detected in the United Kingdom and the 501Y.V2 variant originally found in South Africa (WHO, 2021b). Further, the mutated variant, which is commonly known as Kent strain or technically as B117, has been detected across UK and in more than 50 other countries. The outbreak of this pandemic worsened with the rapid spreading of new variants in certain regions and the accelerated outbreak of the root virus (SARS-COV-2) in many other regions, which shows the devastating and uncontrollable nature of the current pandemic. This unexpected and unprecedented global challenge has stressed the need for scaling up sustainable and effective resilience policies and mechanisms to eradicate the present pandemic and face

similar or more challenging occurrences in the future. Experiencing devastating socio-cultural, economic, and political impacts arising due to global outbreaks and pandemics is not a new incidence. The human evolution has been through hundreds of pandemics caused by infectious diseases or pathogens or zoonotic diseases which have been frequent occurrences throughout the world history (Briand et al., 2011; Georgalakis, 2020; WHO, 2018). Severe acute respiratory syndrome or commonly known as SARS hit several regions in 2003, predominantly Asia and the threat to the public health sector was severe, resulting in more than 8000 confirmed cases. The H1N1, a novel influenza virus in 2009 and another pneumonic disease called Middle East Respiratory Syndrome (MERS) started to spread across the Middle Eastern countries during 2012-2013. The Ebola epidemic in 2014 badly impacted the West African region including Guinea, Liberia and Sierra Leone and then spread out to three other continents by sparking global alert for pandemic preparedness and response as a public health concern. A recent severe epidemic which was experienced in many parts of the world was the Zika virus outbreak in 2015, firstly emerged in Brazil and then started spreading across more than 70 countries. The most recent was a severe outbreak of Plague in Madagascar in 2017, which lasted a longer time period with 2,417 confirmed cases being reported and over 200 verified deaths. This was also a transmissible disease among humans and nine countries and territories were declared as restricted travel destinations due to it being a significant case of bubonic plague. Serious consideration should be given in understanding the magnitude of the damages caused due to 1307 epidemic events that have occurred due to 20 transmissible diseases only during 2011 to 2017, as reported by the WHO (Briand et al., 2011; WHO, 2018).

Accordingly, lessons learnt from the past pandemic and epidemics also should be positively used for mitigating risks of present and future pandemics as many of these diseases or other new variations could possibly re-emerge in the near future. Addressing the grave loss of human lives, economic stability, social

order and integrity, political stability and health resources in the countries and overall global health resilience is yet to be fast tracked. Concept of 'global health security' was being identified by international health experts for governing relevant global and national agencies including national governments as a collaborative body in order to strengthen policies and activities in pandemic preparedness and response. (WHO, 2018).

Sri Lanka showed a satisfactory level of progress in terms of pandemic response especially during the first outbreak by reporting the lowest number of infected persons and deaths in the region and when compared with many of the other countries, up until October 2019. Even though, the second wave which started in the second half of October 2019, recorded an increasing and alarming number of both infected persons and deaths, Sri Lanka is yet identified by the WHO as a nation which is coping well, with cluster transmission in terms of the nature of the pandemic outbreak (WHO, 2021a). However, several recent studies suggest that Sri Lanka's pandemic preparedness and response should be further optimised as current pandemic response has not yet adequately been embedded with the disaster risk reduction framework of the country and heavily rely on the public health sector authority in many aspects (Amaratunga et al., 2020; Ranaweera et al., 2020). In this context, this chapter aims to explore the potential of developing a more comprehensive and multi stakeholder approach for pandemic response in Sri Lanka. Suggestions proposed by above studies provide an insight for developing a more decentralised and professionally engaged pandemic response framework rather, than adopting a more public health-oriented and bureaucratically top-down approach in terms of decision making and involvement in any public health emergency.

