Sri Lanka: a primary health care case study in the context of the COVID-19 pandemic

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Acknowledgements

The primary health care (PHC) case studies were commissioned and overseen by the Alliance for Health Policy and Systems Research, a hosted partnership based at WHO headquarters, in collaboration with the WHO regional offices. This case study was authored by Antoinette Perera, Faculty of Medical Sciences, University of Sri Jayewardenepura, and HSR Perera, Public Health Services, Ministry of Health, and their research team Shyamale Samaranayaka, Shamini Prathapan, Aruni De Silva, Hiranthini De Silva, Subaschandren Kumaran, Nimali Widanapathirana, Nalinda Wellappuli, Nimali Karunarathne, Nadeeka Chandraratne, Rangika Fernando, Chatura Wijesundara, Pubudu Ariyaratne, Susitha Kelum Liyanage, Chandima Jeewandara, and Chamath Fernando. The WHO Regional Office for South-East Asia, the WHO Country Office for Sri Lanka, and a team of independent experts provided critical review and input. Special thanks go to Phyllida Travis and Stephanie Topp for their helpful reviews, and Robert Marten, Jeffrey Knezovich, Sonam Yangchen, Alexandra Edelman, Yasmine Yahoum, Joanna Fottrell and David Lloyd for their support in the development of this publication.

The authors also wish to acknowledge the following experts for their contributions: Hemantha Herath, MRH Swarnathilaka, Vinya Ariyaratne, GM Mala Perera, M Galhena, P Halambarachchi, D Molligoda, K Arulanandem, S Kohombange, Ranjith Dissanayaka, Sankha Randenikumara and Hemaratne Liyanarachchi. The authors also extend their thanks to M M Darshanie, Shirani Ranasingha, Jayanee Jayakaduwa, Thilina Lakruwan, Janani Bhagya, Amitha Jayawardene, Champika Jayaratne and Ridmali Jayawardene.
Executive summary

Sri Lanka is advancing towards universal health coverage (UHC) through efforts to strengthen primary health care (PHC). This has led to a focus on primary curative care using a family practice approach. Supported at a technical level by World Health Organization (WHO), Sri Lanka has identified an Essential Service Package for UHC to be delivered through PHC (1).

With financial support from the World Bank (WB) and the Asian Development Bank (ADB), a policy decision was taken in Sri Lanka in 2018 to reform primary curative care into a state-led family doctor model, clustered around a hospital that provides specialized care (2). The intention was to support the well-established community health services. The Ministry of Health (MoH) and Indigenous Medical Services led this reorganization of PHC in close collaboration with WHO.

It was at a critical stage of these PHC reforms that Sri Lanka faced the COVID-19 pandemic in January 2020. The government established a high-level coordination and steering mechanism supported by different technical task forces to guide health and multisector action in response to the pandemic.

This case study examines PHC in Sri Lanka, including how continuity of essential health care services was maintained from March 2020 to August 2021, and how multisectoral action and community engagement contributed to the COVID-19 response. Both the methodology and the structure of this report reflect the three Astana PHC components of primary care and essential public health functions, multisectoral policy and action, and community engagement.

Sri Lanka's existing prevention-based PHC architecture - rooted in the health unit system established in 1926 as the foundation for community-based care (1) - enabled the country to implement key public health control measures. Essential health functions were largely preserved during COVID-19, including the provision of maternal and child health services. Key strategies adopted by the government and health authorities included risk communication for behaviour change, testing, isolation, border management, treatment and vaccination - all of which were implemented through multisector engagement. While the government was the main provider of care during the initial months of the pandemic, the private sector was utilized as case numbers increased to deliver testing, isolation, quarantine and treatment services for a fee.

Three distinct waves of COVID-19 were observed in 2020 and 2021: wave 1 from January to October 2020, wave 2 from October 2020 to April 2021, and wave 3 from April 2021 to the time of writing in August 2021. The initial emphasis on severe restriction of public activities shifted in May 2020 to that of maintaining public functions but with adherence to a “DReAM” approach based on four basic prevention measures: distancing, respiratory etiquette, aseptic techniques and masks. This approach allowed economic activities to continue. Health guidelines on public activities and work settings were then adapted into an alert-level system in the second wave, during which Sri Lanka conducted a general election and island-wide school examinations.
Executive summary

Sri Lanka started its vaccination programme in January 2021, initially targeting health workers. However, the country has struggled to expand vaccination coverage, especially in the context of global shortages in vaccine supplies. Curative services at all levels of care have had to accommodate COVID-19 patients, which has disrupted and compromised care for non-COVID-19 patients. Further, countrywide movement restrictions to curtail the spread of the virus during the third wave were relaxed to offset hardships experienced by the population and to preserve livelihoods.

