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# National perspectives of COVID-19: case of Sri Lanka

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## 1. Introduction

The nature of crisis is such that its advent is hardly expected and the damage caused is calamitous rendering the validity and efficacy of existing social structures including institutions, governance mechanisms, legal frameworks, and policies questionable. Crises push the society into a phase of transformation, ideally toward better preparedness for an anticipated shock that is similar in nature. COVID-19 is a multifaceted crisis that has not failed to remind the world of the unforeseen, shocking, and catastrophic nature of crises. Widespread severe disruptions caused by COVID-19 within a shorter period have made evident that global preparedness planning pertaining to pandemics needs major improvements. Strengthening national-level preparedness for pandemics has greater accountability for improvements in the global preparedness level (Khan et al., 2020). Throughout the world's history, governments have reevaluated and revised their preparedness plans based on the experience and lessons learned from past pandemics. For an instance, after the H1N1 (2009) outbreak European countries such as the United Kingdom, France, and Germany have revised their national pandemic preparedness plans (Droogers et al., 2019). Furthermore, the Ebola outbreak 2014–16 in Africa provoked the Centers for Disease Control and Prevention (CDC) in the United States to strengthen the preparedness of the health-care facilities (Bell et al., 2016).

However, even prior to the COVID-19 outbreak, the preparedness levels of many of the countries to respond effectively to a contagious outbreak were considerably low. The results of the WHO supported Joint External Evaluation (JEE) have emphasized that only a lesser number of countries fully conform to International Health Regulations (IHR, 2005; Gupta et al., 2018). International Health Regulations (IHR, 2005) have been functioning as an agreement that legally binds 196 countries to work together for Global Health Security. Irrespective of the origin or source, IHR aim at preparing countries to prevent, protect against, control, and provide a public health response to the international spread of diseases (WHO, 2008). Global Health Security Index (GHSI, 2019), which was published a few months before the origin of COVID-19, has highlighted several gaps in existing global preparedness planning. Untested capacities of health security, major political risks, lack of funds, and lack of fundamental health system capacities have been greatly highlighted as gaps in more than half of the evaluated countries (Nuclear Threat Initiative & Johns Hopkins School of Public Health, 2019). Therefore, it is clear that the world needs its health security as well as preparedness planning for biological hazards to be strengthened at the national and local levels.

The first case of COVID-19 in Sri Lanka was reported on 27th January, 2020, which was a Chinese tourist who had arrived in the country 2 weeks prior to the said date. The first local case was reported on 11th March, 2020, which was a tour guide who had contact with a group of Italian tourists (Amaratunga et al., 2020). By 31st March, 2020, the number of confirmed cases in the country had surged up to 122 simultaneously reporting 2 deaths. Through the imposition of stringent measures such as a countrywide curfew, travel bans, and closure of education centres, Sri Lanka was able to manage the first wave of the pandemic recording a total of 3396 cases and a death toll of 13 (Amaratunga et al., 2020; Rodrigo, 2020). The country started experiencing the second wave of the pandemic in early October when a cluster of over 1000 cases emerged around an apparel factory in Minuwangoda, Gampaha, and another cluster was created in a wholesale fish market in Peliyagoda as over 800 fish vendors were tested positive (PTI, 2020). COVID-19 cases which were stagnant at approximately 3300 following the first wave rose by almost a third within a period of 3 days owing to rapid transmission originated in the said clusters (Philips, 2020). As of 11th January, 2021, a total of 48,380 confirmed Coronavirus cases and 232 deaths have been reported in the country. Apart from a considerable number of fatalities, the COVID-19 pandemic has caused major social and economic losses ranging from widening inequalities in access to educational services to a potential fall in the GDP by at least 8% which marks a serious economic downturn (Amaratunga et al., 2020; Kidd et al., 2020).

It is against this background that the present study aims at outlining Sri Lanka's status and response to the first wave of the COVID-19 outbreak. The study also pays attention to the mechanisms in place for current preparedness planning for pandemics and other biological hazards in the country while simultaneously attempting to highlight the gaps characterizing such planning. Furthermore, the study has focused on the major improvements which call for immediate and long-term measures. Therefore, providing key recommendations for policy-makers to improve national-level preparedness for anticipated pandemic threats is the community contribution of this study.

