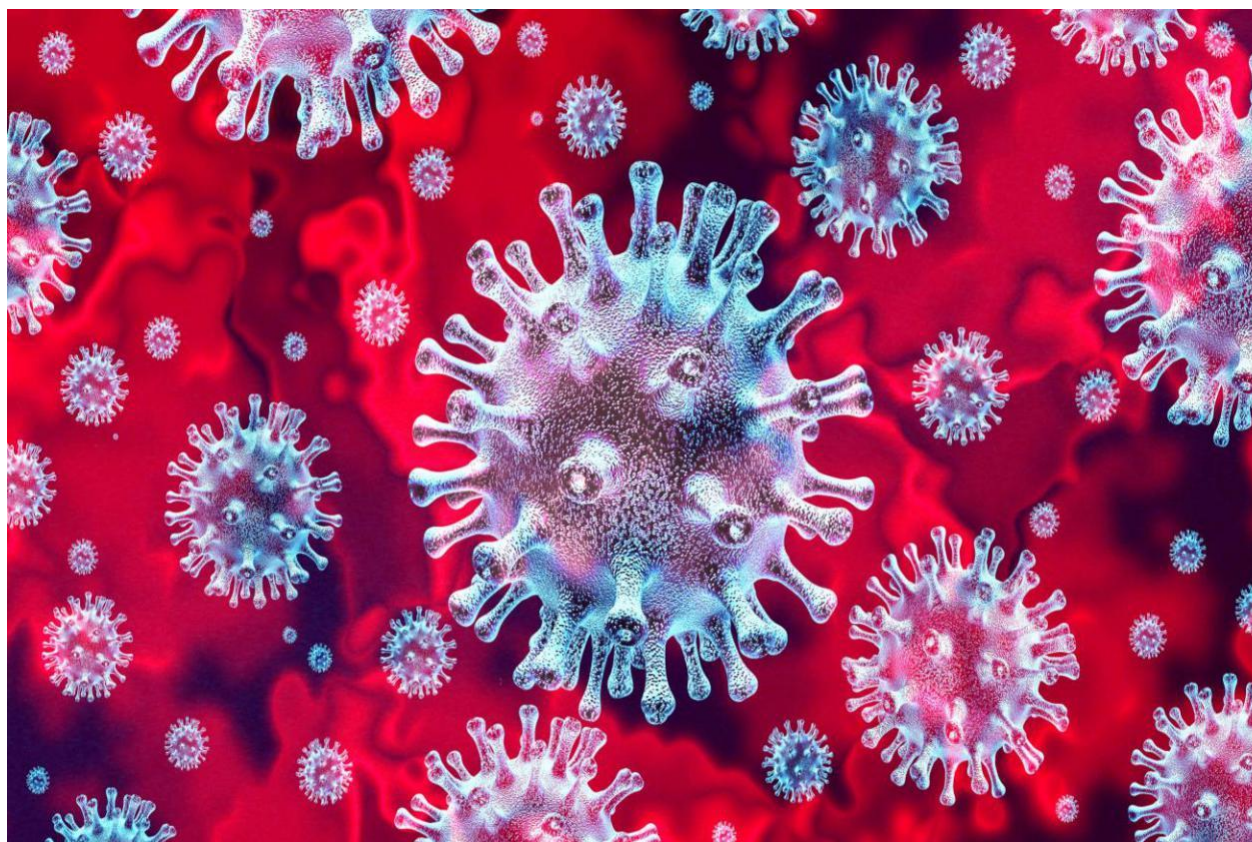




COVID-19 Sri Lanka Strategic Preparedness & Response Plan 2021



Ministry of Health, Sri Lanka

30 April 2021

Table of Contents

Title	Page No
List of Annexures	2
List of Abbreviations	3
List of Figures.....	5
1. SITUATION OVERVIEW	6
1.1 EPIDEMIOLOGICAL SITUATION	6
2. STRATEGIC PREPAREDNESS AND RESPONSE PLAN	9
2.1 STRATEGIC OBJECTIVES	9
2.2 NATIONAL LEVEL PREPAREDNESS AND RESPONSE	11
2.2.1 COORDINATION, PLANNING, FINANCING AND MONITORING	12
2.2.2 RISK COMMUNICATION, COMMUNITY ENGAGEMENT AND INFODEMIC MANAGEMENT	16
2.2.3 SURVEILLANCE, EPIDEMIOLOGICAL INVESTIGATION, CONTACT TRACING, AND ADJUSTMENT OF PUBLIC HEALTH AND SOCIAL MEASURES	21
2.2.4 POINTS OF ENTRY, INTERNATIONAL TRAVEL AND TRANSPORT AND MASS GATHERINGS	24
2.2.5 LABORATORIES AND DIAGNOSTICS	27
2.2.6 INFECTION PREVENTION AND CONTROL, AND PROTECTION OF THE HEALTH WORKFORCE	29
2.2.7 CASE MANAGEMENT, CLINICAL OPERATIONS, AND THERAPEUTICS	31
2.2.8 OPERATIONAL SUPPORT AND LOGISTICS, AND SUPPLY CHAINS	35
2.2.9 MAINTAINING ESSENTIAL HEALTH SERVICES AND SYSTEMS	37
2.2.10 VACCINATION	43
3.0 IMMEDIATE & MEDIUM-TERM NEEDS	46

List of Annexures

Provide additional information, leading officials and contact details of the main areas of the plan of action of the Ministry of Health, Sri Lanka.

	Title	Page No.
Annex I	Country level Coordination, Planning and Monitoring	56
Annex II	Risk Communication and Community Engagement	60
Annex III	Surveillance, Risk Assessment and Rapid Response	62
Annex IV	Points of Entry (PoE)	67
Annex V	National Laboratories	68
Annex VI	Infection Prevention and Control (IPC)	69
Annex VII	Intermediate care centres and ambulance services for COVID-19 patients available on paying basis	72
Annex VIII	List of COVID 19 treatment centres prepared for COVID 19 response	73
Annex IX	List of Hospitals prepared for COVID 19 response	77
Annex X	List of Quarantine Centres established and under the care of Sri Lankan Tri-forces	79
Annex XI	Case management, clinical operations, and therapeutics	81
Annex XII	Operational Support and Logistics	82
Annex XIII	The composition of the committee and subcommittees of National Coordination of Covid-19	83
Annex XIV	List of essential biomedical equipment for patient care	86

List of Abbreviations

COVID-19	Coronavirus disease 2019
ADB	Asian Development Bank
BES	Biomedical Engineering Services
DDGHS	Deputy Director-General of Health Services
DGHS	Director-General of Health Services
HPB	Health Promotion Bureau
HR	Human Resources
ICN	Infection Control Nurse
IEC	Information, Education and Communication
IF	Isolation Facility
IPC	Infection Prevention and Control
LMIS	Logistic Management Information System
MCH	Maternal and Child Health
MLT	Medical Laboratory Technologist
MO	Medical Officer
MoH	Ministry of Health
MOH	Medical Officer of Health
MRI	Medical Research Institute
MSD	Medical Supplies Division
RMSD	Regional Medical Supplies Division
NHSL	National Hospital of Sri Lanka
NIAG	National Immunization Technical Advisory Group
NIID	National Institute of Infectious Diseases

NO	Nursing Officer
PCR	Polymerase Chain Reaction
PHI	Public Health Inspector
PHM	Public Health Midwife
PoE	Points of Entry
PPE	Personal Protection Equipment
QF	Quarantine Facility
RCCE	Risk communication and Community Engagement
RMNCH	Reproductive, Maternal, Newborn and Child Health
SLA	Sri Lanka Army
SLAF	Sri Lanka Air Force
SLN	Sri Lanka Navy
SOP	Standard Operating Procedures
UN	United Nations
UNICEF	United Nations Children’s Fund
VIRAT	Vaccine Introduction Readiness Assesment Tool
WASH	Water Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization

List of Figures

	Title	Page No.
Figure 1	Global and Sri Lanka situation-a comparison	06
Figure 2	COVID-19 cases reported weekly by WHO Region, and global deaths, as of 25 th April 2021	07
Figure 3	Epi curve of COVID-19 patients, Sri Lanka as of 30/04/2021	08
Figure 4	Public health and social measures are supported by multiple response pillars.	10
Figure 5	National, regional and global response support structure	11
Figure 6	COVID 19 Coordination Mechanism in Sri Lanka	12

1. SITUATION OVERVIEW

1.1 EPIDEMIOLOGICAL SITUATION

GLOBAL: Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). The outbreak spreads by person-to-person contact, and the potential public health threat posed is high. The COVID-19 virus infects people of all ages. However, evidence to date suggests that two groups of people are at a higher risk of getting severe COVID-19 disease. These are older people and those with underlying medical conditions. The global spread of COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO) on 30th January 2020 and was later declared a Pandemic.

The pandemic continues to evolve. As of 25th April 2021, more than 146 million cases have been reported in 223 countries and territories, resulting in over 3,092,497 deaths (WHO Corona virus-COVID-19 Dashboard). Transmission of COVID-19 is highly clustered resulting in transmission of infection to a large number of people from a relatively small number of cases. More deaths (80%) have been observed in individuals over the age of 65 years. Males account for a higher proportion of deaths than females (57% of deaths for 51% cases).

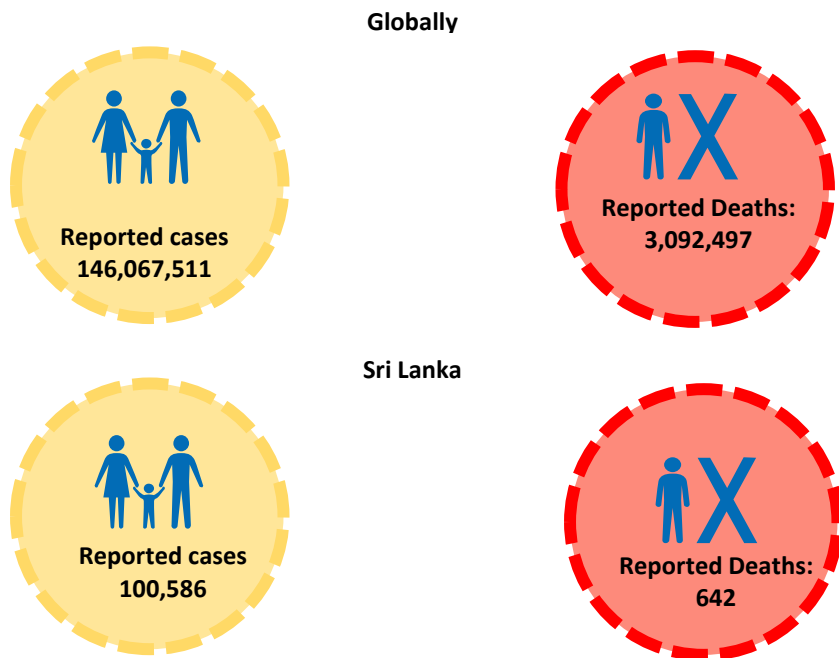


Figure 1: Global and Sri Lanka situation-a comparison (as of 25th April 2021)

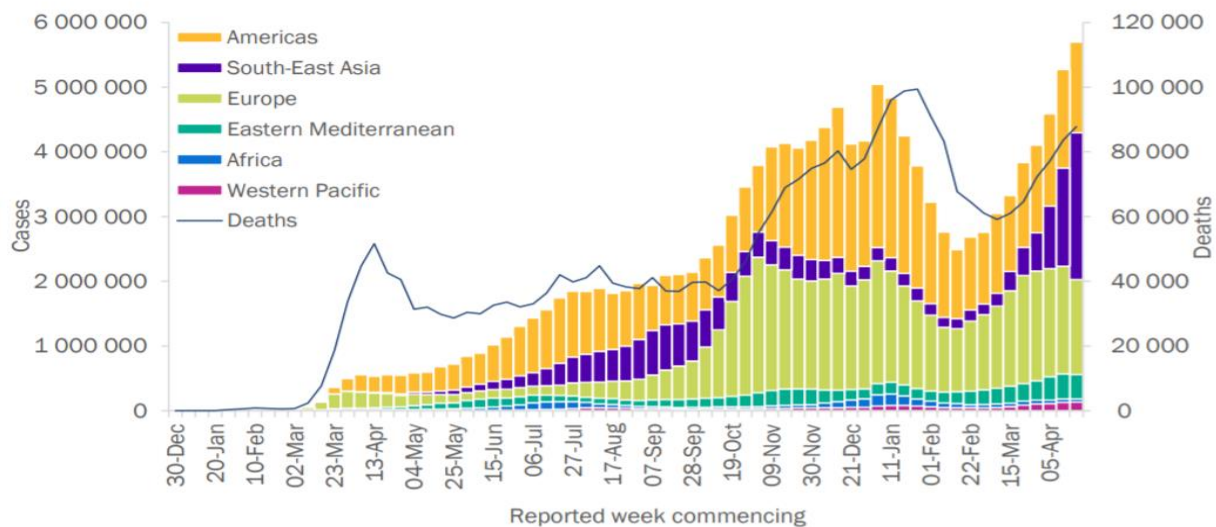


Figure 2: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 25th April 2021

As viruses constantly change through mutations, the emergence of new variants is expected. According to the WHO COVID-19 strategic preparedness and response plan, 1st February 2021, PCR tests remain the gold standard of SARS-COV-2 diagnostic testing for accuracy but other types of tests such as rapid antigen detection test are used in a variety of different settings.