The COVID-19 pandemic has required strong leadership, whole-of-society involvement and community empowerment, evidence-based approaches and sustainable financing to implement a “New Normal” strategy referencing COVID-19 movement restrictions. Sri Lanka’s strong public health system should be preserved and strengthened further with reformed primary care measures to meet the challenges ahead.
Introduction and national context

Sri Lanka is a lower-middle-income country with a population of 21.8 million in 2019 (3). Communities are multi-ethnic and multi-faith, with socioeconomic disparities existing across the population.

The MoH is the lead agency providing stewardship for health service development and regulation. It is also responsible for ensuring resources for health, including trained human resources, drug supply and major developments in health infrastructure. While the government was the main provider of care during the initial months of the pandemic in 2020, the private sector was utilized as case numbers increased to deliver polymerase chain reaction (PCR) testing, isolation, quarantine and treatment services for a fee – Fig. 1 illustrates how the COVID-19 response was integrated within Sri Lanka’s existing allopathic health service delivery system. A strong commitment to PHC supported by existing public health architecture enabled Sri Lanka to face many challenges brought about by COVID-19 in 2020 and 2021, and to rapidly mobilize testing, isolation and contact tracing as part of its pandemic response efforts.

Figure 1. COVID-19 response into existing allopathic health service delivery system
Objective of the study and methodology

This case study examines PHC in Sri Lanka through the lens of COVID-19 from the onset of the pandemic in January 2020 through to August 2021. The study uses three key strategies emphasized in the 2018 Astana Declaration (4) – namely, 1) primary care, 2) multisectoral action and 3) community engagement – to examine PHC in Sri Lanka, how essential health services have been maintained and how multisector and community collaboration contributed to the COVID-19 response during the period under review.

A schematic description of these three key strategies considered to contribute to health and well-being in relation to COVID-19 was captured in a conceptual framework. An indicator matrix was also prepared, and a desk review was conducted.

Data were collected from a review of publications and reports deemed relevant to the conceptual framework. The key objective of the study was to understand the key knowledge (and knowledge gaps) relating to the continuation of essential primary care services, multisectoral response and community engagement as part of the COVID-19 pandemic response.

Primary care

Primary care is delivered through two streams:

1. **Primary curative care services:** The government provides free health services to the population at the point of care. In 2018, 57 million outpatient consultations were recorded within public facilities; a similar number was estimated for private health facilities, but with access to almost all types of care at a cost to patients (5).

2. **Public health services:** Public health services provide preventive and promotive health coverage managed by Medical Officers of Health (MOOH) (6). Integrated national public health programmes range from maternal and child health, school health, food sanitation, occupational health, outbreak investigation and control of dengue, tuberculosis (TB), malaria, filariasis, HIV, rabies and leprosy. In addition, a Disaster Management Programme led by a national coordinator was established after the tsunami in 2004. MOOH are supported by preventive primary care staff assigned to geographically defined populations. Public Health Inspectors (PHI) attached to these units carry out case-based surveillance for all notifiable communicable diseases according to national guidelines. Regional oversight of surveillance is provided by regional health staff comprising Consultant Community...
Physicians (CCP) with postgraduate training in community medicine and Regional Epidemiologists. Field data are transferred to the national disease surveillance system at the central Epidemiology Unit within the MoH.

Epidemiological context

Sri Lanka reported its first imported case of SARS-CoV-2 on 27 January 2020. The first Sri Lankan citizen with COVID-19 was diagnosed on 11 March 2020 (7).

At the time of writing in August 2021, Sri Lanka had experienced three distinct waves of the pandemic: wave 1 from January to October 2020, wave 2 from October 2020 to April 2021, and wave 3 from April 2021 onwards (see Table 1). The initial wave was predominantly characterized by imported cases and localized clusters, with low disease transmission aided by island-wide movement restrictions. Beginning with an outbreak in a garment factory in Western province, the second wave was more protracted and showed diffuse clusters with relatively higher levels of disease transmission. This period was characterized by localized movement restrictions limited to the smallest administrative units in Sri Lanka, known as Grama Niladari divisions (of which there are 14,022).