2. METHODOLOGY AND PROCEDURES

The objective of the study is to identify the gaps in pandemic response activities with specific focus on the divisional secretariat

level and to propose suggestions to enhance the current response mechanism which should be more decentralised and engaged. Therefore, the study focuses its approach based on the qualitative descriptive research design and the collection of data was done in two stages. A desk study was conducted using existing research literature to accumulate both conceptual and secondary data, as the first part of the research. As the second step, eight (8) key informant interviews were conducted to gain a deeper insight, by selecting several respondents who represented decision making and implementation activities in disaster risk governance at the national level, provincial level and also involved in disaster management operations at divisional secretariat level.

Literature mining process was carried out using three well reputed electronic data bases known as ScienceDirect, PubMed and Scopus. Research literature mining process was initiated using the keywords which were derived from the research objectives: COVID-19 pandemic, pandemic preparedness and response, multi-stakeholder approach, pandemic governance in Sri Lanka.

The literature mining was restricted only for published peer-review research articles and excluded unpublished works, working papers, abstracts, books, chapters, reports, thesis and meta-analysis to filter comprehensive research papers. Finally, eight (8) research articles and several grey literature published on pandemic response and governance in Sri Lanka were used for the analysis by synchronising interview data, based on synthesis and thematic analysis approach.

3. COVID-19 PANDEMIC RESPONSE IN SRI LANKA

There is no debate on the effectiveness of the COVID-19 response in Sri Lanka, during the first pandemic outbreak as the performance of the authorities and relevant officials was reasonably satisfied. Sri Lanka was able to manage the first outbreak of COVID-19 quite successfully, thus exemplifying as an efficient model to many of its neighbouring

countries in the region, in terms of minimising the infected and death rates which were reported as 3346 infected and 13 deaths as at 4th October 2020. The first confirmed case of Coronavirus infected person was reported in Sri Lanka on 27th January 2020, who was a Chinese national who arrived in Sri Lanka on 19.1.2020 as a tourist. She was admitted to the National Institute of Infectious Diseases (NIID) and fully recovered by 10th February 2020. Meantime, a Sri Lankan citizen who is a tourist guide, was diagnosed positive as the first local patient and 14 suspected persons were identified by 7th February 2020. With this minor outbreak, 14 hospitals around the country have been identified and prepared as treatment centres for suspected persons which were NHSL, LRH, NIID, TH *Ragama*, DGH Gampaha, DGH Negombo, National Hospital Kandy, TH *Karapitiya*, TH Anuradhapura, TH Jaffna, TH Kurunegala and PGH (MoH, 2020). The institutional preparedness during the first outbreak strengthened the pandemic response very effectively.

However, the second outbreak resulted in more than 69,000 infected persons while 64,000 recovered and discharged by the hospitals, and 356 deaths (up to 08/02/2021) (MoH, 2021a). Yet, in terms of deaths and infected cases, Sri Lanka's performance is considerably better than several other countries in the South Asia region except Bhutan (861 infected and 1 death) and Maldives Islands (17101 infected and 56 deaths) up to 10/02/2021 (WHO, 2021a). Similarly, curtailing the second outbreak also shows a satisfactory achievement when compared with many other countries that are out of the region. The following table (Table 1) shows a comparison of COVID-19 outbreak in terms of infected and death rates, calculated to the one million population for a few countries.

Nevertheless, Sri Lanka's pandemic mitigation efforts and strategies in the first Covid-19 wave were considerably effective in terms of controlling deaths and infected cases when compared with other regional countries such as India, Bangladesh, Pakistan and Afghanistan, where the outbreak is severe (Sarkar et al., 2020). As shown in the above

Table 1. COVID-19 data of selected countries

Country	Cumulative cases per 1 million population	Deaths per 1 million population
<i>Sri Lanka</i>	3181	15
<i>India</i>	7787	112
<i>Singapore</i>	10172	5
<i>Australia</i>	1130	36
<i>South Africa</i>	6360	98

Source: (MoH, 2021b)

table, comparatively Sri Lanka has been able to maintain a low Covid-19 death rate as a percentage of the total population when compared with many other developed nations. However, the optimum output which can be generated within the existing Disaster Risk Reduction (DRR) policies and mechanisms is yet to be enhanced, to strengthen the disaster responsiveness in Sri Lanka, especially with regard to biological hazards. Recent studies explored indicate that there are several loopholes and concerns within the current DRR framework, in responding to public health emergencies with the notable monopoly of public health and a few other sectors in governing pandemic responses (Amaratunga et al., 2020; Dissanayake, 2020).