SRI LANKA: Since the first reported case of a tourist from China infected with the virus in February, Sri Lanka has reported a total of 106,404 confirmed cases of COVID-19 (as of 30th April 2021), with the first indigenous case reported on 11th March 2020. To stem the spread of the virus, the country was placed in lock-down mode, with government offices, airports, schools and other educational institutes closed, and the private sector asked to work in a restricted manner/remotely, with public gatherings/events being curtailed initially.

Only 3396 COVID-19 patients were reported from Sri Lanka till the 4th of October 2020, which composed mostly of Navy and Kandakadu clusters and imported cases. There was 125 active case on 4th October 2021.

On the 5th of October 70 patients were reported from the Brandix Minuwangoda cluster which resulted in a surge in positive cases. Police curfew was imposed in selected areas and districts to control the spread of disease. Despite the measures, a cluster of positive cases was reported from Peliyagoda on 28th October 2020. The total number of cases in Sri Lanka increased to 9791 by 30th October 2020 with 5490 active cases.

As of 31st March 2021, the total number of patients reported was 92,442 of which 87,666 (94.8%) were from sub clusters related to Minuwangoda, Peliyagoda and prison clusters. Following the New year festival significant rise in patient reporting was observed which has resulted a total number of 106,484 patients as of 30th April 2021.

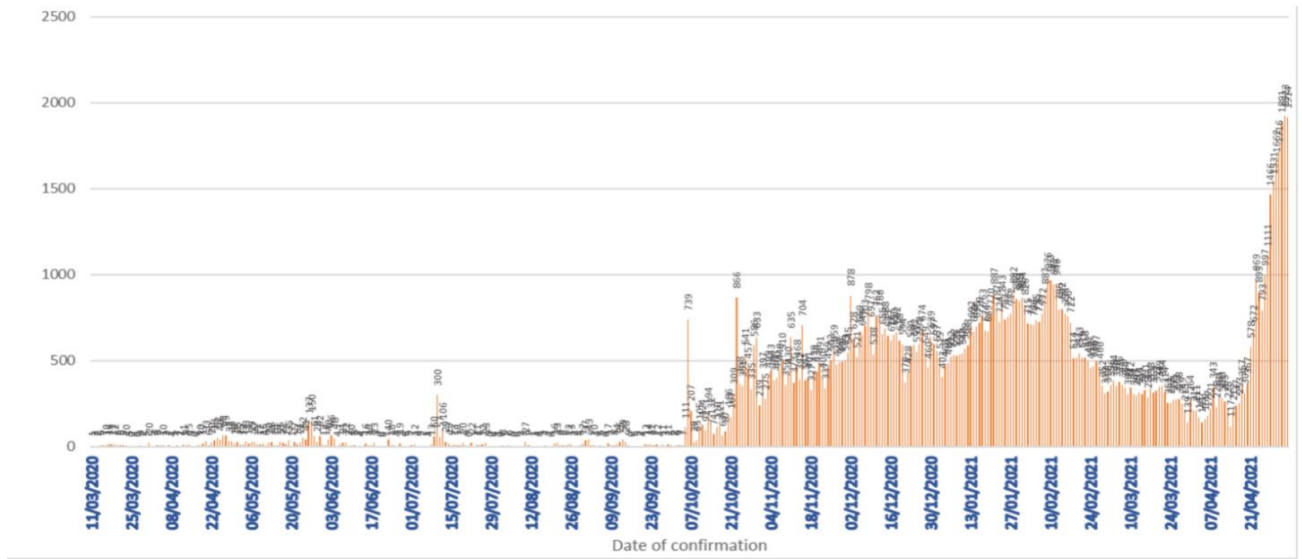


Figure 3: Epi curve of COVID-19 patients, Sri Lanka as of 30/04/2021

Sri Lanka, with guidance from the global WHO documents, has sought to implement a Strategic Preparedness and Response Plan in the 10 areas recommended by the WHO. The country has risen to the challenges of preventing, detecting, and responding to the COVID-19 threat. Containment of COVID-19 is feasible and remains the top priority.

2. STRATEGIC PREPAREDNESS AND RESPONSE PLAN

Goal: The overall goal of this plan is to end the COVID-19 pandemic and build resilience and readiness for the future.

2.1 STRATEGIC OBJECTIVES

Based on WHO global strategy for COVID-19 there is six (06) key strategic objective.

1. **Suppress transmission** through the implementation of effective and evidence-based public health and social measures, and infection prevention and control measures, including detecting and testing suspected cases; investigating clusters of cases; tracing contacts; supported quarantine of contacts; isolating probable and confirmed cases; measures to protect high-risk groups; and vaccination.
2. **Reduce exposure** by enabling communities to adopt risk-reducing behaviours and practice infection prevention and control, including avoiding crowds and maintaining physical distance from others; practicing proper hand hygiene; through the use of masks; and improving indoor ventilation.
3. **Counter misinformation** and disinformation by building resilience through managing the infodemic, communicating with, engaging, and empowering communities, enriching the information eco-system online and offline through high-quality health guidance, and by communicating risk and distilling science in a way that is accessible and appropriate to every community.
4. **Protect the vulnerable** through vaccination, ensuring vaccine deployment readiness in all countries and all populations, by communicating, implementing, and monitoring COVID-19 vaccination campaigns, by engaging health workers, and by building vaccine acceptance and demand based on priority groups, taking into account gender and equity perspectives to leave no one behind.
5. **Reduce mortality and morbidity** from all causes by ensuring that patients with COVID-19 are diagnosed early and given quality care; that health systems can surge to maintain and meet the increasing demand for both COVID-19 care and other essential health services; that core health systems are strengthened; that demand-side barrier to care is addressed; and by ensuring that all priority groups in every country are vaccinated.

- Accelerate equitable access to new COVID-19 tools including vaccines, diagnostics and therapeutics, and support safe and rational allocation and implementation in all countries.

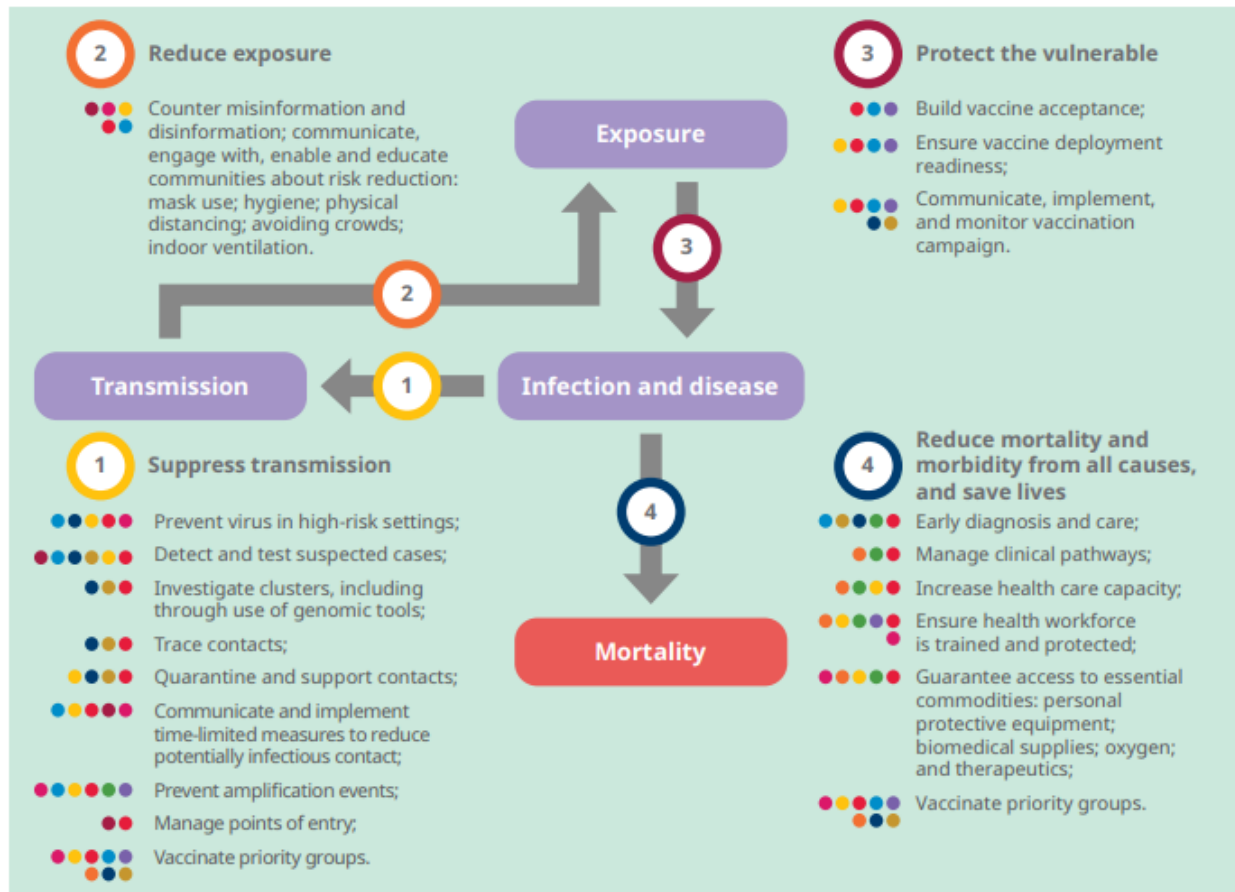


Figure 4: Public health and social measures are supported by multiple response pillars.

2.2 NATIONAL LEVEL PREPAREDNESS AND RESPONSE

This plan is developed by the Ministry of Health based on the guidelines on the Strategic Preparedness and Response Plan of the World Health Organization and in consultation with the relevant stakeholders.

The Strategic Plan developed in 2020, was revised keeping the same core structure and rationale with several key additions and adaptations in response to lessons learnt over the past twelve months. In addition to the nine pillars identified in 2020 SPRP, a pillar on vaccination has added by the WHO as vaccination is a vital tool to reduce morbidity and mortality.