### Table 1. Morbidity and mortality during COVID-19 waves, January 2020 to August 2021

<table>
<thead>
<tr>
<th>Wave</th>
<th>Number of confirmed cases</th>
<th>Number of deaths</th>
<th>Case fatality rate</th>
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<tbody>
<tr>
<td>Wave 1</td>
<td>3396</td>
<td>13</td>
<td>0.38</td>
</tr>
<tr>
<td>(27.01.2020–03.10.2020)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wave 2</td>
<td>92,341</td>
<td>591</td>
<td>0.64</td>
</tr>
<tr>
<td>(04.10.2020–14.04.2021)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wave 3</td>
<td>163,352</td>
<td>2,473</td>
<td>1.51</td>
</tr>
<tr>
<td>(15.04.2021– to time of writing, Aug 2021)</td>
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Source: COVID-19 epidemiological summary, Epidemiology Unit, MoH (8).
Governance structure and leadership for the COVID-19 response

**Political commitment and leadership**

The National Presidential Task Force is chaired by His Excellency (HE) the President and supported by several other special committees, as shown in Fig. 2. Policy, administrative and technical functions were solicited early on in the pandemic response through this structure.

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**Figure 2. COVID-19 Task Force special committees**

![Diagram showing the COVID-19 Task Force structure]

Source: Drawing on The Institute for Health Metrics and Evaluation, 2019 (2).

The National Presidential Task Force frequently reviewed the pandemic response throughout 2020 and 2021 and was supported by different technical and administrative task forces and subcommittees. Critical decisions were made through this structure on the continuation of essential health services, the expansion of government services in the COVID-19 response, the establishment of a special fund for donations and the procurement of vaccines to achieve high coverage within a short time span.

**Strategic planning, guidelines and reviews**

The technical committees chaired by the Director General Health Services (DGHS) were responsible for strategic planning, including the development of guidelines pertaining to movement restrictions, public activities, testing, medical services, quarantine, the duties of health personnel involved in the COVID-19 response and the use of personal protective equipment (PPE).
Legal framework

The Quarantine and Prevention of Diseases Ordinance No.3 of 1897 as amended (Box 1) enabled new regulations to be introduced in Sri Lanka to aid in the control and management of COVID-19. The Minister of Health has the authority to introduce regulations for the purpose of preventing the introduction and spread of any disease, while powers were delegated to the MOOH at local authority level to enhance island-wide implementation of pandemic response measures.

Box 1. The Quarantine and Prevention of Diseases Ordinance No.3 of 1897 as amended

Under the provisions of the Quarantine and Prevention of Diseases Ordinance No.3 of 1897, COVID-19 was declared a quarantinable disease (9), thus widening the scope of provisions that could be applied as part of the pandemic response (10). Further regulations were implemented in October 2020 mandating that “every person in a public place or every person in any other place where such person may come into close contact with another person, in any diseased locality in relation to the Coronavirus Disease 2019 (COVID-19) shall: a) wear a face mask at all times; and b) maintain social distancing of not less than one meter between two persons” (11). Furthermore, the activities conducted by the police force were legitimized under the guidance of health authorities.

The declaration that Sri Lanka in its entirety was a diseased locality allowed for the imposition of travel bans for passengers from certain countries, mandatory quarantine for returnees to Sri Lanka and movement restrictions within the country. The declaration of the place of infection also allowed for restrictions to be imposed on the movement of inhabitants of infected premises, the removal of confirmed or suspected cases of COVID-19 to quarantine centres or hospitals, the occupation of both public and private premises for quarantine purposes and the closure of schools (10).

Mobilization of finances and other resources

Government contributions to healthcare have remained stagnant at around 1.6% of gross domestic product (GDP) since 2010 (12). This meant that, during the pandemic in 2020 and 2021, curative and preventive health services provided a safety net with additional financial requirements managed largely through reallocations made within existing government budgets.

A separate budget line for COVID-19 financing was not established, and instead different departments under the MoH were given the necessary allocations for procurement and capital improvements. Funds were released intermittently to support allowances for staff and other service needs, even though allocations for PHC have been consistently low over time. In 2016, for example, only around 35% of the current health expenditure (CHE) was spent on PHC (13).
Financing also proved difficult for the government’s effort to procure vaccines. However, existing loans and grants from the WB, the ADB and WHO were able to be utilized for the urgent expansion of health facilities and the procurement of equipment. Significant contributions were also made by the private sector and the general public towards hospitalizations, intensive care facilities, quarantine centres and dry rations to marginalized communities. At the time of writing, these contributions had not been costed.

In addition to limited financial resources, inadequate human resources were a challenge for service expansion although several mechanisms were implemented to overcome this. The police and military were deployed for quarantine-related activities during the first and second waves, for example, while several PHC institutions were converted to COVID-19 treatment and Intermediate Care Centres (ICCs) in the second wave with staff given accelerated training. In the third wave, the military health workforce was enlisted in the vaccination programme. Health workers were reassigned from low-workload settings to busier wards and administrators were authorized to reassign health staff from low- to high-transmission areas within districts and provinces. Trainee PHIs were called for duty in high-transmission areas, while task-shifting occurred across sectors such as the police, the military and public administration to support quarantine activities, community mobilization and vaccinations.