Findings of the desk study suggests that existing pandemic response in Sri Lanka is disproportionately public health and military oriented, which is a major criticism with regard to the response strategies often adopted by the country to face the current pandemic (Amaratunga et al., 2020; Dissanayake, 2020; Ranaweera et al., 2020). Moreover, this discourages, unfolding of new paradigms to pandemic response in the context of biological hazards and/or public health emergencies. On the other hand, monopoly in decision making during a critical crisis where none of the sectors in the country are safeguarded in terms of the regular functionalities, tends to dissuade the involvement of all necessary stake holders, which is much needed to regain the 'build back better'.

The COVID-19 task force in Sri Lanka comprises with epidemiologists, medical administrators, infectious disease specialists, military teams, police, politicians and media

under the leadership of the head of state (Hettiarachchi et al., 2020). In terms of short-term responses in public health emergencies, involvement of only key stakeholders or a smaller number of important authorities might be notably feasible in order to ensure time bound effectiveness in decision making, implementation and effective coordination, among different sectors. However, as per the field data, in the long run Sri Lanka needs comprehensive pandemic response strategies and mechanisms which reflect considerable involvement of all key stakeholders and inter-sectorial networking from top level to grass root level, which is considerably lacking in the existing policy making and practices. For instance, frequent involvement of military personnel in pandemic response for certain purposes such as contact tracing, government intelligence service, maintaining social security and safety during a pandemic are acceptable and valued with their training and professional capacities. Nevertheless, the involvement of military personnel in carrying out certain tasks or duties for which they have not gained any proper training, seems to be questionable in terms of ethical consideration (Dissanayake, 2020). Sri Lanka has extensively obtained the services of the military forces to combat the COVID-19 pandemic during the first outbreak and that strategy was an institutional arrangements of the state, for emergency response and as a developing nation the optimal use of available human and physical resources, to face an unexpected disaster (Hettiarachchi et al., 2020). However, current strategies on pandemic preparedness and response activities can be integrated with the involvement of essential stakeholders in the field of nonmilitary and nonhealthy sector, whose involvements and activities are highly professional. For an example, there is a need for more psychologists, social workers, community mobilizers and counsellors to be involved in the quarantine centres to harness peoples' mental health and safeguard social and cultural stability. Further, quarantine places must be equipped with an effective grievance redress mechanism as these centres are utilised by diverse groups such as children, females,

differently abled, elderly persons of different ethnic groups.

It is also suggested that effectiveness of the pandemic response to a greater extent is determined by the response models that are developed by the state and based on the knowledge of the practitioners on strategies and measurements they administrate. As an example, the police involved in mobility monitoring, should be aware of the optimum extent of mobility to control cross sectional travel, in order to make the efforts a success (Erandi et al., 2020). In addition, peoples' psychological issues have largely been under estimated in the context of a pandemic, by disproportionately recruiting mental health professionals to provide necessary counselling to families with infants and young children, pregnant women and other mentally vulnerable population (Patabendige et al., 2020). In this context, this study proposes that pandemic response and governance framework in the country should be more elaborate and decentralised.

4. NEED FOR AN INTER SECTORAL APPROACH AND EFFECTIVE COORDINATION BETWEEN SECTORS

This challenging pandemic has generated a greater socio-economic shock and has resulted in a serious decline of cumulative progress in every sector in Sri Lanka, including public health. Many scholars are exploring appropriate resilient systems for different social contexts, which would be useful to govern pandemic risks effectively, as COVID-19 has become an unprecedented public health emergency, faced by the entire world. The reaction to COVID-19 outbreak highlights the need of rethinking and restructuring of traditional policies and practices of DRR, crisis management and emergency response adaptations as everyone had to deal with 'the unknown of unknowns'. Several governments have already developed complementary approaches to alter the orthodox emergency management procedures and protocols, which were led by the centre of governments (CoGs) based on the political