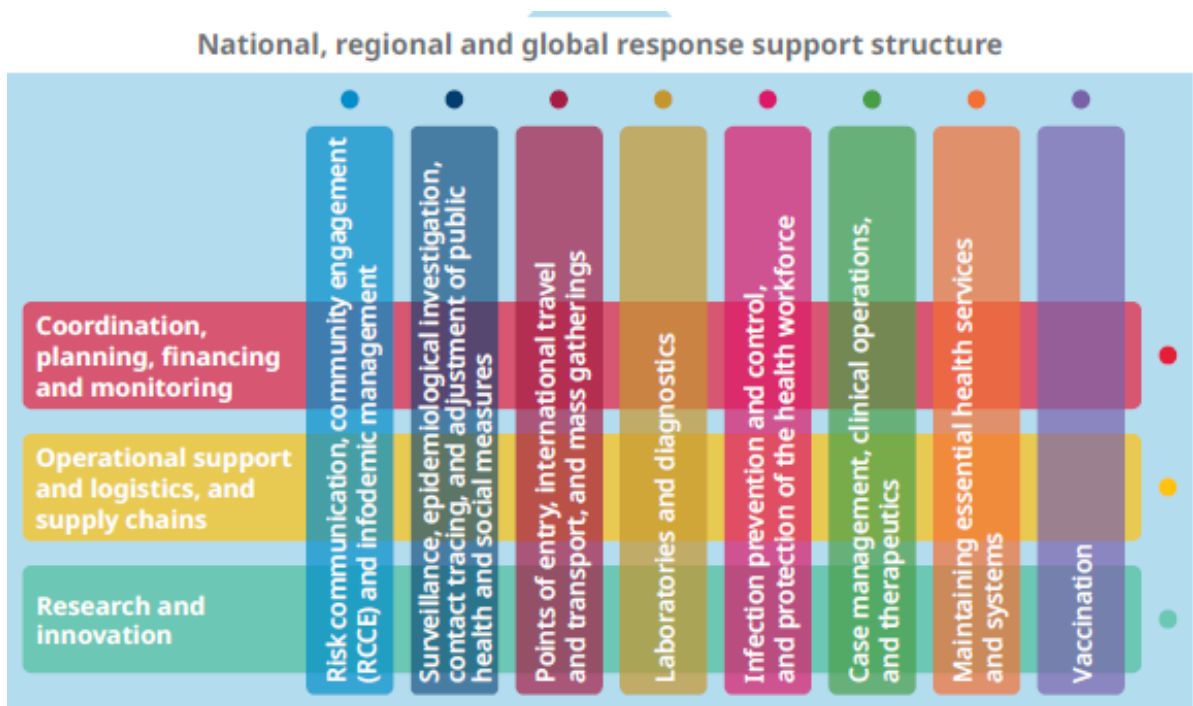
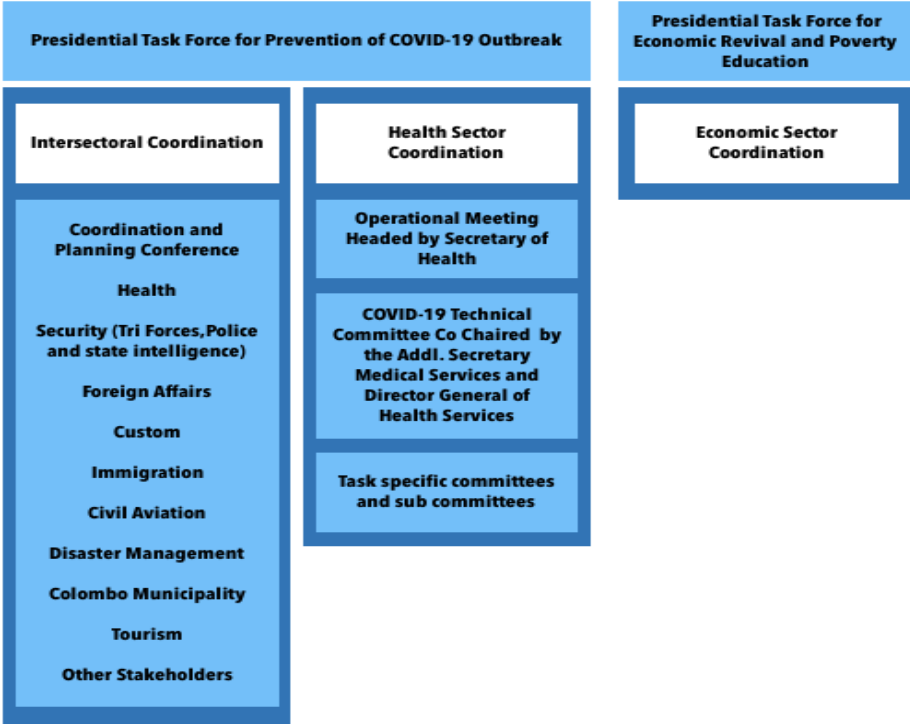


Figure 5: National, regional and global response support structure

2.2.1 COORDINATION, PLANNING, FINANCING AND MONITORING

Priority measures	Some highlights of GoSL response	Way forward
<p>Scaling up emergency response mechanism, coordinated management of COVID-19 response</p>	<p>The COVID-19 country-level coordination has been done at different levels, involving both health and non-health stakeholders, while due attention is given to minimizing the negative effects of the pandemic and the adverse effects on the economy of Sri Lanka.</p>  <p>Figure 6.COVID 19 Coordination Mechanism in Sri Lanka Source: Disaster Preparedness and Response Division</p>	

	<p>1. Intersectoral coordination</p> <ul style="list-style-type: none"> • A presidential task force for the prevention of the COVID-19 outbreak has been established with the Army Commander as the head, who provides assistance, which the health sector has requested with the participation of all other stakeholders, to provide strategic guidance, leadership and coordination. This signifies the priority that has been given at the presidential level to outbreak control. • Regular meetings are held with the leadership of the president with the participation of the highest-level officers representing each sector. In addition, frequent coordination and planning conferences are held to consult experts from health, tri-forces, police and state intelligence services, foreign affairs, customs, immigration, civil aviation, disaster management, Colombo Municipal Council and tourism. • A Health Cluster chaired by WHO Representative and Co-Chaired by MOH and CSO Collective (Sarvodaya) was established to coordinate the support of non-state stakeholders. 	<p>1. Inter-sectoral and health sector coordination</p> <ul style="list-style-type: none"> • Review and update multi-sectoral coordination mechanisms at all levels to support COVID-19 emergency preparedness and response actions (inclusive of private sector, operational partners and civil society). • Use the WHO Partner Platform Dashboard for decision-making. • Define rationale and conduct iterative risk assessments using a systematic approach with the participation of relevant sectors to consider introducing, adapting and lifting public health and social measures (PHSM).
	<p>2. Health Sector Coordination</p> <p>2.1 Ministry of Health Operational Coordination</p> <ul style="list-style-type: none"> • Ministry of Health coordination body held daily operational meetings which were chaired by the Secretary of Ministry of Health, Additional Secretaries and DGHS with relevant DDG's, Directors, and Chief Epidemiologist and other high-level staff from all relevant sectors involved in the COVID-response to assess the situation and make essential decisions. 	<p>2. Health Sector Coordination</p> <ul style="list-style-type: none"> • Regularly review the direct impact of COVID-19 and update the strategies and guidelines according to the pandemic's severity and other health needs of the country. • Document and disseminate best practices and lessons learnt from the COVID-19 pandemic.

	<ul style="list-style-type: none"> Operationalizing the decisions taken at the Covid Management meeting was done daily at the “COVID-19 Preparedness and Response Meeting” headed by Addl. Secretary Medical Services with relevant DDG’s, Directors, and Chief Epidemiologist, and other high-level staff of MoH. National Health Emergency Operation Centre for Covid-19 Prevention and Control was established at the Disaster Preparedness and Response Division to assist the health sector for COVID-19 response through multi-stakeholder coordination. The National HEOC, in communication with all other agencies within the health sector, as well as the tri-forces generates the Joint Situational Update twice a day to be used by critical decision-makers. Regular review of prevention and containment of the epidemic transmission in the districts with all PDHSs and RDHSs is conducted under the guidance of Additional Secretary (Public Health Services). <p>2.2. COVID-19 Technical Committee</p> <p>A COVID-19 Technical Committee Co-Chaired by the Addl. Secretary Medical Services and Director General of Health Services continue to provide technical guidance based on the best possible evidence.</p> <p>2.3. Task-specific committees and subcommittees</p> <ul style="list-style-type: none"> Satellite Health Emergency Operation Centres has been established in all key technical agencies within the health sector such as the Epidemiological Unit, the Directorate of Medical Services, and the Health Promotion Bureau as well as at subnational level in provincial, 	<ul style="list-style-type: none"> Update the national and subnational disaster, emergency and outbreak preparedness and response plans to incorporate the best practices and lessons learnt from the COVID-19 pandemic. Conduct an Intra action review following IHR as required. Explore the mechanism towards coordinated action through grassroot level committees in coordinating with other sectors for proper monitoring of preventive activities e.g. District/village committees. Efforts by the health workers should be supported by other relevant sectors for efficient implementation of activities to mitigate transmission
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	<p>regional, and institutional levels. Regular coordination between National HEOC and Satellite HEOCs was ensured.</p>	
	<p>3. Economic Sector Coordination</p> <ul style="list-style-type: none"> Economic recovery has been a key focus for the government of Sri Lanka targeted since the onset of the pandemic. A separate presidential task force has been established for economic revival and poverty eradication, which carries out a deliberate plan of action to minimize the effects of COVID-19. (Refer Annex I) 	<p>3. Economic Sector Coordination</p> <ul style="list-style-type: none"> Integrate and continue to promote a ‘whole-of-society approach to coordination, specifically to position the health sector response within the broader socioeconomic response and recovery. Liaise and provide public health guidance to socioeconomic sectors for their business continuity planning and adoption of public health measures. Strengthen social protection mechanisms for populations in situations of vulnerability, taking into account socio-economic and cultural contexts, and the unintended negative impact of COVID-19 control measures.
<p>Scaling up COVID-19 planning and monitoring</p>	<ul style="list-style-type: none"> The Strategic Preparedness and Response Plan for COVID-19 has been developed by the MoH with the support of WHO and is guiding the response. A twice-daily joint situational update by the National HEOC and interim review of activities of different directorate by Additional 	<ul style="list-style-type: none"> Update country monitoring and evaluation systems and metrics to assess the effectiveness and impact of planned measures on COVID-19 control, as well as overall population health, social and economic well-being; produce and share

	Secretary Medical Services was used to monitor the COVID-19 preparedness and response.	regular situation reports with WHO and partners.
Scaling up COVID-19 financing	<ul style="list-style-type: none"> • Gaps in financing in the key thematic areas and contribution of development partners to the Ministry of Health were identified. • Additional Secretary Medical Services with participation of DGHS and relevant DDGs arranged an online meeting for RDHS, PDHS, and Incharge medical officers of covid treatment and intermediate care centres to review Covid related activities, to create a platform for share the best practices, and to deliver common messages from the ministry of health. • The WHO methodology-based mid-year interim review 2020 of MoH strategies for covid 19 management was carried out by DPRD under the Guidance of Addl. Sec. Medical Services. A record of it with recommendations was shared with higher officials of MoH. 	<ul style="list-style-type: none"> • Review and update gaps in financing in the key thematic areas and contribution of development partners to the Ministry of Health. • Review of MoH strategies for covid 19 management in 2020 with the participation of all the stakeholders.

2.2.2 RISK COMMUNICATION, COMMUNITY ENGAGEMENT AND INFODEMIC MANAGEMENT

Priority measures	Some highlights of GoSL response	Way forward
Scaling up internal and partner communication	<ul style="list-style-type: none"> • Direct communications made from the Head of State level. • Regular task force meetings were conducted regarding the COVID-19 situation in Sri Lanka with active and regular participation of main stakeholders. Quick communication 	<ul style="list-style-type: none"> • Increase and improve internal communication pathways, centrally as well as to regional and district offices.

	<p>channels for internal communication were established (e.g., WhatsApp groups, Viber groups).</p> <ul style="list-style-type: none"> • Communication with other stakeholders for risk communication, such as UN agencies, the education sector, local government authorities, the corporate sector, telecommunication networks, the Department of Government Information, and media agencies have also been established, including regular meetings. • Internal communication with different Directorates of the Ministry of Health (MoH), provincial, regional, institutional level and other related departments are established including health care workers at all levels. 	<ul style="list-style-type: none"> • Activate or strengthen Risk communication and Community Engagement (RCCE) coordination mechanisms and working groups in coordination with UN agencies, different levels of government organizations, civil society, and other partners to ensure the efficient use of each organization’s strength and audience. • Work closely with relevant committees and advisory groups such as the National Immunization Advisory Group, to ensure RCCE and infodemic objectives are considered within advisory group recommendations.
<p>Risk communication system strengthening</p>	<ul style="list-style-type: none"> • The risk communication network has functioned under the leadership of the Health Promotion Bureau (HPB) of MoH, with the support from WHO and UNICEF. • Capacity building of district-level health care workers on Risk Communication was done via online training programmes. • Behaviour surveys at different settings and rapid assessment of community perception on adhering to COVID-19 preventive activities among selected communities were conducted. 	<ul style="list-style-type: none"> • Better leverage the development partners tools and resources to collectively respond to COVID-19 RCCE needs. • Develop minimum standards and indicators for community engagement, to serve as a guide for stakeholders to establish an enabling community engagement environment. • Capacity building of relevant health staff on risk communication to ensure accurate information is given to patients.