How primary care and essential public health functions are responding to COVID-19

In 2019, staff in Sri Lanka’s central Infectious Disease Hospital were trained by local and international personnel on using PPE and handling suspected cases of infection; they also rehearsed a disaster drill for an Ebola virus-like illness. This meant that the health sector was not wholly unprepared for the first wave of COVID-19 in January 2020, and by March 2020 a trained team from the National Disaster Management Programme had been mobilized to deliver prevention activities.

In the first wave, Sri Lanka adopted a case-based intervention approach to COVID-19 with contact tracing of confirmed cases. The three main pillars of epidemic control – isolation of patients, stringent contact tracing and quarantine of contacts – necessitated the rapid expansion of laboratory testing, isolation measures and quarantine facilities. Similar control measures were implemented in the second wave, with the exception being a shift to home quarantine of close contacts due to delays in finding care facilities for individuals who were asymptomatic. Quarantine facilities were maintained for returnees to Sri Lanka.
Trends in essential health services

Review of MoH maternal and child health indicators during 2020 compared with previous years show that the coverage of essential maternal and child health services was maintained during the first year of the pandemic, apart from the percentage of preschoolers weighed and coverage of school medical inspections, which can be attributed to the closure of preschools and schools during this period.

Patient utilization of primary curative care services were affected from the beginning of the pandemic. There was a considerable drop in outpatient department (OPD) visits to all institutions in 2020 compared to 2019 (see Fig. 3, Fig. 4 and Fig. 5). Utilization of private General Practitioner (GP) services in four provinces showed a similar pattern (see Fig. 6). During the first and second waves of COVID-19, utilization of both public and private primary curative care services decreased markedly. Patient attendance increased after wave 2 but remained below pre-COVID-19 levels.

Figure 3. Patient attendance at selected OPDs in tertiary care hospitals, 2019–2020

Source: Medical Statistics Unit, MoH.
**Figure 4.** Patient attendance at selected OPDs in divisional hospitals, 2019–2020

Notes: Divisional Hospital type A (DHA); Divisional Hospital type B (DHB).

Source: Medical Statistics Unit, MoH.
Figure 5. Patient attendance at selected primary medical care units (PMCU), 2019–2020

Source: Medical Statistics Unit, MoH.
These findings could be attributed to some nonfunctioning ambulatory care services and changes in health-seeking behaviour of patients. Patients may have been reluctant to access health care services due to fear of contracting COVID-19. In several provinces the Department of Ayurveda provided immunity-boosting ayurvedic preparations and health advice to quarantined households through their community doctors.

In a telephone survey among primary care patients it was found that the majority (78.9%) took their noncommunicable disease (NCD) medication without disruption (14). A two-month supply of medication for NCD patients was delivered either by hand or via post to all patients registered at state NCD clinics.

Comparative objective outpatient morbidity statistics are not routinely available in government hospitals. However, indoor morbidity statistics that represent admissions of severe illness reveal a considerable reduction in 2020 for diseases related to the respiratory system when compared to 2019 (15).

Different consultative methods such as remote consultations were used by primary care providers in 2020 and modifications were made to improve the safety of staff and patients for in-person consultations (16–18). The MoH provided official guidance periodically for curative services at all levels. Primary care professional bodies also prepared guidelines focused on COVID-19 primary care and non-COVID-19 disease and service management (19).
Strategies for scaling up COVID-19 emergency primary care services

Prior to COVID-19, emergency patient care services available in primary curative institutions were being scaled up gradually with international donor support. Such services include the identification and stabilization of emergency cases, resuscitation with basic life support measures, referrals, communication and transportation, and management of minor emergencies.

Sri Lanka has a countrywide ambulance service that mobilizes patients in emergency situations from home to the closest appropriate-level government facility. This service was instrumental in transporting confirmed cases of COVID-19 to government isolation hospitals (level-2 institutions) during the period under review, in addition to transporting all other emergency patients in the initial phase of the pandemic.

There were fewer designated facilities for COVID-19 patients in 2020, when individuals were instead admitted to acute care isolation units in secondary and tertiary care hospitals where specialists were on hand. Under this protocol, suspected COVID-19 patients were discouraged from attending primary care facilities, which were maintained to provide essential care for non-COVID-19 patients. With increased demand for emergency services in the third wave in 2021, however, the need for emergency services within primary care facilities rose.