intentions (OECD, 2020). In many countries, all approaches relevant to this emerging field are mainly focused on short-term specific issues and therefore, the involvement of stakeholders representing different sectors and professions is very limited (Ogie & Perez, 2020; Pereno & Eriksson, 2020). This was very common in many countries, especially during the first pandemic outbreak as the nature of outbreak was novel. Sri Lanka, being a tropical country has been exposed to several biological hazards or epidemics including dengue, malaria, and other seasonal infectious diseases. Hence, each year with the monsoon, the relevant authorities maintain a high scale of public health interventions based on the free public health policy. What is required is a strong incorporation of pandemic governance to the existing epidemic control framework with an holistic approach (Ranaweera et al., 2020).

From another perspective, the COVID-19 pandemic exemplifies the systemic nature of effects, creating a variety of cascading social and economic impacts due to complexly interconnected structures. This unavoidable crisis sparks the need for fragmented institutions to be more integrated and synergised and shift from fewer stakeholders to more stakeholders ranging from the private sector to local governments and civil societies. This new paradigm requires daring policy actions to regularise functions in the healthcare systems, education, safeguard employability and businesses and maintain the stability of economy. Further, trusted political will and leadership must be comprehended with the faith and expectations of the citizens and the role of governments. This is necessary to promote national resilience and preserve well-being with agile and innovative responses at the highest level, while co-ordinating and collaborating with lower levels of government and a large array of stakeholders (OECD, 2020).

High-level institutional arrangements and commitments are paramount in governing and managing policy responses to the pandemic or any other biological hazards, disregarding the context. It is suggested that there should be a strong focus and integration between

three main dimensions in the institutional arrangement, for combating pandemics or epidemics.

1. Coordination and strategic planning
2. Use of evidence for informed decision-making
3. Communicating decisions to the public (OECD, 2020).

To enhance the effectiveness and sustainability of pandemic responses, all necessary institutions, organisations, groups, and individuals must have an opportunity to involve and integrate with diverse task loads, particular to their own capacities and professions. Nevertheless, in many countries, health institutions, healthcare providers, managing authorities, universities, research centres, welfare clusters, non-government organizations (NGOs), healthcare networks and professional consortiums, play a significant collaborative role in pandemic response, to shift or make a smooth transition from short term plans to long-term strategies (Pereno & Eriksson, 2020).

Ludvigsson (2020) emphasises that the success of COVID-19 response in Switzerland has been doubled up in an effective manner by gathering a range of stakeholders during the first outbreak. Interestingly, Swedish universities and education institutes have been encouraged to engage in COVID-19 research as key stakeholders, who were in the outer circle of the central government, in order to provide scientific insights for timely decision making. Therefore, it is apparent that, further decentralising of necessary decision-making powers and authority within the national resilience framework is required, to promote active involvement of different stakeholders. This will provide more effective and efficient approaches to the existing DRR policies and practices in the country.

5. EMBODYING BIOLOGICAL HAZARDS ADEQUATELY IN TO DRR POLICIES AND PRACTICES

Sri Lanka has several strengths to develop its pandemic preparedness and response activities very effectively using the existing DRR framework and human and institutional capacities. It is obvious that, free public health and education policies established in the country about nine decades ago have navigated a considerable improvement of human and social development in Sri Lanka. Increase of several social development indexes over the decades such as Human Development Index (HDI) (0.780) and average life expectancy (76.8 years) shows the positive impacts of education and health policies in the country. Literacy rate recorded at 92.5% is the second highest in the region next to Maldives. Many of the public health indicators of the country, outperform such indicators of several other nations in South Asia and East Asia (CBSL, 2020). These social indicators prove that the existing public health, education and welfare policies and approaches in the country have positively impacted the current social development. Moreover, these rates speculate that the existing public health and education mechanisms in the country also have its rigor to perform extraordinary standards as a developing nation, which has been socially and economically damaged by a thirty-year separatist war.