## 2. A global perspective of preparedness planning for pandemics and other biological hazards

At the time of writing, the Coronavirus has reported over 50 million confirmed cases and 1.2 million deaths worldwide (WHO, 2020). The pandemic, however, is beyond a health crisis. If this is to be elaborated, COVID-19 has plunged the global economy into a recession with the World Bank forecasting a 5.2% contraction in the global GDP. This represents the deepest recession since World War II (World Bank, 2020). A recent United Nations (UN) report has estimated that close to 71 million people across the world will be pushed into extreme poverty in 2020 as a result of the pandemic (United Nations, 2020). Moreover, the economic impacts of the virus do not correlate with illness and mortality rates. Thus, even those countries that have recorded lower case numbers and deaths have been severely affected by indirect economic losses, especially due to global value chain disruptions and reduced international demand for products (Noy et al., 2020).

In the 1970s, disaster related studies underwent a paradigm shift from “defining disasters primarily as physical occurrences, requiring largely technological solutions” to viewing disasters as a result of the complex interaction between a damaging event and the vulnerability of a society (Birkmann, 2013). Conforming to this view, COVID-19 has imposed disproportionate effects on vulnerable groups including refugees and migrants, people with disabilities, the aged, the informal sector, and the poor thereby aggravating inequalities (United Nations, 2020). Apart from this, the pandemic has compelled the imposition of strict containment measures including lock downs and curfew which have not only raised human rights concerns but also caused adverse psychological impacts. In addition to the fear of contracting the virus, people tend to suffer from anxiety, distress, and depression resulting from separation from loved ones and loss of freedom (Cao et al., 2020; Iasevoli et al., 2020; Jiao et al., 2020). The multitude of unfavorable effects caused by the pandemic are not limited to those that have been discussed. Nevertheless, it should be clear by now that COVID-19 is “more than a health crisis; it is a socio-economic crisis, a humanitarian crisis, a security crisis, and a human rights crisis” (United Nations, 2020).

Taking into account the diverse effects of COVID-19, the United Nations (2020) in its ‘COVID-19 Engagement Strategy’ advocates a risk perspective that places emphasis on enhancing preparedness for pandemics and promotes the emulation of a multisectoral, ‘whole of society’ approach to do so (UNDRR, 2020). A ‘whole of society’ approach calls for collaboration and coordination among public authorities constituting but are not limited to administrative authorities, Disaster Management authorities, health authorities; the media; private sector; international organizations; and the civil society toward improving preparedness for a future risk of a pandemic (United Nations, 2020).

Several global frameworks have advocated integrating biological hazards into overall disaster risk reduction (DRR) planning and fostering multisectoral approaches toward pandemic preparedness planning. The Sendai Framework for Disaster Risk Reduction (SFDRR) (2015–30) has widened the scope of risks to include risks related to biological and technological hazards, not limiting to risks related to natural and man-made hazards. Furthermore, the SFDRR promotes multihazard management of risk including biological hazards within and across all sectors as well as at all levels (UNDRR, 2015). The paramount

importance of preventing infectious diseases such as AIDS and Tuberculosis has been taken into account by the 2030 Agenda for Sustainable Development Goals (SDG) since repercussions of pandemics have overwhelmed the pillars of sustainable development; economic, social, and environmental aspects, throughout history. Moreover, the agenda has emphasized addressing the growing antimicrobial resistance which is an intensifying factor of the frequency of infectious disease outbreaks (United Nations, 2015). In a multisectoral approach toward pandemic preparedness, a strong collaboration between health authorities and DRR authorities is a pivotal factor (UNDRR, 2020). This comes in line with a guiding principle of the Health Emergency and Disaster Risk Management Framework developed by the World Health Organization (WHO) to foster strong relationships between the health sector and other actors of disaster management to heighten the efficacy of prevention and preparedness as opposed to response. A sound multisectoral and multidisciplinary collaboration is imperative in mitigating health risk. While the health sector plays a leading role in managing the risk of infectious diseases, many disaster risk management (DRM) activities aimed at protecting health such as the maintenance of critical infrastructures, transportation, and food security should be performed by other sectors. Further, a comprehensive approach for risk management related to health risks, especially infectious diseases, enhances the cost-effectiveness and efficiency of the process (WHO, 2019).