Between January 2020 and the end of May 2021, more than 150,000 COVID-19 patients were hospitalized in public health facilities (20). Prior to the pandemic, upgrades to emergency services mainly focused on conditions that did not require oxygen therapy. Throughout 2020 and 2021, all institutions were provided with PPE and training to equip staff to handle COVID-19 patients, while utilization of the curative system was scaled up during different phases of the pandemic response, which included converting primary care institutions to ICCs for COVID-19 patients.

To manage the high COVID-19 case load during the third wave, the government established a mechanism for home care services that was linked to a dedicated 24/7 call centre for selected districts with a high prevalence of cases. A designated doctor was accountable for each patient under the supervision of a specialist family physician.

Strategies for maintaining essential health services

Different strategies were adopted in Sri Lanka to ensure continuity of non-COVID-19 essential health services in 2020 and 2021 (21–23).

Health staff had to be trained on new operational guidelines to maintain essential services while also taking relevant precautions for COVID-19. Online platforms and pre-recorded material were used for this purpose (24–30).
Mixed approaches were used to enable patients to obtain NCD medications: for patients of public health services medicines were delivered via the postal system, field staff and volunteers; for the estate communities (i.e., plantation-associated worker communities) medicines were delivered by the MoH through the Plantation Human Development Trust when movement restrictions were in place. A web-based platform was also introduced to deliver medicines to patients through state-owned and private pharmacies.

A decision for future strengthening of primary care services was made based on the experience of the national primary care hotline that was established in the first wave of COVID-19. The design of this hotline took into account the policy of registering people to their closest health care facility, with the intention of giving wider access to primary care. A telemedicine system was also established at 16 public-sector nephrology clinics, where patients had the opportunity for audio, video or e-chat consultations through their mobile phones. Another telehealth system was adopted in Galle district to ensure continuity of maternal care.

Additionally, referrals and health-seeking behaviour from primary care to higher-level health centres declined in 2020 as COVID-19 patients were managed at hospitals. At this time, service loads were redistributed; patients were referred back to primary care and patients requiring urgent access to information about COVID-19 could call designated hotlines.

During the first wave of the pandemic, the private sector gave telecommunication support for the establishment of a risk grading and referral system to better manage the COVID-19 case load. This system operated through the establishment of the “1390” National COVID-19 hotline, which was functional for a period of two months (April/May 2020). Public with concerns about COVID-19 could call and, based on a set of structured questions, patients were either asked to call again, referred to an isolation hospital, or linked with emergency transfer services. This happened at a time when home-based care was not being encouraged and the key strategy was isolation away from home and treatment in identified hospitals.

Ongoing primary care reforms and their place in the COVID-19 response


As part of the response efforts, designated hospitals at higher levels were identified initially, which encouraged the bypassing of primary curative care hospitals. As the COVID-19 case load increased, however, all primary-level curative hospitals with inpatient care were identified as level-1 COVID-19 care hospitals. Meanwhile, due to limited capacity in these facilities, a hotline was established as a separate service to that provided by the doctors working in primary curative care hospitals.

Over time, the government and the MoH increasingly recognized the importance of expanded primary curative care and therefore, in May 2021, a decision was taken to manage COVID-19 cases at home where possible.
Progress reviews conducted on two development-partner-assisted projects on primary care strengthening (WB and ADB) have pointed towards the critical need for expanding and developing the right skills mix at the primary care level alongside the need for simultaneous investments in infrastructure.

**How multisectoral policy and action are responding to COVID-19**

**Overview of Sri Lanka’s multisector strategy**

The COVID-19 response throughout 2020 and 2021 depended on multisectoral action. In the initial phase from January to March 2020, multisector engagement occurred through invitations to participate at the task-force level and in the subcommittees that were set up to coordinate with the National Presidential Task Force (see Fig. 3 and related discussion of the governance structure put in place). The risk communication led by the MoH through the mass media played a critical role in educating all sectors on the COVID-19 response and their potential contributions to this.

The economic challenges led to a high-level policy decision by the National Presidential Task Force acknowledging that prolonged movement restrictions were not feasible financially. As part of this, it was understood that multiple sectors needed to resume work under a so-called New Normal approach (referencing movement restrictions enacted as part of the COVID-19 response) (31). Consequently, restrictions were eased from May 2020 following the first wave and guidelines were introduced on the gradual reopening of the economy. This policy approach was intended to balance the multiple functions and contribution to the economy of different sectors alongside their potential to facilitate the spread of COVID-19.