National Council for Disaster Management (NCDM) established under the Sri Lanka Disaster Management Act No. 13 of 2005 is the apex body concerning disaster management (DMC, 2014). NCDM is comprised of the Ministry of Disaster Management (MDM), Department of Meteorology (DOM), Disaster Management Centre (DMC), National Building Research Organisation (NBRO), and National Disaster Relief Services Centre (NDRSC). Apart from this body, a set of national and international humanitarian agencies also operate in several disaster-prone areas in the country, in line with the mission of NCDM in policy making and handling ground operations. The disaster management institutional structure has been

designed by the NCDM which is chaired by the President and vice-chaired by the Prime Minister of the country and it extends to the level of Village Disaster Management Committee which represents the grass root level affected community (CEDMHA, 2017). Decentralisation of the DRR activities has been effectively integrated with District Disaster Management Coordinating Units (DDMCUs) and sub-national level disaster management committees. Furthermore, de-concentration of policy structures of DRR sub-national level disaster management plans and village level plans have also been developed (DMC, 2014). However, the existing DRR framework reflects less emphasis on pandemic and epidemic preparedness and response, which is paramount for the current situation in the country. As revealed by the key informant interviews, village level committees are frequently established in disaster-prone areas and many other villages have not been adequately integrated with these grass root programmes. Even though this is logical for natural hazards, all villages must have committees for biological hazards especially in pandemic and epidemic context. The most feasible approach to sustain these village level committees, is vesting the decision making and financial powers to the DSs to function as independent response units.

In this context, several studies suggest that the existing policy framework can be further improved and integrated with public health emergencies for combatting biological hazards within the current DRR framework, particularly to pandemic and epidemic response in the country. What is required is an effective inter sectoral and multi stakeholder approach to strengthen the public health resilience. An example to back this analysis, is the lack of integration between the anti-malaria campaign (AMC) and COVID-19 mitigation programmes in the country, even though both are operating under an umbrella of pathogens or infectious diseases of the public health sector in Sri Lanka (Amaratunga et al., 2020; Ranaweera et al., 2020). Ranaweera et al., (2020) suggests that expertise and resources of the AMC have not been directly utilised for programmes to combat COVID-19

and coordination between multiple sectors and departments is highly unsatisfactory. It was further highlighted, that there should be sound public health infrastructure with adequate and trained field staff, to facilitate contact tracing and expedite scientific testing protocols, as these are the two most significant elements in both COVID-19 and malaria combatting programmes in the country. The lack of coordination between departments and institutions as reflected in the programmes being carried out, is a significant gap in terms of intersectoral coordination during health emergencies. Conversely, preparedness for lowering the risks and vulnerability of biological hazards and mitigating compound impacts, have not been adequately grasped by the existing infectious disease control activities in Sri Lanka.

6. DIVISIONAL SECRETARIATS AS PANDEMIC GOVERNING FOCAL POINT: MORE DECENTRALIZED APPROACH

Governance of pandemic is a very critical component in pandemic response as there are several stakeholders involved in the process including centre of governments (CoGs), responsible institutions, departments, external organisations, and partners, civil societies, and the community. In Sri Lankan pandemic governance context basically, decentralisation up to the DS level has been concentrated for decision making during a disaster under the provisions of emergency relief and post-disaster management. The Disaster Management Act No. 5 of 2013 of Sri Lanka, vests powers to district secretaries and divisional secretaries to function in an emergency. However, a greater number of divergences such as limitations of financial powers, relying on certain upper bureaucratic approvals etc. could be observed especially, in the implementation of DRR activities and programmes in a health emergency, at the divisional secretariat level. Further, lack of updated information on village population at local level in terms of identifying beneficiaries for relief services and other state facilitations and also inconsistency in circulars and regulations issued at sub-national level

with regard to the relief services, are some of the common concerns that have been identified. (Amaratunga et al., 2020). Hence, pandemic response is yet to be enhanced, especially with regard to the coordination gap between top level and sub-national levels, lack of decision-making power for immediate implementations and also to implement emergency response activities, that are to be carried out in different grass root clusters, etc.