	<ul style="list-style-type: none"> • Readiness surveys and telephone surveys were conducted to assess the level of engagement and to assess the facility requirement among the field level health care workers. • Advocacy to the political hierarchy at different levels, religious hierarchy, private sector, top officials, ayurvedic medical practitioners and tourist Board on tourists. 	<ul style="list-style-type: none"> • Workplace risk communication activities need to be strengthened by empowering employers as well as employees at covering all types of workplaces.
Public Communication	<ul style="list-style-type: none"> • Risk communication and Community Engagement strategy were developed to educate and actively communicate with the public on COVID-19 prevention and control. • Development and implementation of a risk communication media campaign in collaboration with MoH, HPB, WHO, UNICEF, UN RCO and other agencies. • Risk communication targeting different festive seasons were conducted involving key persons and community leaders by HPB and WHO. • The DReAM campaign has been implemented in collaboration with the MoH, WHO, and the Itukama (Presidential Fund). • Hotlines and important numbers shared widely and one-to-one communication was established by answering the public queries 24/7/365. 	<ul style="list-style-type: none"> • Develop communication packages on revisions to policy and guidelines. Ideally this should be completed before the change is announced publicly. • Releasing an official statement using easy-to-understand and accessible language and explaining the change and why it was made will increase trust in the system. • Identify and work with trusted community groups and influencers (e.g. doctors, community leaders, religious leaders, health workers, community volunteers, unions) as well as local groups (e.g. women’s and youth groups, associations for people living with disabilities, business groups, traditional healers) to ensure both community

	<ul style="list-style-type: none"> • Media activities were streamlined by appointing a media spokesperson and providing guidance to the media on responsible reporting. Prime time media slots from magazine programmes, talk shows, myth-busting sessions in main news and news scroll bars were obtained to communicate and to educate the public. Media advertisements on basic preventive measures aired frequently in mass media to incorporate healthy behaviour into the daily routine. • Information, education, and communication (IEC) material were prepared on COVID-19 in all three main languages and also in foreign languages (eg: Chinese). Animation clips, placards, pictograms, posters, leaflets, stickers, banners, digital signage, and other illustrative materials with correct information prepared and displayed at proper locations. Whenever possible, materials included measures to make it more accessible, such as closed captioning or sign language interpretation. • Availability of a blue tick verified official FB page and an official Viber community (with over half a million members), Twitter account and YouTube channel with followers ranging from the highest ranks of the government, well known non- 	<p>inclusion and consistency of RCCE approaches through outreach</p> <ul style="list-style-type: none"> • Build on RCCE experiences and capacities built during the response to strengthen the role of communities in support of longer-term preparedness and emergency risk management functions, as well as their role in the primary health care approach. • Primetime media slots for public service announcements should be provided free of charge for the Ministry of Health and public partners to disseminate vital messages. • Engage media personnel in training or series of discussions on responsible journalism. • Human resource issues such as a lack of Tamil translators, type setters at HPB need to be resolved.
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	governmental activists, diplomatic dignitaries to ordinary public enabled social media campaign.	
Infodemic Management	<ul style="list-style-type: none"> Active rumour monitoring and producing situation reports to relevant stakeholders for necessary action. 	<ul style="list-style-type: none"> Rumour and misinformation monitoring systems should be updated to include an analysis of the reach of the pieces of content of rumours. A systematic format for responding to rumours and misinformation should be implemented with templates to quickly counter myths publicly.
Communicating with affected communities	<ul style="list-style-type: none"> Essential drugs were provided to affected communities including elderly people through Mother Support Groups (MSG) and elderly people were supported to cope with the disease. A stigma mitigation campaign was conducted by HPB targeting affected communities such as people working in specific sectors (e.g., garment factory workers, fishery community) by HPB. Another mass media campaign on the topic was conducted with HPB, UNICEF, and WHO. Through Non-Government Organizations such as Sarvodaya and interfaith organizations, affected communities were addressed and their support for COVID-19 prevention activities was sought. 	<ul style="list-style-type: none"> Community engagement with a wider group of local-level CSOs should be strengthened to ensure we reach as many affected communities as possible Identify and map marginalized and at-risk populations to engage with culturally appropriate messages using relevant channels and community networks/influencers. Integrate into RCCE dialogue and community leadership the mitigation of effects on livelihoods, reducing demand-side barriers to access essential health services, and respond to other health concerns or threats to their survival and dignity

	<ul style="list-style-type: none"> • Creation of awareness among targeted communities in enterprises through webinars and physical programmes. (Refer Annex II) 	<p>while ensuring participation of the community and vulnerable groups.</p> <ul style="list-style-type: none"> • Ensure the community perspective is included in materials to increase their applicability and use.
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2.2.3 SURVEILLANCE, EPIDEMIOLOGICAL INVESTIGATION, CONTACT TRACING, AND ADJUSTMENT OF PUBLIC HEALTH AND SOCIAL MEASURES

Priority measures	Some highlights of GoSL response	Way forward
Scaling up Surveillance, Epidemiological Investigation and Contact Tracing	<ul style="list-style-type: none"> • Quarantine act provides legal background for quarantine and surveillance mechanisms in Sri Lanka. The presence of a well-established public health system and active involvement of security forces enabled activation of the Pandemic Influenza Preparedness Plan as a response to the COVID-19 pandemic. • The Ensured integration of COVID-19 surveillance in existing platforms such as ILI/SARI surveillance for early identification of COVID-19 cases. • The quarantine strategy and the discharge criteria were revised from time to time based on global evidence. • Laboratory surveillance was expanded covering other areas of the country. • PCR Testing of the high-risk categories identified according to timely updated guidelines (Refer Annex III) • Mechanisms for contact tracing established. 	<ul style="list-style-type: none"> • All cases should be mapped using digital platforms (GIS) where possible for real-time information sharing with accessibility to enter and utilize the data at a regional level. Every district advised on the need to have a situation update in their locality, based on indicators and data required to be included in the situation report. • Identify needs to strengthen contact tracing, active case finding, isolation, cluster investigation, as well as testing at all levels. • Identify needs to strengthen diagnostic capacity at all levels. If capacity is insufficient, prioritize testing and measures that can reduce spread (e.g. isolation of cases) following WHO guidance.

	<ul style="list-style-type: none"> • Surveillance for early identification of possible positive (for COVID-19) employees at vulnerable places like workplaces and monitoring the preparedness and response was ensured. • Mandatory pre-departure and Day 1 PCR testing was done among travelers. • The strengthened national disease surveillance system at pre-arrival, on arrival and post-arrival stages at points of entry. 	<ul style="list-style-type: none"> • Assess the need to include in surveillance strategy the use of genetic and serological surveillance or sero-epi studies, to measure the effective extent of infection in the general population or subpopulations and the proportion of undetected or unreported infections (e.g. asymptomatic infections, insufficient testing capacity, or people who do not seek or cannot afford to seek care). • There should be a committee consisting with Epidemiologists to assess the situation daily /weekly based on the situation and recommend scientific decisions based on the surveillance and contact tracing pattern.
Capacity Building, systems strengthening and information sharing	<ul style="list-style-type: none"> • An integrated information system (National COVID 19 Surveillance System) has been established by the Ministry of Health for the COVID – 19 designated hospitals to enter data related to the COVID 19 response, including data on daily resource review, equipment requirement and individual case information and laboratory information. • Surveillance systems and control measures enhanced by introducing methods and materials to monitor transmission intensity, control measures and inform response decisions. • Prepared Daily Situation Reports / Weekly Epidemiology Reports (WER) and disseminate to all levels including WHO. 	<ul style="list-style-type: none"> • Digital platforms shall be utilized to capture COVID-19 data at subnational levels. The laboratory data and clinical data should be entered into the same data base for decision-making.

	<ul style="list-style-type: none"> • Staff was trained to conduct systematic risk assessments (including mathematical modelling) and equipped with essential equipment and other resources. 	
Strengthening adjustment of public health and Social Measures	<ul style="list-style-type: none"> • Key decisions regarding movement restriction, quarantine and testing were taken giving due consideration for the epidemiological evidence and regularly monitored disease trends. Assess the existing systems and plans of action for appropriateness in the control measures using suitable measures. • Guidance for laboratory testing of employees regularly was introduced, to BOI enterprises. • Workplace COVID – 19 daily alerts, a Google alert form was introduced to the BOI enterprises Appointing focal points from BOI industries, banks and government ministries and monitoring the preparedness and response of work settings through them (Direct monitoring from the national level) 	<ul style="list-style-type: none"> • Use local situation assessments (transmission level and response capacity and performance) to guide actions or changes to the response strategy, particularly concerning the adjustment of PHSM. • Conduct capacity assessment and risk analysis for specific settings, including mapping of vulnerable populations or events such as mass gatherings.
Strengthening Preparedness at workplaces especially among the most vulnerable and important (BOI, Banks and Gov. Ministries and Economic centres)	<ul style="list-style-type: none"> • Revised guidance – A set of comprehensive (revised) guidelines were formulated for 6 main industries of the country introducing modified bio secure bubble concept and dedicated boarding houses to strengthen preparedness and response. 	

<p>Epi investigations conducted and the genomic sequencing work done in the country .</p>	<ul style="list-style-type: none"> • Department of Immunology and Molecular Medicine and Allergy, Immunology and Cell Biology Unit of University of Sri Jayewardenepura. The laboratory performed several rounds of sequencing and the results are shared on the open source platform Nextstrain (https://nextstrain.org/sars-cov-2/). • Sero-surveillance survey among the Navy personnel infected with COVID-19 and their close contacts in the outbreak at Naval Base, Welisara. • Sero-surveillance survey among the infected and contacts in the COVID-19 outbreak in the legislative premises of Colombo Municipal Council in the City of Colombo, Sri Lanka. 	
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2.2.4 POINTS OF ENTRY, INTERNATIONAL TRAVEL AND TRANSPORT AND MASS GATHERINGS

Priority measures	Some highlights of GoSL response	Way forward
<p>Public Health Emergency Contingency Plan implemented at POEs</p>	<ul style="list-style-type: none"> • International Health Regulation 2005 (IHR-2005) requires a Public Health Emergency Contingency Plan (PHECP) to be implemented in designated points of entry (PoE) for responding to events that may constitute a public health emergency of international concern (PHEIC). Sri Lanka has developed the following document; Public Health Emergency Preparedness and Response Plan for Sea Ports in Sri Lanka, National Public Health Contingency Plan for Designated 	<ul style="list-style-type: none"> • Conduct regular risk assessments, using global, regional and/or national and local risk data to inform the calibration of risk mitigation measures in the context of international travel and mass gatherings. • Develop a protocol for expediting immigration and health clearance as part of promoting long-stay tourism in Sri Lanka.

	<p>Airports in Sri Lanka, With the recommendations of Joint External Evaluation (JEE) conducted in 2017, developed the National Action Plan for Health Security of Sri Lanka, 2019-2023.</p> <ul style="list-style-type: none"> • The National Public Health Contingency Plan for PoEs is implemented at all PoEs • Case definition was prepared according to the WHO guidelines and investigation protocols also developed and shared with all health workers and at the PoEs. • The government intensified measures on travelers and contacts, quarantine and isolation of cases including mandatory reporting of travelers. • Home quarantine guidelines were disseminated. • All incoming passengers were requested to fill in a Health Declaration Form at the Health Office of the PoE. This is scrutinized by the health officers of the particular Health Office. • All incoming passengers are directed to pass through the thermal scanner or shall be subjected to a handheld non-contact thermometer for detection of fever. • If the passenger is having a fever or falls into the case definition category, he/she is further investigated as follows; • If the passenger is falling into the ‘suspected case’ category, he/she shall be escorted to the isolation area and arrangements will be made to transfer to a designated hospital. This will be informed to the Chief Epidemiologist. 	<ul style="list-style-type: none"> • Develop data sharing mechanism among all stakeholders- Aviation, MoH and SLPA. • Communicate to travelers’ information about COVID-19 related entry and exit requirements, prevention, health care, local public health and social measures in place, sanctions for breaching regulations in place. PoE key information to be displayed on the MoH website.
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	<ul style="list-style-type: none"> • The required details of the Health Declaration Form will be submitted to the Epidemiology Unit. • If passengers are to be quarantined as per the policy decisions taken by the Ministry of Health depending on the COVID 19 global spread, such passengers will be transferred to quarantine centres with the coordination of the tri forces. • Capacity building of the health staff including the provision of the latest updates of disease information, SOPs, and handling of sick passengers, are conducted. 	
Capacity building & systems strengthening	<ul style="list-style-type: none"> • Awareness programs conducted for different non-health staff categories at PoE (AASL, Sri Lankan Airlines, Duty-Free, Customs, Immigration). • Established assessment and isolation facilities at Points of Entry to cater to ill passengers until they are transferred to designated hospitals. • Risk communicated to all travelers. • Regularly monitor and evaluate the effectiveness of readiness and response measures at PoE and adjust plans as appropriate risk communication to all travelers. <p>(Refer annex IV)</p>	<ul style="list-style-type: none"> • Develop communication materials and provide information on processes from takeoff until completion of quarantine process. • Equip and train staff at the point of entry in appropriate actions to detect, manage and refer ill passenger(s) and identify their contacts, and to carry out cleaning and disinfection; prepare for novel public health approaches for resumption of international traffic, including at points of entry, as well as public health and social measures, and their implementation at points of entry.