Different sectors had to adjust to and internalize the New Normal way of working, which was rolled out using a series of instruction notes and guidelines for work settings based on what became known as a DReAM approach (see Box 2) (31,32).
When literature on COVID-19 prevention messaging was analysed, the behavioural messages could be categorized into the following four areas:

### Key precaution area | Preventive measures for COVID-19
--- | ---
**Physical distancing** | • Maintain a safe distance from everyone  
• Maintain at least 1 meter (3 feet) distance from yourself and others  
• Avoid close contact with people who are sick  
• Avoid going to crowded places

**Respiratory etiquette** | • Cover your nose and mouth with your bent elbow or a tissue when you cough or sneeze  
• Throw used tissues in the trash  
• Make sure you, and the people around you, follow good respiratory hygiene

**Aseptic procedures/Minimize the pathogen** | • Clean your hands often. Use soap and water or an alcohol-based hand rub  
• It is better to wash hands:  
  - before touching your face  
  - after leaving a public place  
  - after blowing your nose, coughing or sneezing  
  - after handling your mask  
  - after caring for someone who is sick  
• Clean and disinfect frequently touched surfaces/areas daily  
• Avoid touching your eyes, nose or mouth frequently

**Masks** | • Cover your mouth and nose with a mask when around others  
• Wear masks correctly

The Public Health Services division of the MoH put forward the DReAM acronym to summarize the above practices, which was then adopted for official communication and guidelines in public and work settings:

**D – Distancing**

**Re – Respiratory etiquette**

**A – Aseptic techniques**

**M – Masks**

All COVID-19 health guidelines were based on the DReAM principles in Sri Lanka and suitable operational procedures were developed for organizations.

Source: Ariyarathne et al. (32).
In April 2020 the MoH, WHO Sri Lanka and the Itukama (“Responsibility”) Project – a national fundraising initiative to support the pandemic response – launched the “Towards a New Normal” campaign (31, 33). This was designed to reinforce the importance of public health behaviours to control COVID-19 and consisted of two arms: Wagakiyamu (“Be responsible”), which focuses on the obligations of organizations/enterprises, and Meteren jeewithe (“Taking conscious measures for a new way of life”), which focused on the duties of the public. The campaign used symbols that were used universally as a reminder of the DReAM approach. The overall goal was to create awareness, to reinforce existing knowledge and to build favourable attitudes and practices especially in public activities and work settings to limit the spread of COVID-19.

Multisector response to adopt COVID-19-specific policies

The New Normal guidelines were presented by the health sector to the government in the form of an advocacy brief in May 2020 (33). The brief outlined the key interventions expected by different sectors.

Coordinating and implementing the multisector response

High-level consultation through the National and Technical COVID-19 Task Forces and decentralized implementation were key in the multisector response.

Relevant sectors were invited to participate in discussions with the COVID-19 Task Forces and to review interventions made by specific sectors, including in relation to food distribution and the continued functioning of the business and tourism sectors. WHO and other United Nations (UN) partners contributed technical expertise for the pandemic response.

The existing government administration structure (Fig. 7) at district, divisional and village level was utilized during the pandemic response in 2020 and 2021 to implement the instructions provided by the MoH. The Ministry of Public Administration, Home Affairs, Provincial Councils and Local Governments, as well as other relevant ministries, participated in this structure through their officers at village, divisional and district level. Urban Councils (UCs) adopted a similar arrangement. Implementation of these committees at village level was based largely on the leadership of health and local authorities; urban areas have a different administration structure, with Ward Committees (WCs) that are similar to the Village Committees (VCs) in rural areas. Implementation of the decentralized mechanisms varied.
How multisectoral policy and action are responding to COVID-19

Financial structures linked to the multisector response

The government took several strategic decisions to support multisector functions during the pandemic response from January 2020 through to August 2021. Deadlines were extended for the payment of taxes and loans, and continued support was provided to poverty alleviation schemes. Food and financial support schemes were also supported through the local administration structures for families under home quarantine and for poorer households during periods of movement restrictions.

The government also facilitated mechanisms that encouraged the private sector and the public to contribute financially to the COVID-19 response. Contributions were absorbed in the National Health Development Fund, which is a nonspecific fund that was utilized during the pandemic, as well as the Itukama Project, which is a COVID-19-specific fund generated from individual contributions. The Itukama Project directly sponsored the New Normal campaign in 2020 (32).

Source: The authors.
Large private-sector companies collaborated in the island-wide New Normal social marketing campaign through branding and co-sponsorship of public-awareness materials on COVID-19 produced by the MoH (33, 34). Philanthropists, professional bodies, the private sector and civil society organizations (CSOs) (e.g., the Rotary Club, the Lions’ Club) also contributed through direct donations of equipment and PPE to institutions in need.