Analysis suggests that there are many potential policy amalgamations that can be done to increase the effectiveness of pandemic response activities at sub-national level. One such aspect is effective networking and coordination between essential stakeholders. Many public departments, universities, volunteer agencies, private sector organisations and the community can be efficiently integrated into pandemic response activities, vesting necessary powers for contingency and financial decisions at sub-national level. This system further ensures the unique and contextual approach for each divisional secretariat/village/community which could also consist of notable cultural diversity prevalent in the area. Nature of issues related to the livelihoods of people, social problems, level of poverty, psychological issues, relief needs, and overall grass root involvement firmly depend on the specific culture of the community, which are attributed to a prolonged period based on the ethnicity, religion, beliefs, language, attitudes, etc. Therefore, governing a pandemic and an epidemic at sub-national level, as a specific cluster is very effective, since a national level blanket approach for pandemic response is less effective, in many aspects. Results of the key informant interviews highlight that with the national authority, vesting direct powers to the Divisional Secretariats (DSs), these authorities can be empowered as independent governing bodies to engage in pandemic response based on own decision making and implementation rights and having the capacity to formulate regulatory and advisory committees, by assigning necessary stakeholders. As noted, what is needed is the full potential of decision-making powers and necessary infrastructure capacities to function as a complete self-

regulatory body. This system further ensures the unique and contextual approach, known as ‘cluster-based approach’ for sub-regions which reflect considerable cultural diversity and requirements.

The following figure (Figure 1) shows the structure of the presidential task force appointed for dengue control in Sri Lanka. As indicated, the protocol flow of the process is from the president to the village dengue committees. The task force is of the view that, village committees should be the more actively involved in dengue prevention activities. This committee must implement the action plan, under the technical guidance of the relevant Medical Officer of Health/ Public Health Inspector and with the assistance of respective Grama Niladaris (village admin officers) in the area. These committees are mostly headed by the Divisional Secretary and the chairperson of the local government authority (MoH, 2017). This process and the programmes are also heavily depended on the public health

authorities and involvement of other relevant stakeholders is very much needed.

Another potential at sub-national level (DSs level) is, involvement of a larger number of public officers at divisional secretariat level in areas such as finance, statistics, information gathering, development, public health, livelihood development, legal, police, child protection, probationary, social welfare, elderly caring, poverty alleviation etc., within the public administration system in Sri Lanka. This institution set up can be certainly elevated as an independent body with decision making powers and financial authority for different aspects of pandemic preparedness and response and also to develop case-based expert committees, propose strategies and work routines, to collect data for effective reporting (Amaratunga et al., 2020), and to proceed with necessary implementations without overly depending on top-level decision making. This body can act as a local or sub-national level agent for data management, emergency communication, contact tracing, relief activities, creating awareness, progress monitoring and post-pandemic coordination when required.

7. A MORE INVOLVED AND COMPROMISED APPROACH FOR PARTICIPATION OF STAKEHOLDERS IN PANDEMIC PREPAREDNESS AND RESPONSE

Lack of participation and collaboration of different stakeholders and inefficient coordination among the different sectors, is identified as a main drawback in pandemic response, in Sri Lanka even within the public health sector (Ranaweera et al., 2020). This is even very common in the national DRR framework. For instance, several departments and ministries such as DMC, Meteorology, Health, local government and provincial councils, Sri Lanka Army, Police, hospitals, National Water Supply and Drainage Board, public media, airports and Civil Aviation have been exclusively entrenched with the current DRR activities while certain potential sectors such as education, higher education including

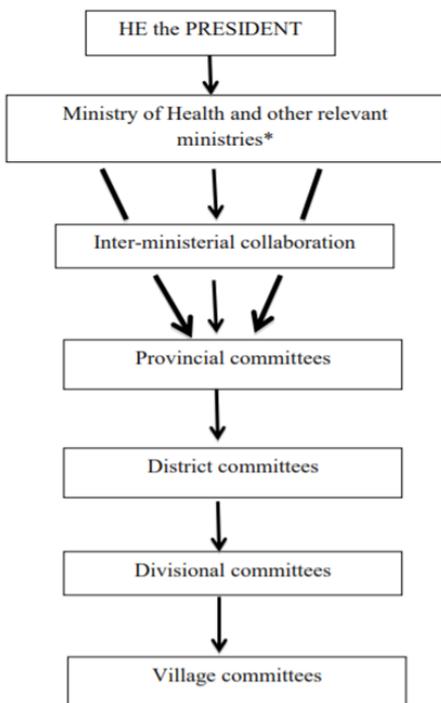


Figure 1. Structure of the presidential task force on dengue control

Source: (MoH, 2017)