It is also important to note that the COVID-19 pandemic and its cascading crises have exacerbated the vulnerabilities caused by other hazards. Disaster prone countries are faced with the increased risk of other disasters (e.g., hydrometeorological events) occurring concurrently with the pandemic and of such parallel disasters resulting in compound vulnerabilities (UNDRR, 2020). For instance, Sri Lanka had to manage the impacts of the Southwest monsoon and also, the “Burevi” cyclone during the second wave of the COVID-19 outbreak in the country. Disaster management authorities with the assistance of numerous agencies such as triformes, police, and public health authorities have taken several actions to enhance the preparedness of the community for these multiple hazards (WFP, 2020). Elaborating on this, more than 75,000 people were evacuated well before the cyclone hit the Eastern coastline of Sri Lanka. Schools were closed down during the period when the cyclone crossed the land of Sri Lanka (Karunathilake, 2020). The Disaster Management Centre has reported that a total of 12,252 people in 6 districts have been affected by the cyclone influenced weather (UNICEF Sri Lanka, 2020). The probability of such compound events has rendered the widely followed siloed approaches to hazards problematic. The UNDRR (2020) has, thus, deemed the advocacy of a multihazard approach to enhancing preparedness for pandemics and other biological hazards crucial.

This chapter examines the extent to which preparedness planning for pandemics and other biological hazards in Sri Lanka comply with the global discourse and standards briefed above with specific reference to its current status and gaps.

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### 3. Methodology

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This chapter is based on a study conducted for examining the current status, gaps, and ways of improving the integration of preparedness planning for biological hazards into DRR strategies. The chapter has drawn on a review of secondary literature including policy

and legal documents pertaining to DRR and preparedness for biological hazards, national and international reports on DRR and preparedness for biological hazards, national action plans, and standard procedures related to biological hazards, scholarly articles, internet sources, and reports published by national and international organizations. Further, this chapter has been informed by primary data gathered through in-depth interviews conducted with 19 key informants from the disaster management and public health sectors in the country. Key informants from the disaster management sector constituted representatives from the Preparedness Planning Division of the Disaster Management Centre (DMC); District Disaster Management Coordinating Units (DDMCUs) in four selected districts; a UN organization; two International Non-Governmental Organizations (INGOs); a national level business association in Sri Lanka; a District Secretariat of a selected district; the Divisional Secretariat of the same district and a Medical Officer of Health (MOH) office in a selected Divisional Secretariat Division of Sri Lanka. Key informants from the health sector involved representatives from five national level health sector organizations in Sri Lanka. The interviews were conducted based on a semi-structured interview guide that contained questionable areas on Sri Lanka's response to COVID-19 and preparedness planning for biological hazards.

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## 4. Results and discussion

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### 4.1 Preparedness planning for biological hazards in Sri Lanka: current status