2.2.5 LABORATORIES AND DIAGNOSTICS

Priority measures	Some highlights of GOSL response	Way forward
<p>Test suspect cases per latest case definition, contacts of confirmed cases; test patients identified, through surveillance systems</p>	<ul style="list-style-type: none"> • With the declaration of the pandemic, the laboratory sector, Ministry of Health Sri Lanka prepared to initiate testing of COVID-19. On 25 January 2020 the National Influenza Centre of the Department of Virology, Medical Research Institute (MRI), under the guidance of the Director-General of Health Services (DGHS) and Deputy Director-General of Laboratory Services (DDG LS) established in-house molecular testing for SARS-CoV-2 virus. The test was validated by the WHO corona reference laboratory, University of Hong Kong. • These initial supports from the University of Hong Kong and Robert Koch Institute, Germany fulfilled the initial testing requirements in Sri Lanka at the time when commercial assays were not freely available. This prompt action paved way for the successful expansion of the testing from the initial capacity of 600 to 22, 000 test per day at present (30th April 2021) in 37 PCR laboratories, which includes 28 government sector laboratories (twenty under Ministry of Health, two (2) at Ministry of Defense and six (6) laboratories under Ministry of Higher Education) and nine (9) private sector laboratories performing testing. • WHO facilitated the development of a Laboratory Strategy for COVID-19 testing in Sri Lanka in June 2020. 	<ul style="list-style-type: none"> • Continue to support laboratory testing for the diagnosis of COVID -19 among clinically suspected COVID-19 cases. • Continue to support the laboratory testing for COVID-19 surveillance activities including testing contacts; testing high-risk groups; testing ILI cases in sentinel sites; testing returnees from overseas; testing overseas travelers and testing postmortem samples while ensuring appropriate prioritization of testing. • Generation and dissemination of data relevant to testing for decision-making related to control measures through a functional laboratory information management system (LIMS) to ensure traceability of results and facilitate data management and sharing. • Performing local validation of tests kits before country registration procedures. • Facilitate external quality assurance measures for COVID-19 testing. • Ensure legislative support is in place, including enforcement of regulations for the transport and

	<ul style="list-style-type: none"> • Labotary capacity was developed by adding laboratory equipment worth 380 Mn LKR. • Procured medical equipment for molecular laboratories; (ERHSP-UNOPS). • Strengthening of laboratories of cluster system under Primary Healthcare Strengthening project. • Four of the Government laboratories participated in the WHO supported Global External Quality Assurance Programme (EQAP) conducted by the University of Hongkong in May 2020 with all four laboratories recording 100% accurate results. Furthermore, twenty-five (25) laboratories of the government sector participated in the WHO supported EQAP conducted by Australia in February 2021 and the results are pending. • The University of Sri Jayewardenepura is conducting genomic sequencing of the SARS-CoV2 virus with support from the Australian Government through WHO. The laboratory at National Institute for Cancer care (Apeksha Hospital) is planning to commence genomic sequencing, shortly. • Use of Antigen RDT for clinical, surveillance and contact tracing initiated from November 2020. WHO SEAR donated 50,000 Ag RDT kits to the Government of Sri Lanka. • Combating anti-microbial resistance (Awareness/ Strengthening of AMR surveillance/ Capacity building/ Monitoring and Evaluation) <p>(Refer annex V)</p>	<p>sharing of specimens and genomic data, quality and biosafety.</p> <ul style="list-style-type: none"> • Develop accelerated or designated customs procedures to facilitate the import of diagnostic materials and donations. • Promote local manufacturing of selected consumables including high-grade molecular consumables, PPE and swabs. • Adopt strategies to minimize the non-availability of reagents and consumables internationally and nationally due to the monopoly of suppliers. • Recruit and train additional staff of all relevant categories for laboratory and clinical environments. • Establish nationwide laboratory infrastructure, manned and supervised by trained personnel that has the capability and tools to respond to the new threats within a period of days to weeks when necessary.
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2.2.6 INFECTION PREVENTION AND CONTROL, AND PROTECTION OF THE HEALTH WORKFORCE

Priority measures	Some highlights of GOSL response	Way forward
<p>Scaling up of IPC and protection of the health workforce from Covid 19</p>	<ul style="list-style-type: none"> • A system for assessing all patients at admission with a designated triage area, allowing for early recognition of possible COVID-19 and immediate isolation of patients with the suspected disease was established. IPC measures were in place at triage areas. • A proper mechanism was adapted for the transportation of patients with COVID-19. Health care workers are provided with adequate PPE as required by the nature of their function. • A mechanism is in place to identify and mitigate transmission of COVID-19 in hospital premises and to assess the risk level of an exposed health worker by an expert team for necessary action. • Forecasting plans for personal protective equipment (PPE) and other IPC consumables as well as stockpiling plans are developed to ensure adequate PPE in the health facilities. • National IPC Guidelines updated (in 3 languages) and training for health care providers conducted. The IPC guideline revised including the patient referral pathway, the IPC focal point concerning case management. Appraisal of the National IPC guideline conducted. • MoH has adopted guidelines on Health Care Waste management to be used at the COVID-19 treatment hospitals. Further, the hospitals were provided with necessary facilities for waste disposal 	<ul style="list-style-type: none"> • Prepared and shared the SOPs for collection of specimen, management and safe transportation for diagnosis. • Assessment of IPC readiness for facility inpatient areas for priority activities • Development of contingency plans for PPE shortages and other IPC consumable • Periodic appraisal of the National IPC guidelines • Environmental and engineering control measures to be developed and adopted to improve ventilation in crowded areas such as clinics (bioengineering) • Expansion of awareness programmes on IPC & PPE for health care workers • Implement a mechanism to ensure the quality of PPE. • Shall evaluate implementation of IPC procedures (requires an internal monitoring tool and an external assessment) • Evaluate the implementation of IPC procedures, update the IPC guidance and document • A national plan of action shall be developed for supply chain management of PPE (which shall

	<ul style="list-style-type: none"> • With the Global shortage of PPEs, the apparel industry in Sri Lanka started manufacturing PPEs locally. • The capacity of Infection Prevention and Control assessed at all healthcare providing institutions and isolation centres. Continuous online training programmes followed this on IPC by the Education, Training and Research unit of MoH for healthcare staff at the institutional level. • IPC measures have been implemented in the following settings by providing properly trained staff with essential equipment, material and PPEs; <ul style="list-style-type: none"> - long term care institutions including elderly homes -Community -Private healthcare facilities -Other places – shopping complexes -when performing PCR -vaccination centres • Provided facilities for the vulnerable groups Eg; YED unit provided disable friendly sinks to the healthcare institutions with WHO support • Access to safely managed water and sanitation was ensured in the hospitals, quarantine centres and ICC. • Monitoring and evaluation was carried out by the MoH for the district level staff (WHO also facilitated some meetings with E&OH and district level staff where IPC measures were also discussed) 	<p>include needs assessment, procurement, stockpiling, transport, distribution) to ensure continuous stock at health care and community level.</p> <ul style="list-style-type: none"> • Shall recognize and record capacity of IPC personnels. • Strengthening of the institutional monitoring of IPC done by the Infection Control Nurse. • Support implementation of research and development studies focusing on understanding SARS-CoV-2 infection among health • Workers and improving compliance with IPC measures. • Implement and monitor IPC and public health measures in community settings. • In line with the Framework to Reopen Schools, ensure schools have access to adequate safe water, handwashing stations, cleaning supplies, proper ventilation, and, wherever possible, establish or expand sex segregated toilets or latrines including provisions for menstrual hygiene management. • Implement occupational health IPC programmes and plans to ensure safe working conditions.
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	<ul style="list-style-type: none"> • Circulars and guidelines on conducting risk assessments were issued for public health staff • Data stratified by sex, age and other important factors are critical to identifying trends, gaps, and disparities in order to adjust public health and social measures and adapt health systems to address disparities. • Vaccination of healthcare workers was carried out. Workers of the MoH Head Office was coordinated by DPRD under the Guidance of Addl. Sec. Medical Services. • Collection and analysis of disaggregated data is central to a Human Rights-Based Approach to Data (HRBAD) (Refer annex VI) 	
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2.2.7 CASE MANAGEMENT, CLINICAL OPERATIONS, AND THERAPEUTICS

Priority measures	Some highlights of GOSL response	Way forward
Treat patients and ready hospitals for surge; enhance triage procedures; activate surge plans for health facilities	<ul style="list-style-type: none"> • Sri Lanka has been able to effectively manage the number of cases of COVID- 19 with a total case fatality rate of 0.48%. This has been greatly contributed by the state decision to treat all cases at a state-run health care facility free of charge. This has not only provided universal access to COVID-19 services up to the level of ICU and ventilation 	<ul style="list-style-type: none"> • Surge capacity development based on the hospital assessment completed by WHO / MoH • Expansion of patient information system for COVID / medical decision support system among the COVID 19 treatment facilities

	<p>support but also prevented people from going into poverty due to care for COVID.</p> <ul style="list-style-type: none"> • With the second wave of cases, Intermediate Treatment Centres were established to care for asymptomatic and mild cases. ICU capacity is identified and mapped, including the Defense University Hospital; MoH expanded the ICU and HDU capacity at BH and other tertiary care facilities . • Guidelines on risk assessment and management of healthcare workers who have been exposed to a suspected or diagnosed case of COVID-19 disseminated. Triage system and algorithms to identify priority cases; surge plan in place. • Clinical practice guidelines developed and shared with health care providers, including dead body management. • Revised the discharge criteria. • Formulated norms for facilities and equipment to be made available in treatment and intermediate care centres at the COVID 19 Preparedness and Response Meeting headed by Addl. Sec. Medical Services. • An assessment of all II/III care hospitals was completed with the technical support of the WHO and this information used for improving the surge capacity of these hospitals. • Following the emergence of the second wave, the MoH changed the management modality and the discharge criteria to still maintain the 100% inclusion of all cases in state healthcare. The discharge criteria were initially changed to that of 14 days and then changed to 10 days. 	<ul style="list-style-type: none"> • Map vulnerable populations and public and private health facilities and workforce (including traditional healers, pharmacies, long-term living facilities, and other providers), and identify alternative facilities that may be used to provide treatment. • Initiatives to de-stigmatize COVID-19 among health care professionals and frontline workers • Continuously assess the management capacity of the health services networks to coordinate with various providers, and to ensure continuity of care. • Continuously assess the human resources needs (skilled workforce). Take actions to grow workforce capacities including mental well-being. • Continuously assess the availability of biomedical equipment including oxygen source capacity and respiratory devices high flow, BIPAP, mechanical ventilation and associated consumables and accessories. Take actions to avoid the unavailability of tools for the work force. • Continuously assess the availability of essential medicines, including COVID-19-specific therapeutics (i.e. corticosteroids) to care for COVID-19 patients in either ambulatory or hospital settings. Take actions to avoid the unavailability of tools.
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	<p>A three-layered clinical management process was initiated: level I (intermediate care centres for asymptomatic), level II for Divisional Hospitals under consultant cover for mild cases and level III for tertiary care and specialized care with ICU and ventilator support. Treatment facilities were developed according to the need of caseload in different levels. COVID treatment facilities were established in Primary care (Divisional) hospitals and other non-health institutes (Eg: Training centres) for asymptomatic diagnosed patients. All the centres were attended by medical staff and consultant coverage was arranged by the nearest secondary care hospitals.</p> <ul style="list-style-type: none"> • Facilities were provided for patients who seek paid services (Refer annex VII) . • Symptomatic patients and patients with complications who may need interventions and ICU care were admitted to identified secondary care and tertiary care hospitals where dedicated ICU beds are available for COVID patients. Highly complicated symptomatic patients were managed at IDH hospital. (Refer annex VIII) • The number of hospitals declared to house patients were increased covering all provinces on the island, to ensure readiness to respond to many suspected and confirmed cases. Treatment facilities were developed according to the number of hospitals declared to house patients were increased covering all provinces on the island, to ensure readiness to respond to many suspected and confirmed cases. (Refer to Annexure IX) 	<ul style="list-style-type: none"> • Develop, monitor and update operational plans and assign financial resources for health service delivery to ensure a timely response to the needs of COVID-19 patients. • Continuously assess and update management processes to respond to the increased demands of COVID-19 patients. • Continuously assess the burden on the local health system, and capacity to safely deliver primary health care services and other essential health services (see Pillar 9). • Define regulatory pathways for quality assurance. • Shall conduct mapping of Private and Government health facilities. • Shall continue identification of alternative locations that may be useful for case management. • Shall ensure guidance for the care of self-isolated persons with mild disease and guidance for referral to health care facilities. • Shall continue the dissemination of information and training staff in the management of severe acute respiratory infections (SARI) and on COVID-19 protocols.
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	<ul style="list-style-type: none"> • Specific hospital/s has been dedicated to managing emergency Obstetric cases and emergency surgical cases. Twenty-eight isolation units were established in major hospitals to ensure continuity of care. • Home quarantine is directed at the close relatives and other contacts of confirmed cases rather than institutional quarantine when there are adequate facilities. • If necessary, the family members and contacts were sent to the Quarantine Centres established in many districts on the Island (these are mainly managed by the tri-forces). Further details are given in Annexure X. • The people coming from other countries (locals as well as foreigners) were also subjected to mandatory quarantine at these centres for 14 days. Anybody in a quarantine facility becomes a confirmed COVID-19 he/she was transferred to a treatment facility. • If death occurs the cremation of the body will be conducted by the Health Authority responsible with the assistance of the Police following all precautionary measures. Burial is allowed in a selected safe place. • Measures taken to avoid stress on health staff and shortage of supplies the shall be further strengthened. Training of staff continued, and all safety precautions were taken. Staff benefits ensured including the arrangement of quarantine facilities. • National instructions for the prevention of disease spread, patient management, and continuation of other patient care management 	<ul style="list-style-type: none"> • Shall continue establishing triage and screening areas in all health care facilities. • Shall further improve ICU capacity required for severe cases. • Shall join clinical expert groups to address challenges in clinical care and promote global collaboration. Shall organize to assess; diagnostics, therapeutics, and clinical trials if required. • Shall adopt international research & Development efforts and WHO protocols for special studies. • Shall further evaluate case management procedures and document outcomes • Shall have mechanisms in place to identify and prevent burnout among health care staff in clinical management.
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	<p>including surgeries and procedures amidst the situation were reviewed and further developed.</p> <ul style="list-style-type: none"> • Additional Secretary Medical Services arranged online training on patient management and IPC through ETR to the health staff working in COVID 19 treatment and intermediate care centres. • Standard protocols for case management and IPC were disseminated.(Refer annex XI) 	
<p>Strengthening Preparedness at workplaces especially among the most vulnerable and important (BOI, Banks and Government Ministries and Economic centres)</p>	<ul style="list-style-type: none"> • Revised guidance – A set of comprehensive (revised) guidelines were formulated for 6 main industries of the country introducing modified biosecure bubble concept and dedicated boarding houses to strengthen preparedness and response. 	<ul style="list-style-type: none"> • Include simple tips to prevent burnout and provide mental health and psychosocial support.