**How communities are responding to COVID-19**

**Communication to engage communities and other stakeholders**

Mass media, social media and mobile phones were used in the initial wave of the pandemic (January–April 2020) for general communication with the public, reinforced by a strategic social marketing programme. In 2020, mobile phone penetration was 143 phones per 100 persons and internet penetration was 799 connections per 100 persons (35). Information was delivered on the disease and the general precautions to be taken, plus guidance on service delivery changes such as the mechanisms to obtain medicines for chronic conditions (36).

Daily televised briefings by key officials during the periods of movement restriction were effective at influencing the rapid response. Yet breaking news clips by the media were sometimes stigmatizing and provoked fear, while initial communications from the government and MoH failed to recognize the protracted nature of the virus. The MoH monitored public concerns and rumours and addressed these through their communication channels, with the MOH’s Health Promotion Bureau (HPB) designated as the focal point for risk communication.

With the relaxation of restrictions after the first wave, community engagement became more important. In September 2020, a social marketing approach was used to introduce the New Normal campaign, with financial support from the Itukama Project. This campaign was based on the DReAM principles outlined in Box 2, informing different sectors and the public of new practices to resume activities in the country. Targeted communication was rolled out for different communities and settings – health officials worked closely with specific groups (urban, rural, religious and by occupation) to address their needs and CSO and village networks were utilized for local awareness-raising.

The HPB continuously monitored the risks that needed to be communicated throughout different waves of the pandemic in 2020 and 2021 and enlisted support from mass media outlets to educate the public on an ongoing basis. The HPB’s social media platforms had considerable reach, while the Bureau also had the advantage of its “1999” public hotline for community engagement. This hotline and a separate social media monitoring mechanism enabled the HPB to analyse the nature of queries about COVID-19 and to develop community engagement material that was appropriate to the changing situation.
How communities are responding to COVID-19

The toll-free 24-hour hotline that operated prior to COVID-19 was strengthened to deal with concerns relating to the virus and to combat misinformation. Key issues identified through this hotline and by monitoring news/social media were addressed in media releases, guidelines for the public and internal protocols/circulars (37).

Participatory structures and models

Peer-led and group-action settings were also used as part of a participatory approach. These were utilized in particular among youth, estate populations and urban undersettlement areas. Training was conducted for Women Community Leaders in Colombo District in collaboration with the Sarvodaya Community Development Division (SCDD) to empower women to promote COVID-19 protective measures and improved health-seeking behaviours. The *Nagara Suwa Udaana Wedasathahana* ("Urban Health Champion") Programme was initiated in the 21 urban undersettlement flats in Colombo Municipal Council and Kolonnawa MoH areas as part of efforts to engage and empower lower socioeconomic communities.

Group-led methods were used in village settings to target families with similar social backgrounds. For example, posters were displayed with a checklist to encourage daily behaviours and practices to limit virus transmission within households.

Volunteer groups were mobilized in estate communities to be vigilant in the case of returnees from high-risk areas when the movement restrictions began in 2020. As part of these measures, 3000 volunteers visited homes to help the community adopt preventive measures and to encourage returnees to self-quarantine. Records were maintained of locations and movements, and the details were shared with the local public health authority via the MOOH.

Community-level risk communication was supported by CSOs such as Sarvodaya and through village-level networks. CSOs were involved in many activities to promote community engagement through the Civil Society Collective for COVID-19 Response, which included other organizations such as Women in Need, HelpAge, People’s Action for Free and Fair Elections (PAFFREL) and Sarvodaya. This Collective conducted many training programmes for community leaders that promoted community engagement and resulted in the formation of village-level *Suwaadayaa* ("awakening the health") committees. These committees took leadership in addressing emerging issues in the pandemic such as stigma and discrimination of individuals and families, as well as in establishing preventive measures in public and work settings with monitoring and evaluation mechanisms put in place.

Musical programmes and awareness-raising initiatives for mental health promotion and COVID-19 protection were carried out in partnership with the SCDD for the urban-settlement flat residents in the Colombo Municipal Council area. SCDD also organized programmes for children and youth (aged 3–8, 9–12 and 13–19 years) that focused on art and creative activities, supported by SCDD.
Engagement with influential religious leaders

Sri Lanka comprises multi-faith communities and religious leaders who are considered to be influential persons. During the pandemic between January 2020 and August 2021, several religious festivals and observances were carried out under strict COVID-19 precautions.

At different times, the HPB rolled out several advocacy programmes that targeted religious leaders collectively and also as separate religious groups. Local religious leaders played an active role in communicating COVID-19 prevention measures in a manner that was sensitive to different cultures and religions.

Press conferences conducted by the MoH had the participation of all religious leaders at different points in time. In addition, these influential leaders also communicated to different segments of the public about the DReAM principles, NCD treatment adherence, PCR testing, vaccination and quarantine procedures.