The Quarantine and Prevention of Diseases Ordinance chapter 222, No. 3 of 1897, makes provisions for the prevention of the introduction of the plague and all other contagious and infectious diseases into Sri Lanka and the prevention of the spread of said diseases within and outside of Sri Lanka (Ministry of Health, 2010). In most regulations framed under this Ordinance, the Director-General of Health Services has been assigned as the proper authority for facilitating the prevention of the spread of said diseases (Ministry of Health, 2010). In accordance with the provisions of said ordinance, the public health authorities in the country including the Disaster Preparedness and Response Division (DPRD) at the Ministry of Health, Nutrition and Indigenous Medicine (which is the central authority for coordinating health-related activities in disaster situations) plays the central role in preventing and/or mitigating the risk of biological hazards, particularly pandemics and epidemics (DPRD, 2018). Furthermore, the Quarantine Unit and Epidemiology Unit, which are recognized as the co-focal points of implementing IHR (2005) in Sri Lanka, have the responsibility of performing risk assessments pertaining to infectious diseases in the country, forecast and generate early warnings, and monitor the activities for mitigating biological hazards in the country (Quarantine Unit, 2018). Elaborating on the dissemination of early warnings and risk communication pertaining to pandemics and epidemics, health authorities have been provided with legal provisions to do so by the aforementioned Ordinance. For an instance, the disease surveillance system, which is legally mandated by the Quarantine and Prevention of Diseases Ordinance of 1897 and includes only public health authorities, has been used in disseminating early warnings for communicable disease outbreaks (Ministry of Health, 2010).

Being the responsible technical agency for mitigating risks related to biological hazards in Sri Lanka, Ministry of Health, Nutrition, and Indigenous Medicine (MOHSL) initiated the response to COVID-19, by appointing a 22-member National Action Committee for COVID-19 to control the spread of the virus in Sri Lanka. The committee consisted of representatives and experts from public health, government administration, defence, aviation, and immigration and emigration, etc. (Ceylon Chamber of Commerce, 2020). Based on the advice and expert knowledge of the aforementioned committee, the Government of Sri Lanka (GoSL) took several stringent measures such as travel bans for foreigners from countries at high risk, mandatory quarantine processes, closure of public places, and islandwide travel restrictions to curb the spread of virus. In line with the multisectoral approach implemented by GoSL toward responding to COVID-19, MOHSL published the 'Sri Lanka Preparedness and Response Plan COVID-19' in April 2019 which has been devised based on the WHO strategic plan (Amaratunga et al., 2020; Ceylon Chamber of Commerce, 2020). The action plan has focused on nine priority areas where public health authorities have been vested with pivotal responsibilities. For instance, Disaster Preparedness and Response Division (DPRD) functioning under the purview of MOHSL has been accountable for coordination among multiple stakeholders of the GoSL's response mechanism and health authorities. Likewise, Epidemiology Unit, Health Promotion Bureau (HPB), Quarantine Unit, and Medical Research Institute have been performing activities pertaining to the main action areas demonstrated in Fig. 6.1 (Ministry of Health and Indigenous Medical Services, 2020).



FIGURE 6.1 Main action areas of MOHSL's response to the first wave of COVID-19 in Sri Lanka.

It is therefore evident that preparedness planning and response to biological hazards is predominantly a health sector-led process with a crucial role being played by the MOHSL. However, the country's approach toward preparedness planning for pandemics and other biological hazards is characterized by a number of gaps that have been discussed in detail below.

## 4.2 Preparedness planning for biological hazards in Sri Lanka: gaps

### ***4.2.1 The absence of a unified legal framework and system of governance to facilitate the transfer of expertise, resources, and lessons learned from one hazard context to another***

It was mainly following the devastation caused by the 2004 Indian Ocean Tsunami that Sri Lanka saw the instigation of a systematic approach to DRM. The Southern and Eastern coasts of Sri Lanka were in ruins following the catastrophe and the magnitude of the disaster which took the island by shock urged the introduction of policies, agendas, and formalized mechanisms to manage disaster risks (Disaster Management Centre, 2014). Immediately following the Indian Ocean Tsunami, a Parliament Select Committee on Natural Disasters was appointed to provide recommendations for the establishment of a national mechanism and system for DRM in the country. Accordingly, the Sri Lanka Disaster Management Act No. 13 of 2005 was instated as the legal framework for DRM in the country.