2.2.8 OPERATIONAL SUPPORT AND LOGISTICS, AND SUPPLY CHAINS

Priority measures	Some highlights of GoSL response	Way forward
<p>Strengthen Operational support and logistics, and supply chains</p>	<ul style="list-style-type: none"> • Mapped all possible resources available and supply systems in health including MSD and RMSD as well as other systems and implemented the logistic management strategies. 	<ul style="list-style-type: none"> • Shall review and revise procurement processes and Logistic Management System (LMIS) at MSD and RMSD. Introduce and implement a new logistic management strategy.

	<ul style="list-style-type: none"> • Conducted country inventory review of supplies based on WHO Disease commodity package and COVID 19 Kit and establish a central stock reserve. • Reviewed supply chain control and management system for medical and other essential supplies. • Assessed the capacity of suppliers (national and international) to meet the increased demand. • Training of personnel involved in supply chain management • Continue provision of PPE for health staff to meet the preparedness for COVID cluster outbreak. • Promotion of manufactures in the private sector for supply PPE items to local and export market • Ensured uninterrupted supply of medical and laboratory equipment and consumables for curative care services. • Use of Global Portals for procurement of essential commodities at a negotiated price. <p>(Refer Annex XII)</p>	<ul style="list-style-type: none"> • Training of personnel involved in supply chain management. • Engage with the key stakeholders, particularly MSD, SPC, laboratories and diagnostics, case management, IPC, and vaccination to provide estimates of supply requirements based on the 2021 response plan, and map/update available resources and supply systems in health and other sectors; and conduct/update in-country inventory review of supplies. • Identify central stock reserves, for COVID-19 case management. • Establish the means to gather key monitoring and performance information, including Key Performance Indicators (KPIs) monitoring of lead times, supply gaps and optimization (efficiency, consumption rates, loss rates, access to local markets). Plan for Monitoring and evaluation of Logistic Management Information System (LMIS) • Working with the CSCS plan for (1) transition of longer-term solutions and member state autonomy through the use of Long-Term Agreements (LTAs); (2) sharing of technical guidance; (3) continued access to scarce essential supplies.
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2.2.9 MAINTAINING ESSENTIAL HEALTH SERVICES AND SYSTEMS

Priority measures	Some highlights of GOSL response	Way forward
<p>Strengthen maintaining essential health services and system</p>	<ul style="list-style-type: none"> • Guidelines were issued on managing clinic services for NCD and steps had been taken to deliver the monthly drug stocks to the doorsteps of patients with the support of the Postal Department and Department of Police. • Patients with NCD in quarantine centres were provided medications through the Sri Lanka Army. Outreach clinics were conducted to issue medicines for patients with NCD in isolated areas. • Furthermore, in specific localities which were locked down for long periods, mobile medical clinics were conducted with the support of main government hospitals. Drugs were issued to the patients receiving treatment for chronic diseases and facilities to measure blood pressure, blood sugar and medical consultation were made available. • Remote healthcare was initiated to prevent overcrowding and to minimize exposure of high-risk immune-compromised NCD patients such as those undergoing kidney transplant or on dialysis to COVID- 	<ul style="list-style-type: none"> • Plan to continue with the provision of strategic support to MOH and other stakeholders to maintain essential health services along with the COVID response. • Adoption of simplified mechanisms and protocols to govern essential public and private health service delivery in coordination with response protocols. • Conduct functional mapping of health facilities for acute, chronic and long-term care, including those in public, private (commercial and non-profit) and military systems. (This is a shared action with Pillar 7: Case Management) • Create and implement a roadmap for phased implementation and timely scale-up of a workforce hiring, deployment and redistribution strategy.

	<p>19. The NCD Bureau in collaboration with the private sector launched the "My Doctor telemedicine system" in 16 government Nephrology clinics.</p> <ul style="list-style-type: none"> • A web-based mechanism was established to deliver medicines to the homes of the patients who usually purchase drugs from the private sector. Pharmacies delivered medicines for a reasonable fee. • More hotlines and m-based and e-based models were introduced for inquiries, requesting appointments and health message delivery in non-COVID-19 health subjects, e.g. National Mental Health helpline. • The NCD Bureau used digital platforms to disseminate health information. Messages were disseminated via mass/social media on recognizing danger signs of NCD emergencies and how to reach for medical services in an emergency. Facebook and YouTube were utilized to disseminate lifestyle advice during the lockdown. Relevant experts frequently conducted awareness programmes on mass media on NCD care. • Routine EPI services were maintained. • RMNCAH (Reproductive, Maternal, Newborn and Child Health)-routine services were functioned except in lockdown areas/curfew areas. • During the second wave in October-November 2020, approximately 110 pregnant mothers have been identified as COVID-19 positive. 	<ul style="list-style-type: none"> • Ensure dedicated budgets for national planning and activities for maintaining essential health services. • Document adaptive responses (e.g. teleconsultation, integrated primary care, remapping of referral pathways) and incorporate. • Map the presence of vulnerable and hard to reach populations and ensure that they are included in COVID-19 plans. • Generation and dissemination of data relevant to the importance of maintaining essential services for decision-making are underway, including upgrading of dashboards of higher-level authorities with indicators on the functioning of essential other health services. • Programmes/hospitals/units to develop specific activity plans with timelines and targets. To ensure continuity of essential services, HR requirement and new delivery models should be developed along with the demands of the COVID-19 response. • Strengthen /upgrade essential health service delivery as per stage /phase of the pandemic to reach the vulnerable and marginalized groups • Scaling up routine and in-service pieces of training on virtual platforms.
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	<ul style="list-style-type: none"> • Four designated maternal hospitals for COVID infected pregnant mothers (BH Homagama, BH Theldeniya, BH Kattankudy and New DGH Matara “Kamburugamuwa) were established. • Maternal deaths were reviewed as a desk review which revealed COVID related excess deaths were due to transport restrictions, delays in accessing health care and fear and stigma. • School health activities were discontinued the school closures. Child growth monitoring and promotion were also affected due to lockdown interventions and stigma due to COVID. • A small survey among under 5 children living in urban slum communities had revealed that wasting has increased by 34.5%, stunting has decreased by 17.9% and overweight has increased by 151% compared to 2019 in the cohort of children living in urban under settlement areas. • TB, HIV, Leprosy, Dengue control and surveillance, Malaria POR activities were continued with necessary changes. However, active screening of prison inmates for TB, HIV has been withheld. • Control Programmes have taken extra steps to ensure the continuation of ART services and treatment for other STIs. • Outpatient care services in institutions were continued in non-lockdown areas. Inpatient care services were also continued. Routine surgeries and investigations have been withheld in lockdown areas. However, emergency surgeries and surgeries on cancer patients were not disrupted. 	<ul style="list-style-type: none"> • More programme communication tools to improve community engagement on re-oriented health service delivery. • Establish a national level multi-stakeholder mechanism, a committee to address mental health and psychosocial issues and develop a mental health and psychosocial support response plan (action plan) for COVID-19. • Establish mental health care facility for SARS-CoV-2 infected people with mental health condition or substance abuse disorders. • Ensure the availability of essential psychotropic drugs at all levels of treatment centres including the out-reach clinics and continue to provide essential psychotropic drugs, where possible with longer-term prescriptions in order to avoid frequent visits to health care facilities • Ensure the basic safety facilities (PPE, safe place, vehicles) are provided to conduct out-patient clinics, outreach clinics, and regular function of inpatients care, intermediate care services and community follow-ups • Ensure provision of mental health and psychosocial support to the frontline health care workers for
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	<ul style="list-style-type: none"> • National Call Center 1390 established under the supervision of Addl. Secretary Medical Services directly answer the issues of the public related to services delivered at the Primary Medical Care Institutional Level. • The Directorate of Mental Health and National Institute of Mental Health with the support of WHO strengthened the National Mental Health Helpline (1926) and expanded the National Mental Health Helpline to all the districts to enable increased referral and district-based support during the pandemic. • The National Institute of Mental Health immediately established a isolation unit with the support of the Sri Lankan Army for the COVID suspected persons taking treatment for mental health conditions and made as a national referral center for persons with mental health conditions during the COVID outbreak. • NIMH renovated two wards from the ERHSP funds (WB) to provide internal treatment to COVID 19 positive patients with mental illness. • The directorate with the support of other stakeholders supported continuation of medication for patients under long term care for psychopharmacological medication, drug stocks for two consecutive months were delivered through the Sri Lanka Postal service and the community mental health staff- to their doorsteps. • The Directorate of Mental Health, National Institute of Mental Health, Sri Lanka College of Psychiatrist and Sri Lanka Psychologist Association continued with mass media programmes on psychological 	<p>promotion of their mental health and psychosocial well-being.</p> <ul style="list-style-type: none"> • Ensure a working network that includes links between a wide range of mental health, psychosocial, and social support actors. • Introduce a program to address the psychosocial impact on people and families directly affected by COVID-19. • Develop actions towards preventing stigmatization, discrimination, and exclusion due to race, sex, or illness due to COVID-19. • Provide training for community leaders and agents on PFA and identification of people who require specific care (primarily virtual training). • Ensure the consumer and carer network will be established in all districts of Sri Lanka to empower consumer capacity in promoting mental well-being, preventing suicides, reducing social stigma through sharing life experience during an emergency. • Develop a mechanism to identify mental health and psychosocial research priority during an emergency and collect data and dissemination information for the wellbeing of the community.
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	<p>wellbeing and emotional balance and available mental health services in the country.</p> <ul style="list-style-type: none"> • Directorate of Mental Health of the MoH, Sri Lanka College of Psychiatrists, WHO and MHPSS (Mental Health and Psychosocial communities provided continued access to essential mental health services and medications. • Medical Officers of Mental Health (MOMH) teams and the community of Psychiatry Nursing Officers conducted home visits to the most vulnerable patients for the administration of injectable medicines. The mobile clinics were conducted in the lockdown areas with public health measures. • The DMH with the help of the National Technical Committee on Mental Health developed guidelines for health administrators to promote the mental wellbeing of frontline health personnel and curtail future mental health conditions. • WHO helped MoH to conduct a Mental Health Wellbeing Programme dedicated to frontline health workers and their families. • National Call Centre named “Suwasawana” was established with a computer network system under the supervision of Addl. Secretary Medical Services to manage all correspondence received through the hotline “1907”. The main aim of the system is to establish a centralized system to address the greivances of the public. • “Suwasariya” 1990 ambulance service continued with the transport of patients with COVID 19 and other emergencies. They were given 	<ul style="list-style-type: none"> • Preparation and dissemination of information and social communication for the general population, focusing on mental health promotion. • Establish simplified purpose-designed governance, finance, coordination and monitoring. • Introduce dashboards to visualize key essential non COVID health service delivery items (ie: FP Coverage; Immunization coverage; etc) at the Task force/ EOC level.
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	<p>special training on transportation of COVID 19 cases with mental illness.</p> <ul style="list-style-type: none"> • Most of the capacity building programmes were continued using virtual means. Infrastructure facilities and technical support to adopt online training procedures for digital dialogues were provided by GOSL, and other developmental partners. • Scenario based Reference guide with all circular instructions was designed and disseminated on Maintaining RMNCAYH services during the COVID pandemic in early 2021. • MoH established National Steering Committee on Management of Substance Use disorders to prevent and control and manage persons with Substance use Disorder. The management protocol for heroin withdrawal was developed and disseminated. Nearly 10 out-patient facilities identified to manage substance use disorders and circular sent to all relevant stakeholders. • MoH together with National Authority on Tobacco and Alcohol, National Dangerous Drug Control Board, SLCP and civil society organizations implemented many support services for targeted individuals and community wide health promotion and advocacy programmes. 	
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2.2.10 VACCINATION