Religious leaders were consulted when specific guidelines were formulated for religious activity that involved community participation. Furthermore, a mechanism was established to showcase the innovative approaches adopted within different communities as part of the New Normal approach via a regular news segment on a state media channel. This platform provided the opportunity to share best practices and success stories with the public.

Enhanced participation through VCs

The high-level governance structure and village-level implementation structure became operative through official health guidelines within Sri Lanka’s decentralized administrative system. The VCs for COVID-19 prevention were set up through this administrative structure and were still evolving at the time of writing, with further follow-up needed to ensure their sustainability. The need for more responsibility at the local level was understood during the third wave of the pandemic; however, coordination could be strengthened further between the two levels of the system. For example, VCs could be supported by existing ground-level field officers who represent other sectors such as agriculture, trade and child protection, alongside other Development Officers. The National COVID-19 Task Force would benefit from CSO representation for more effective community engagement.
Conclusion and lessons learned

Sri Lanka was able to roll out a countrywide public health response to COVID-19 in 2020 and 2021 through existing primary-level community health services rooted in the health unit system initiated in 1926 (1). The emphasis was on behaviour change, testing, isolation and treatment. Public health measures were supported by Sri Lanka’s legal framework (through the Quarantine and Disease Prevention Ordinance as amended) and were widely broadcast through the media in all three languages spoken in the country. The measures were operationalized by public health staff and were monitored over time, with necessary support action taken by mobilizing the police, army, navy and air force. Public health personnel were ably assisted in contact tracing by the national intelligence system.

The Disaster Management Programme of the MoH that was initiated after the tsunami in 2004 contributed to the success of pandemic control activities during the first wave of COVID-19 in early 2020. Capacity-building efforts for staff at the central Infectious Disease Hospital in 2019 also played an important part.

The existing health service delivery system for curative care was adapted into a referral system for the COVID-19 response, supported by community health services. National referral guidelines were coordinated and implemented at a subnational level, with COVID-19 patient referrals guided through national protocols that linked ambulance systems with provincial and national institutions.

Essential health services, for example for maternal health care, continued to be delivered during the second wave of the pandemic from October 2020 to April 2021 with reasonably high utilization rates. Changes in health-seeking behaviour were observed, however, with reduced utilization of OPD facilities. The drivers for these changes in behaviour need further exploration, although they likely relate to fear of COVID-19 transmission, social distancing practices that led to fewer episodes of illness or previous overutilization of government facilities. Even private facilities were utilized less, and a shift towards teleconsultations occurred. Evidence suggests that a notable number of people practiced self-care during the pandemic.

The primary curative care system was undergoing reformation at the onset of the pandemic, supported by international donors. However, the focus of this support had to change to the pandemic response. A national PHC hotline linking people to their closest hospital was followed by home-based management of patients under the guidance of primary care specialists in late-May 2021. This eased the burden on PHC institutions and brought relief to some patients who were required initially to leave their homes to be hospitalized. Timely implementation of the primary care reforms could have minimized the burden on the health system further.

The relaxation of COVID-19 restrictions and resumption of work after the first wave in 2020 was successfully guided by the MoH using the towards a New Normal approach (33). The DReAM principles were widely used in a social marketing campaign to enable the gradual reopening of the economy.
In Sri Lanka’s multi-faith society, leaders of all faiths took an active role in the pandemic response. Their sustained commitment to raise awareness and engage communities has been important. The community response via donations and volunteerism was also substantial, and while overall financial accounts for the COVID-19 response were not yet published at the time of writing, central financial commitment and international donor support were available in 2020 and 2021.

The escalation of COVID-19 cases in the third wave from April 2021 to the time of writing drastically changed the situation. In the past, patients often bypassed primary-level hospitals in emergencies as these facilities were less equipped to treat patients needing oxygen as lifesaving therapy. In wave 3, however, the substantial rise in positive cases significantly stressed the PHC system. More financial support is likely to be needed to scale up the COVID-19 response to accommodate emergency care and increase testing capacity. At the time of writing there was a need for high-level follow up of VCs and their implementation status as part of the continued response.

At different phases of the pandemic, emphasis was made amidst restrictions to preserve economic functions. Key contributors to the economy (i.e., the garment industry and tourism) were allowed to function supported by special operating guidelines.

High-level governance and technical mechanisms enabled Sri Lanka to successfully control two waves of COVID-19, yet the escalation of cases during the third wave required timely decisions. Governance mechanisms were put to the test in balancing public health strategies with the preservation of the economy. The declining economic situation poses a challenge to decision-making around future pandemic response efforts.
References


This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for South-East Asia (SEARO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.