This Act provided for the establishment of the National Council for Disaster Management (NCDM) and the Disaster Management Centre (DMC) (Jayasiri et al., 2018). Chaired by H.E. President and with vice chairmanship provided by the Prime Minister of the country, the NCDM functions as the supreme governing body of disaster management while the DMC functions as its executing agency (Disaster Management Centre, 2014). In December 2005, the Ministry of Disaster Management was established as the main decision-making body of DRM in Sri Lanka. Several agencies including the DMC, Department of Meteorology (DoM), the National Building Research Organization (NBRO), and the National Disaster Relief Services Centre (NDRSC) have been established and operate within the purview of the Ministry of Disaster Management (Amaratunga et al., 2020; Disaster Management Centre, 2014; Siriwardana et al., 2018). Complying with the provisions of the Sri Lanka Disaster Management Act No. 13 of 2005, the National Disaster Management Plan, the National Emergency Operations Plan, and the National Disaster Management Policy were introduced as the main policy and planning documents governing and guiding DRM in Sri Lanka.

According to the legal provisions provided by the aforementioned Act, the DMC has been vested with the power to function as the central authority to coordinate the countrywide DRM program (including activities such as conducting risk assessments and issuing and dissemination of early warning) with the right of gaining the assistance of mandated agencies to implement DRM activities with regard to specified hazards including biological hazards. MOHSL has been provided with legal provisions by the same Act to function as the responsible ministry in mitigating impacts of biological hazards and assist the DMC in overall DRM mechanism in the country (Disaster Management Centre, 2014). Under the purview of



MOHSL, several agencies are responsible for subcomponents of overall preparedness planning for biological hazards (e.g., DPRD, Quarantine Unit, and HPB). As mentioned before, the Quarantine and Prevention of Diseases Ordinance, Chapter 222, No. 03 of 1897, has designated the Director-General of Health Services (DGHS) of the MOHSL as the accountable authority for mitigating and preventing the spread of infectious diseases within and across borders of Sri Lanka (Ministry of Health, 2010).

The DGHS, thus, has the authority for independent decision-making with regard to the mitigation and prevention of the risks posed by infectious diseases such as epidemics and pandemics as per the provisions of said Ordinance. The existing legal framework evidently provokes preparedness planning for biological hazards to be undertaken in isolation and with almost the exclusive involvement of health authorities in contrast to facilitating multi-sectoral cooperation and the transfer of expertise, resources, and lessons learned from one hazard context to another (Amaratunga et al., 2020). A legal framework that harnesses a siloed approach to preparedness planning for biological hazards stands problematic, especially in the context of compound events as described below (Amaratunga et al., 2020).

#### ***4.2.2 The absence of a national framework to guide preparedness for concurrent hazards***

Similar to the regions of Guatemala and El Salvador, certain districts of Sri Lanka were faced with the threat of other hazards occurring in parallel with the pandemic situation. These situations of parallel events demanded the configuration of preparedness and response mechanisms to address compound vulnerabilities which resulted from such events. For example, with the onset of the Southwest monsoon, the district of Ratnapura, a generally flood-prone district, was faced with the risk of floods striking the area amid the COVID-19 pandemic. Thus, preparedness planning for floods in the district took a new turn in the year 2020. For example, while in other years families residing in flood-prone areas were evacuated to safety houses, steps had to be taken in the said year to reduce the number of safety houses as far as possible and evacuate vulnerable families to the houses of their relatives/friends. This was done with the objective of containing a potential spread of the pandemic. Further, before people were registered at a safety house, they were checked for fever by the Public Health Inspectors (PHIs) and the Public Health Midwives (PHMs). If a person was diagnosed with fever, they were admitted to a hospital and were therefore not allowed to occupy a safety house. In the same way, the disaster management authorities of the District of Badulla were compelled to configure the execution of preparedness activities for landslides to suit the new normal. In certain districts like Polonnaruwa, the spread of other epidemics such as Dengue and Leptospirosis had to be curtailed simultaneously with efforts to curb the spread of COVID-19. Such evidence therefore calls for the need to emulate a multihazard approach to preparedness planning for epidemics and pandemics (UNDRR, 2020). As discussed prior, the existing legal framework for preparedness planning for biological hazards in the country does not allow for a multihazard approach, instead promotes a siloed approach that thereby weakens the country's capacity to effectively prepare for and address concurrent hazards and the resulting compound vulnerabilities, respectively.