Priority measures	Some highlights of GOSL response	Way forward
<p>Development and implementation of a national deployment and vaccination plan</p>	<ul style="list-style-type: none"> • Sri Lanka is one of the AMC countries that will receive the vaccine for 20% of its population (4.2 million) free of charge under the COVAX facility. • A National Coordinating Committee (NCC) for COVID-19 Vaccine chaired by the Secretary of Health was convened. Dr. Lakshmi Somathunga, Additional Secretary (PHS) was appointed as the national coordinator for COVID-19 Vaccine. Three technical subcommittees were appointed -technical subcommittee for Prioritization, Targeting and Surveillance for Covid-19 Vaccine, technical subcommittee for maintenance of cold chain and logistics on Covid-19 Vaccine and technical Subcommittee for costing for implementation of Covid-19 Vaccine. • The National Advisory Committee on Communicable Diseases (ACCD) appointed a technical working group, the National Immunization Technical Advisory Group (NITAG) to provide guidance on vaccine selection, prioritization of population groups and development of national Deployment and vaccination Plan (NDVP). • Health Ministry accepted the offers made by GAVI, WHO, UNICEF and other partner agencies for logistic support, extended for smooth vaccine deployment in the country. 	<ul style="list-style-type: none"> • Based on the overall National Vaccine Deployment Plan, the country will develop vaccine-specific guidelines for each campaign based on type of vaccines and identifying priority groups. • Early advocacy and communication have been identified as a key area to improve the acceptability of the vaccine by the respective risk groups • Support the adoption of efficient and expedited regulatory pathways for approval and regulatory oversight of COVID-19 vaccines (i.e. emergency use authorization, exceptional approval/approval mechanism based on reliance/recognition, abbreviated procedure, fast track, etc.), including risk-based pharmacovigilance and post-marketing surveillance of products. • Review and address specific training requirements of the involved staff for vaccination and reporting events. • Ensure NITAG and associated working groups, or the equivalent, are established and resourced to enable a policy recommendation/advice on the use of COVID-19 vaccines.

	<ul style="list-style-type: none"> • Application for the vaccine request was submitted during the first week of December 2021. In addition, the Government of Sri Lanka has explored the possibility of getting down additional vaccines through the diplomatic channel and bilateral agreement. <p><u>Country readiness:</u></p> <ul style="list-style-type: none"> • The National Immunization Technical Advisory Group (NITAG) developed a ToR to outline the mandate of the technical working group. • As of October 2020, according to the Vaccine Introduction Readiness Assessment tool (VIRAT), Sri Lanka has completed two major activities, the formation of the National Coordinating Committee (NCC) and NITAG while many of the other activities were in progress. VIRAT is a national level tool to be used by the MoH with the support of the partner organizations. It is a planning road map that ensures adequate readiness for Covid 19 vaccine. • The National Coordinating Committee (NCC) for Covid-19 Vaccine chaired by the Secretary of Health was established on 18 November 2020 and continued working in close collaboration with COVAX mechanism and other avenues for assurance of vaccine deployment. Additional Secretary(Public Health Services) serves as the national coordinatoir for COVAX mechanism • Three technical subcommittees were appointed for different tasks; technical subcommittee for Prioritization, Targeting and Surveillance for Covid-19 Vaccine, technical subcommittee for maintenance of cold chain and logistics on Covid-19 Vaccine and technical subcommittee for 	<ul style="list-style-type: none"> • Using NITAG prioritization recommendations, review epidemiological data and operationally define target populations that will be prioritized for access to vaccines, estimate their numbers, and develop a delivery strategy for reaching these populations. • Ensure that the data related to underlying health conditions are captured in the health information system to help planning the prioritization of vaccination for populations at risk for severe COVID-19. • Ensure Adverse Events Following Immunization (AEFI) working group is in place and the existing AEFI committee has been expanded to include the experts involved in adult disease management. • Identify funding gaps in operational costs and if needed apply to multilateral back funding and in-country donor funding • Integrate vaccine readiness and deployment coordination into existing country COVID-19 multi-sectoral incident management (or equivalent) system or national coordinating committee. • Ensure stringent reporting and monitoring mechanism for immunization, vaccine supply chain
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	<p>costing for implementation of Covid-19 Vaccine submitted a report on assigned tasks within a week to facilitate necessary planning activities on vaccine rollout (Refer Annex XIII)</p> <ul style="list-style-type: none"> • The technical expert working group of ACCD convened the 2nd meeting on 27 November 2020 at the Epidemiology Unit, MoH. The main objectives were the identification of target groups for vaccination and completion of vaccine request before the scheduled deadline, 7th December 2020. In alignment with SAGE recommendations on prioritization, the committee decided to consider three priority groups: the frontline health workers and other key front-line workers actively involved in COVID-19 outbreak management, older age groups and persons with co-morbidities. • The request for Technical Assistance (TA) for the implementation of the major activities identified in the COVAX Readiness and Preparation Plan and VIRAT/VRAF was submitted on 27 November 2020. • The National Deployment and vaccination plan (NDVP) was developed and presented to the ACCD and to the NCC was then finalized. The final version of the NDVP was uploaded in the partner’s platform for the review by the regional reviewers. <p><u>Capacity building</u></p> <ul style="list-style-type: none"> • EPI programme manager, Consultants and regional level technical persons participated in a series of regional and global level training programmes under the areas of regulatory preparedness, NDVP development, AEFI and AEFI surveillance, cold chain management etc. 	<p>management and AEFI. This is essential for further vaccine supply and provision of funding.</p> <ul style="list-style-type: none"> • Plan and conduct vaccine effectiveness surveys among different target groups and for different types of vaccines.
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3.0 IMMEDIATE & MEDIUM-TERM NEEDS

Main Areas	Immediate Needs	Estimated Budget (USD)	Medium-Term Needs	Estimated Budget (USD)
COORDINATION, PLANNING, FINANCING AND MONITORING	Establishment of virtual meeting and coordination.	3,500.00	Conduct After Action Review.	10,000.00
	Platform (Zoom for Business United).	10,000.00	Documentation of lessons learnt and best practices.	10,000.00
	Conduct Intra-action review .		Review and update health sector emergency management plans at the national level (2 residential workshops).	8,000.00
			Review and update health sector emergency management plans at subnational (26 residential district workshops).	104,000.00
	Total	13,500.00	Total	132,000.00
RISK COMMUNICATION, COMMUNITY ENGAGEMENT AND INFODEMIC MANAGEMENT	Revision of policy and guidelines on risk communication.	50,000.00	Recruitment of Tamil translators and type setters.	200,000.00
	Strengthen RCCE coordination mechanisms	25,000.00	Update rumors and misinformation monitoring systems	100,000.00
	Develop minimum standards and indicators to assess community engagement	10,000.00	Strengthen community engagement at local-level	100,000.00

	Capacity building of relevant health staff on risk communication	200,000.00		
	Strengthening of Workplace risk communication capacity	100,000.00	Conduct program to address marginalized and at-risk population	100,000.00
	Train media personnel on responsible journalism.	15,000.00		
	Advertising in Primetime media slots.	300,000.00		
	Total	700,000.00	Total	500,000.00
SURVEILLANCE, EPIDEMIOLOGICAL INVESTIGATION, CONTACT TRACING, AND ADJUSTMENT OF PUBLIC HEALTH AND SOCIAL MEASURES	Development of digital platforms (GIS) for real-time information sharing with accessibility to enter and utilize the data at a regional level.	250,000.00	Strengthen genetic and serological surveillance.	1000,000.00
	Strengthening of contact tracing, active case finding and isolation.	100,000.00	Conduct capacity assessment and risk analysis for specific settings,	300,000.00
	Facilitate cluster investigation,	200,000.00	Conduct regular risk assessments	200,000.00
	Strengthening of testing capacity at all levels.	150,000.00		
	Total	700,000.00	Total	1,500,000.00
POINTS OF ENTRY, INTERNATIONAL TRAVEL AND	Human Recourse Requirement	3,000,000.00	Development of a protocol for expediting immigration and health clearance as part of	100,000.00
	Medical officers for PoEs			

TRANSPORT AND MASS GATHERINGS	Two MOs Airport Health Office /BIA (Temporary)		promoting long-stay tourism in Sri Lanka.	
	One MO Galle Port Health Office (Temporary)		Development of data sharing mechanism among all stakeholders- Aviation, MoH and SLPA.	300,000.00
	One MO Trincomalee Port (Permanent)		Equip and train staff at the point of entry to manage ill passenger(s) and identify contacts, carry out cleaning and disinfection.	200,000.00
	One MO Hambantota Por (Permanent)			
	One MO Jaffna Airport (Permanent)			
	Public Health Inspectors for PoEs			
	One PHI for Colombo Port Health Office (Permanent)			
	One PHI for MRIA (Permanent)			
	One PHI Jaffna Airport (Permanent)			
	Furniture/Equipment for Extension of Mattala Airport Health Office	1,000,000.00		
	Provision of vehicles to Quarantine Unit & Port Health Offices	3,000,000.00		
	Quarantine Unit-Van			
	Port Health Office Trincomalee – Double Cab			

	<p>Port Health Office Hambanthota – Double Cab</p> <p>Conduction of regular risk assessments at global, regional, national and local level.</p> <p>Communication of information to travellers about COVID-19 related entry and exit requirements.</p> <p>Develop communication materials to travellers on quarantine process</p> <p>Total</p>	<p>500,000.00</p> <p>1000,000.00</p> <p>500,000.00</p> <p>9,000,000.00</p>	<p>Total</p>	<p>600,000.00</p>
LABORATORIES AND DIAGNOSTICS	<p>Provide allocations for Purchasing COVID Equipment for Line Ministry & Provincial Council Institutions</p> <p>Strengthening of laboratory testing for the diagnosis of COVID -19.</p> <p>Strengthening of support the laboratory testing for COVID-19 surveillance activities</p> <p>Establishment of system for local validation of tests kits.</p>	<p>9,000,000.00</p> <p>2,000,000.00</p> <p>500,000.00</p> <p>500,000.00</p>	<p>Establishment of laboratory information management system (LIMS).</p> <p>Facilitate external quality assurance measures for COVID-19 testing.</p> <p>Ensure the availability of legislative support/regulations for the transport and sharing of specimens and genomic data.</p>	<p>13,000,000.00</p> <p>1,000,000.00</p> <p>500,000.00</p>

	Recruitment and training of additional staff.	1,000,000.00	Develop custom procedures to facilitate the import of diagnostic materials and donations.	2,000,000.00
	Strengthening of laboratory infrastructure	15,000,000.00	Promotion of local manufacturing of selected consumables.	10,000,000.00
	Total	28,000,000.00	Total	26,500,000.00
INFECTION PREVENTION AND CONTROL, AND PROTECTION OF THE HEALTH WORKFORCE	Development of SOPs for collection of specimens, and safe transportation.	100,000.00	Implementation of occupational health IPC programmes for safe working conditions.	200,000.00
	Assessment of IPC readiness for priority activities	50,000.00	Implementation of research and development studies focusing on CoV-2	100,000.00
	Development of contingency plans for ensure availability of PPE and IPC consumable	50,000.00	Implementation of a mechanism to ensure the quality of PPE.	200,000.00
	Annual appraisal of the National IPC guidelines	100,000.00		
	Training programs to introduce bioengineering concepts to hospital infrastructure.	100,000.00		
	Training programmes on documents of IPC guidance and	200,000.00		