universities, research institutes as well as social work and mental health programmes are less reflected (DMC, 2014). According to the DMC (2014), anticipated stakeholders for health hazards such as epidemics, communicable diseases, bird flu, AIDS, SARS, poisoning etc. and possible biological and other health hazards, are mentioned as the Ministry of Health, Epidemiology Unit, Department of Health Services, Medical Research Institute, and others as relevant. This explains that, identifying non-health sector stakeholders in the involvement of responding to biological hazards, is seriously misunderstood and inadequate.

Decentralised pandemic response body at sub-national level, can effectively be integrated and involved as a unit of operation for public health emergencies since it has enough potential to develop multi-stakeholder appraisal. Further, this can promote adequate and proportionate involvement of different stakeholders including public departments, universities, research institutions, volunteer agencies, NGOs, private sector organisations, sociologists, anthropologists, social workers, psychologists and volunteers at community level who are available and willing to cooperate at each sub-national level.

Many countries such as Canada, Singapore, and Korea, which have been effectively mitigating this challenging COVID-19 pandemic are better prepared in terms of pandemic response and, particularly regarding pandemic governance. One strong policy that these countries have been adopting in fighting many biological hazards, is the multi-stakeholder and multi-sectoral approach which has been developed based on the lessons learnt from the SARS epidemic. For example, networking scholar associations, universities and research institutions are empowered to be involved with detection and screening infectious diseases, real time data sharing with national and international agencies and collaborations and developing professional alliances to address specific technical, social and economic issues faced in the context of a pandemic (Jang & Choi, 2020; Kim &

Ashihara, 2020; OECD, 2020). Further, many countries which have performed successfully and effectively responded to COVID-19 outbreaks are permitting the relevant pandemic and epidemic response bodies, to function very independently having minimal interference. Accordingly, many members who are involved with the relevant countries' pandemic and epidemic response bodies are completely released from their primary duties assigned in government offices, committees, departments, and other missions assigned by the CoGs. These tactical committees and governing bodies have been assigned to respond to the COVID-19 pandemic as independent bodies, without any political and other external interference (OECD, 2020).

8. CONCLUSION

There are several improvements to be done as discussed below to enhance the effectiveness of the existing pandemic preparedness and response framework in Sri Lanka. It is observed that even though the current DRR framework has certain strengths in advocating and implementing effective preparedness and response activities from national level to community level, the pandemic or epidemic governance is less integrated and inadequately incorporated. Therefore, a strong integration between the current DRR framework and biological hazards is required. Furthermore, many lessons can be learnt from countries which have successfully responded to the COVID-19 pandemic and other pathogens such as SARS, Ebola and H1N1 to enhance current DRR policies and practices in Sri Lanka. It is noted that, many countries which have satisfactorily administered the 'build back better' concept have adopted a multi-stakeholder and decentralised governing mechanism. Moreover, regulatory bodies that are established for pandemic response must be independent governing agencies without having any political or other external interferences or influences. All members of such regulatory bodies should not be permitted to be engaged in their primary duties, if they represent any state or non-state organisation, institution or department in order to utilise

their optimum potential and obtain the maximum commitment. Considering the above suggestions, pandemic response in Sri Lanka can be more decentralised to include the DS level within the existing DRR framework and promoted as 'cluster-based' or 'case-based' response approach, in line with national DRR protocols. Furthermore, the pandemic response needs to be more multi-stakeholder oriented, and a coordinated effort is needed to ensure a new paradigm of sustainable healthcare and professionally led process is adopted towards a smooth transition and a resilient public health system in Sri Lanka.

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