### **4.2.3 Inadequate implementation of pandemic preparedness activities as part of overall DRR efforts**

Similar to the Sri Lanka Disaster Management Act No. 13 of 2005, the National Disaster Management Plan identifies epidemics as a disaster form that has caused a high level of losses and damages and posed a high impact on the population based on a brief assessment of the disaster situation in Sri Lanka that had drawn on historical records (Disaster Management Centre, 2014). Hence, it is evident that a considerable level of emphasis has been placed within the planning process on taking into account biological hazards like epidemics and pandemics in the country's DRR activities like performing risk and vulnerability assessments. Regardless, there is not enough evidence to support that this has been practically implemented in the country to a significant level.

Elaborating on this, an official from a UN organization claimed during key informant interviews that much attention has not been paid to epidemics in most of their disaster preparedness activities in the country. Furthermore, the key informant mentioned that out of 100–150 villages where disaster preparedness activities have been carried, none of the villages had prioritized epidemics as a key hazard. Though dengue has been a serious case in villages from the Eastern Province, it has not been recognized as a serious issue in DRR activities. The general approach followed in identifying and prioritizing disasters in the country has been pointed out as a reason why adequate attention has not been paid to epidemics and pandemics in DRR activities in Sri Lanka. Elucidating his experiences in executing disaster preparedness activities in certain localities, the same official claimed that disasters that occur in a certain area are identified and prioritized based on a disaster prioritization matrix that considers the severity and frequency of hazards in the area as key criteria for prioritizing hazards. The severity and frequency of hazards are gauged taking into consideration the history of hazards in the area revealed through people's accounts of their past experiences with disasters and information from the DisInventar (the disaster information management system in Sri Lanka). Hence, this existing gap calls for the need to reconsider the current approach to identifying and prioritizing disasters, and overall DRR activities for that matter, so that biological hazards such as epidemics and pandemics are attributed adequate significance in said activities.

Furthermore, a risk profile for Sri Lanka was carried out with the objective of generating spatial information on various types of hazards, vulnerable areas, and risks in order to be used as a decision-making tool for disaster preparedness and mitigation programs. However, such risk profiling was carried out prioritizing five hazards, namely floods, droughts, landslides, cyclones, and coastal hazards (including tsunami, sea surges, sea-level rise, and coastal erosion). Evidently, attention was not paid to biological disasters such as epidemics and pandemics in this risk profile (Disaster Management Centre, 2014; UNDRR, 2019). In addition to this, it was revealed during the key informant interviews with officers from the DDMCUs that while district-level risk assessments have been carried out for natural hazards, biological hazards have been largely overlooked in these activities. Nevertheless, maps containing Dengue hot spots have been drawn by public health authorities in certain districts, particularly the Regional Epidemiologist. However, whether these maps reflect comprehensive risk assessments is questionable.

Likewise, it is evident that though preparedness for biological hazards, particularly epidemics, has been acknowledged to a certain extent in DRR-related planning and legislation in the country, the actual implementation of activities in this regard has been minimal.

#### ***4.2.4 Insufficient attention is paid to pandemic preparedness in subnational-level disaster preparedness and response Plans***

The primary responsibility concerning disasters in the country is vested with the national government but, corresponding to the administrative system in the country, this responsibility has been decentralized into subnational levels including Provincial Councils, District secretariats, Divisional secretariats, Grama Niladhari Divisions, and Local Authorities (constituting Municipal Councils, Urban Councils, and Pradeshiya Sabhas). Ensuring the participation of all administrative levels and multiple stakeholders in the disaster risk reduction and management process has been the main tenet of this decentralized approach (Disaster Management Centre, 2014). The Sri Lanka Disaster Management Act No. 13 of 2005 has made necessary legal provisions for the formulation of subnational-level Disaster Management plans and establishment of Disaster Management committees at the community/village level, divisional level, district level, and provincial level (Disaster Management Centre, 2014). Currently, the district-level disaster management plans have been formulated for all districts of the country; these plans have placed emphasis on preparedness for and response to natural hazards thereby overlooking to a significant degree the prevalence of biological hazards and the need to proactively prepare for and effectively respond to them. For an instance, an officer from a DDMCU stated that the relevant district has developed its district disaster management plan in 2018 and has not considered epidemics and pandemics to a considerable extent.

This was further proven by a key informant from another DDMCU. The respondent stated that a district disaster management plan has been formulated for the related district 6–8 years back and it has been updated every year. In 2020 the DDMCU has revised the whole plan but it mainly focused on natural hazards like floods, however biological hazards have not been paid much attention. The input from the key informant interviews with officers from DDMCUs portrays that biological hazards have been overlooked to a great extent in devising the district-level disaster management plans. However, with the prevailing consequences of COVID-19, the district disaster management authorities have realized the paramount importance of taking into consideration biological hazards in devising and formulating district level disaster management plans. Furthermore, the significance of close collaboration between disaster management and health sector authorities for heightening the efficacy of DRR planning at the subnational level by transferring necessary technical knowledge was highlighted during the interviews.

#### ***4.2.5 Limited mechanisms for mitigating cascading effects of pandemics in the long run***

The cascading crises caused by the COVID-19 pandemic at the global level have been manifested at the national level. For example, the pandemic has slowed down the country's key economic sectors including manufacturing (e.g., textiles) and services (e.g., tourism) (Vithanage, 2020; Weerathunga & Samarathunga, 2020; Wimalaweera, 2020). The informal sector including daily wage earners and Small and Medium Scale Enterprises have been

subject to a greater degree of economic vulnerability while economic stress, job insecurity, and anxiety have been permeating those employed in diverse sectors of the economy (Robinson & Kengatharan, 2020; Wimalaweera, 2020). Apart from the strain caused on the economy, the psychosocial well-being of certain population groups has drastically declined during the pandemic period. An aspect that can be highlighted in this regard is the stigmatization and labeling of people who have contracted the virus. COVID-19 patients have been projected and ostracized as ‘wrongdoers’ and ‘culprits’ largely by the media and some segments of the society, respectively. This has in turn resulted in people being reluctant to disclose their symptoms (if any) and reveal their histories (Bandara et al., 2020; Rozais, 2020). Containment measures such as the imposition of an islandwide curfew, closure of schools and other public spaces, and banning public gatherings have led to an increase in child abuse and domestic violence. The same containment measures have resulted in the closure of alcohol stores which has thereby surged up the demand for home-brewed alcohol sold at black market prices (Norulf, 2020). Upon the closure of schools, the GoSL has opted for the provision of educational services online. Access to such services has been the exclusive privilege of children from middle- and high-income families, leaving children from low-income families disadvantaged, thus widening existing social inequalities (Kadirgamar & Thiruvarangan, 2020).

The GoSL appointed three task forces to tackle the detrimental socioeconomic effects of the pandemic, one of which was responsible for ensuring the continuity of essential services and the others in charge of economic revival and the uninterrupted provision of educational services (Centre for Policy Alternatives, 2020). The GoSL also provided a grant of LKR 5000 to low-income families and economically vulnerable populations as a single payment with the purpose of easing the financial burden of these population groups (Department of Government Information, 2020). However, the services rendered by these task forces and the provision of said grant barely represent mechanisms for mitigating the discussed socioeconomic effects in the long run. Such response measures offer short-term solutions that fail to address the persistent vulnerabilities that underlie mentioned socioeconomic effects. Therefore, it is important to shift the focus from response to building resilience of both the economy and society to minimize the adverse economic and social implications of epidemics and pandemics. A resilience building approach calls for a number of activities that range from empowering vulnerable groups at the village level to establishing private–public partnerships to foster economic resilience.

#### **4.2.6 Lack of private sector participation**

In light of UNDRR’s (2020) proposals for a ‘whole of society’ approach to improving pandemic preparedness and with close to 5 million people being employed in the private sector of Sri Lanka (Satharasinghe, 2018), the importance of private sector participation in preparedness planning for biological hazards cannot be denied. While such private sector participation is currently at a low level in Sri Lanka, several suggestions have been made by key informants, highlighting private sector contribution to pandemic preparedness. Firstly, preparedness planning for biological hazards could be incorporated into business continuity plans (BCPs) so that organizations are able to respond proactively rather than reactively to a future onset of a pandemic or epidemic. Similarly significant in this regard is an attempt to orient corporate social responsibility (CSR) and sustainability activities of private sector organizations toward epidemic and pandemic preparedness.

Commenting on the role of the private sector in preparedness planning for pandemics and epidemics in Sri Lanka, a key informant from a national level business association in Sri Lanka pointed at the need to bring in new concerns and practices to occupational health and safety procedures in private sector organizations. In other words, the suggestion was to integrate pandemic and epidemic preparedness into occupational health and safety procedures in private sector organizations. In relation to this, the Occupational Health Unit of the Directorate of Environmental and Occupational Health in the Ministry of Health, Sri Lanka, has produced a set of guidelines for preparedness and response to COVID-19 in work settings ([Directorate of Environmental Health Occupational Health and Food Safety, 2020](#)). However, according to the same key informant, what's required is the inclusion of some of these or related guidelines into the Occupational Safety and Health Administration (OSHA) regulations of all private sector organizations in order to strengthen preparedness for biological hazards. This thereby entails mainstreaming preparedness for biological hazards into the general administration and everyday procedures of private sector organizations. For example, if every organization in the private sector maintains a database of employees with noncommunicable diseases, the organization can pay special attention to their needs during a pandemic or epidemic situation as they are deemed to be more vulnerable than others.

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## 5. Conclusion

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This study has provided a brief overview of Sri Lanka's response to COVID-19 while highlighting the current status and gaps pertaining to preparedness planning for biological hazards in the country. The findings portray that the existing legal framework for DRM in Sri Lanka supports a siloed approach to preparedness planning for biological hazards where much of the responsibility in this regard is vested with health authorities in the country. The framework does not adequately promote multisectoral collaboration among various organizations and agencies which stands paramount in an attempt to effectively prepare for and respond to compound events such as pandemic–natural hazard hybrid scenarios. Furthermore, the findings demonstrate that although DRM-related planning and policing in the country have acknowledged the importance of preparedness planning for biological hazards, not many activities have actually been implemented in this regard. Preparedness for pandemics and similar biological hazards in Sri Lanka is further hindered by lack of attention paid to preparedness planning for biological hazards in subnational-level disaster management plans, lack of focus on resilience building of communities to mitigate the adverse social and economic impacts of such hazards, and lack of private sector engagement in preparedness planning for biological hazards.

Based on these findings, the following recommendations can be made to improve Sri Lanka's preparedness for pandemics such as COVID-19 and similar biological hazards. The existing DRM-related legal documents should be revised and consolidated to support a unified legal framework and system of governance that allows for the transfer of relevant expertise, infrastructure, and lessons learned from previous hazards contexts to situations of pandemics (e.g., the transfer of Early Warning infrastructure). Further, current approaches to prioritizing disasters should be rethought and revised so that new trends in hazards, the

increasing complexity of hazards, interconnections between different hazards (e.g., the potential rise in the incidence of Dengue following floods), transboundary nature of certain hazards, and hazard impact including cascading effects are taken into consideration. This will be a key step in ensuring that pandemic preparedness is incorporated into national-level DRR efforts.

It is also recommended that subnational-level DRR plans are updated to address biological hazards. Strengthening the national focus on building economic and social resilience over immediate response to disasters through significant shifts in DRM policing and planning and through the integration of disaster aspects into urban planning, the national development agenda, and rural development initiatives is critical in an attempt to enhance the country's preparedness for biological hazards. In addition to this, the private sector should be identified as a key stakeholder in preparedness planning for biological hazards. Measures such as business continuity planning incorporating biological hazards and place to enhance private sector preparedness for biological hazards and establishment of a standard mechanism for responding to biological hazards (e.g., by integrating guidelines on such response to OSHAs) stand pivotal in enhancing private sector's contribution to preparedness planning for biological hazards.

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