	<p>application of IPC measures & PPE for health care workers</p> <p>Development of monitoring and evaluation tools for implementation of IPC procedures</p> <p>Monitoring of IPC and public health measures in community settings.</p> <p>Total</p>	<p>50,000.00</p> <p>50,000.00</p> <p>700,000.00</p>	<p>Total</p>	<p>500,000.00</p>
<p>CASE MANAGEMENT, CLINICAL OPERATIONS, AND THERAPEUTICS</p>	<p>Develop alternative treatment centres in the public and private sector for case management.</p> <p>Programs to de-stigmatize COVID-19 among health care professionals and frontline workers</p> <p>Programme to assess and build the capacity of the human resources (skilled workforce).</p> <p>Ensure the availability of biomedical equipment for the workforce.</p>	<p>2,000,000.00</p> <p>500,000.00</p> <p>1,000,000.00</p> <p>10,000,000.00</p>	<p>Expansion of patient information system with medical decision support for the COVID 19 treatment facilities.</p> <p>Continuously assess and improve capacity to safely deliver primary health care services and other essential health services (see Pillar 9).</p> <p>Collaboration program with expert groups to address challenges in clinical care and promote global collaboration.</p>	<p>10,000,000.00</p> <p>1,000,000.00</p> <p>5,000,000.00</p>

	<p>Ensure the availability of essential medicines.</p> <p>Ensure availability of guidance for the care of self-isolated persons and for referral to health care facilities.</p> <p>Improvement of triage and screening areas in all health care facilities.</p> <p>Adopt international research & Development efforts and WHO protocols for special studies.</p> <p>Ensure availability of biomedical equipment for patient care (Refer annex XIV)</p> <p>Total</p>	<p>1,000,000.00</p> <p>500,000.00</p> <p>2,000,000.00</p> <p>1,000,000.00</p> <p>10,000,000</p> <p>28,000,000.00</p>	<p>Strengthening of hospitals and ICUs along with the demands of the COVID-19 response.</p> <p>Total</p>	<p>64,000,000.00</p> <p>80,000,000.00</p>
OPERATIONAL SUPPORT AND LOGISTICS, AND SUPPLY CHAINS	<p>Review and revision of procurement processes and Logistic Management Information System (LMIS) at MSD and RMSD to introduce and implement new logistic management strategies.</p>	<p>12,000,000.00</p>	<p>Strengthening of storing capacity of logistic and medicine, for COVID-19 case management.</p>	<p>20,000,000.00</p>

	Capacity building of staff on supply chain management. Monitoring of performance (KPIs) on lead times and supply gaps.	2,000,000.00		
	Adapting the CSCS plan for supply chain management MSD	1000,000.00		
	Total	15,000,000.00	Total	20,000,000.00
MAINTAINING ESSENTIAL HEALTH SERVICES AND SYSTEMS	Development of protocols to govern essential public and private health service delivery in coordination with response protocols.	1,000,000.00	Strengthening of provision of health facilities for acute, chronic and long-term care, including those in public, private and military systems.	100,000,000.00
	Ensure timely scale-up of a workforce hiring, deployment and redistribution strategy.	9,000,000.00	Upgrading of dashboards of higher-level authorities with indicators on the functioning of essential other health services.	5,000,000.00
	Strengthen / upgrade essential health service delivery as per stage /phase of the pandemic to reach the vulnerable and marginalized groups.	8,000,000.00	Establishment of a national level multi-stakeholder mechanism and psychosocial support response plan (action plan) for COVID-19.	1,000,000.00
	Scaling up routine and in-service training on virtual platforms.	1000,000.00	Develop communication tools to improve community engagement on re-oriented health service delivery.	2,000,000.00
	Establishment of mental health care facility for SARS-CoV-2	500,000.00		

	<p>infected people with mental health conditions.</p> <p>Promotion of mental health and psychosocial well-being of the frontline health care workers through mental health supportive programs.</p> <p>Introduction and execution of a program to address the psychosocial impact on people and families directly affected by COVID-19.</p> <p>Training for community leaders and agents on PFA and identification of people who require specific care (primarily virtual training)</p> <p>Total</p>	<p>500,000.00</p> <p>1,000,000.00</p> <p>1,000,000.00</p> <p>22,000,000.00</p>	<p>Total</p>	<p>108,000,000.00</p>
VACCINATION	<p>Develop vaccine-specific guidelines for each campaign based on stock levels in identifying priority groups.</p> <p>Advocacy and communication program to improve the</p>	<p>500,000.00</p> <p>500,000.00</p>	<p>Establishment of a health information system to help planning the vaccination for COVID-19.</p> <p>Adoption of efficient and expedited regulatory pathways for approval and regulatory</p>	<p>2,000,000.00</p> <p>1,000,000.00</p>

	<p>acceptability of the vaccine by the respective risk groups.</p> <p>Training of the involved staff for vaccination and reporting events.</p> <p>Integrate vaccine readiness and deployment coordination into existing country COVID-19 multi-sectoral incident management system.</p> <p>Vaccine coverage of 80% of population for COVID 19</p> <p>Total</p>	<p>3,000,000.00</p> <p>1,000,000.00</p> <p>194,913,000.00</p> <p>199,913,000.00</p>	<p>oversight of COVID-19 vaccines.</p> <p>Total</p>	<p>3,000,000.00</p>
Grand Total		320,026,500.00		237,732,000.00

Annexure I

Country level Coordination, Planning and Monitoring

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Quarantine Unit

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Brigadier Coordination

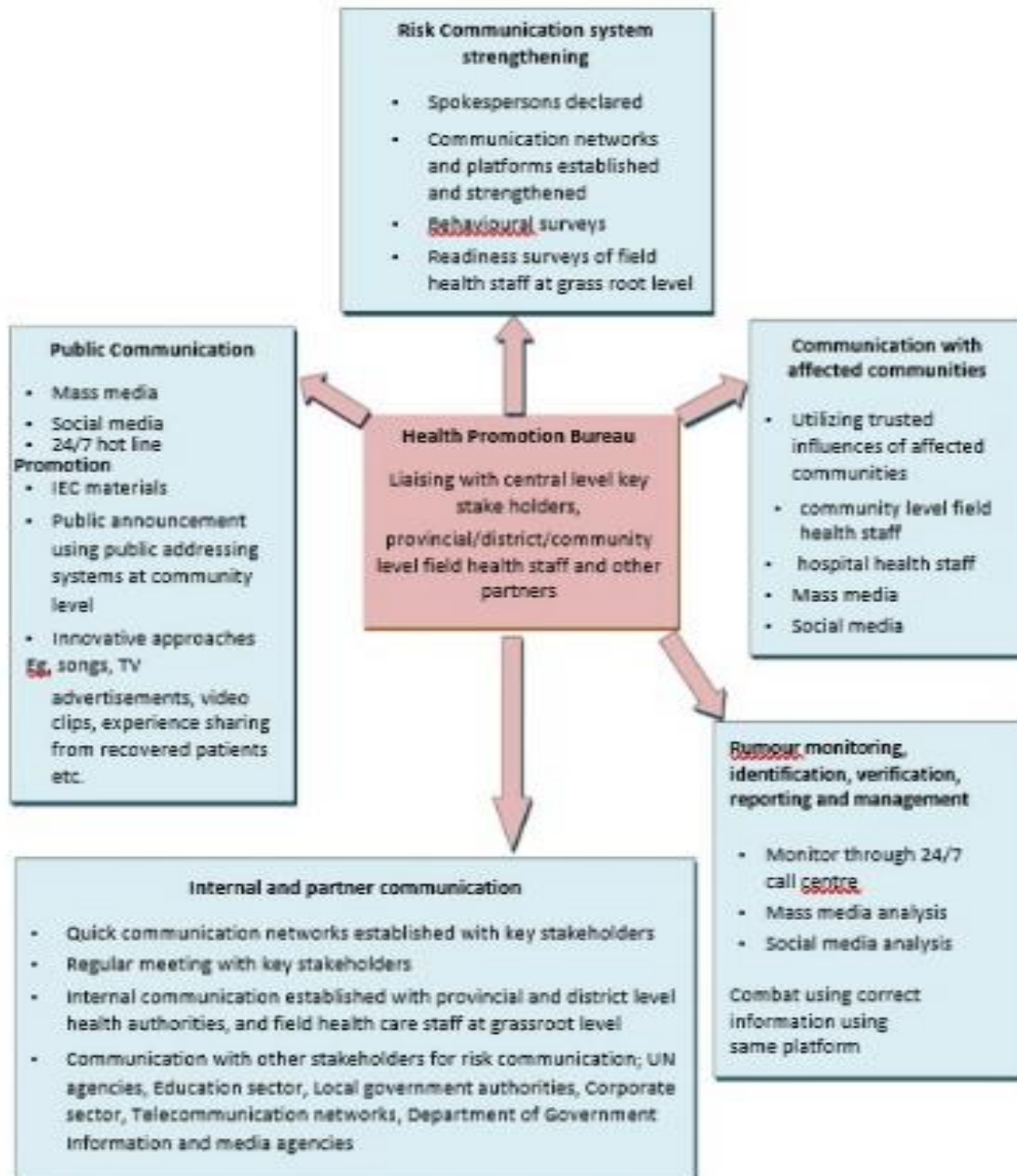
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Annexure II

Risk communication and Community Engagement



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Annexure III

Surveillance, Risk Assessment and Rapid Response

PCR Testing of the high-risk categories identified according to timely updated guidelines

The contents of the letter issued by the Director-General of Health Services, Ministry of Health dated 05.04.2020 on “Updated interim case definitions on COVID-19 and advice on initial management of patients is given below.

The present recommendation is to isolate and test all clinically/ epidemiologically suspected cases of COVID-19 infected patients.

All patients with medical/ surgical, obstetrics/gynaecological or paediatric conditions should receive the usual standards of care in keeping with clinical status, in a designated area. Management of these patients should NOT be delayed under any circumstances pending the COVID-19 test result.

All confirmed cases **once stable** should be transferred to a designated COVID-19 Treatment Centre.

Clinically Suspected Case:

A. A person with ACUTE RESPIRATORY ILLNESS (with Cough, SOB, Sore throat; one or more of these) with a history of FEVER (at any point of time during the illness) returning to Sri Lanka from ANY COUNTRY within the last 14 days.

OR

B. A person with ACUTE RESPIRATORY ILLNESS (with Cough, SOB, Sore throat; one or more of these) AND having been in **close contact*** with a confirmed or suspected COVID-19 case during the last 14 days before the onset of symptoms;

* **Close-contact:** A person staying in an enclosed environment for > 15 minutes (e.g. same household/workplace/ social gathering/ travelling in the same vehicle). OR who had direct physical contact?

OR

C. A person with ACUTE RESPIRATORY ILLNESS (with Cough, SOB, Sore throat; one or more of these) with a history of FEVER (at any point of time during the illness), with a **history of travel to or residence in a location designated as an area of high transmission of COVID_19 disease** as defined by the Epidemiology Unit, MoH during the 14 days before symptom onset.

OR

D. A patient with **acute pneumonia** (not explainable by any other aetiology) regardless of travel or contact history as decided by the treating Consultant.

- Management of such patients should not be delayed under any circumstances. Patients should receive the standards of care in keeping with the known underlying cause in a designated area (ETU/Isolation Unit/Designated Respiratory Unit/ Designated Ward/ HDU/ICU).
- A sample for the PCR test obtained and sent (**not the patient**) to a designated laboratory.
- Once the result is available, if positive, the patient (Once stable) can be transferred to a designated COVID-19 treatment centre.

OR

E. A patient with fever and in **respiratory distress** as evident by RR > 3 per minute, SpO2 < 90% on room air, regardless of travel or contact history and **without a definable cause**, as decided by the treating Consultant.

- Management of such patients should NOT be delayed under any circumstances.
- Patients should receive the standards of care in keeping with the known underlying cause in a designated area (ETU/Isolation Unit/Designated Respiratory Unit/ Designated Ward/ HDU/ICU).
- A sample for the PCR test obtained and sent (Not the patient) to a designated laboratory.
- Once the result is available, if positive, the patient (Once stable) can be transferred to a designated COVID-19 treatment centre

F. Any person **irrespective of the presence of symptoms**, with an epidemiological link to a confirmed COVID-19 case who needs testing, as decided by the Regional Epidemiologist or the Central Epidemiology Unit

Confirmed case:

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Disposition of cases:

Disposition of suspected cases

- All patients fitting to the above-suspected case definitions (**A, B, C**) should be admitted and transferred by ambulance to the closest designated hospital (refer to updates on the list of designated list of hospitals) for confirmatory testing and management. **This should be done only after stabilizing the patient and in prior consultation with the respective designated hospital**, adhering to necessary infection prevention and control (IPC) precautions.

- In the case of **D and E**, the patient should be managed in the same hospital in a designated area (ETU/Isolation Unit/ Designated Respiratory Unit/ Designated ICU). A sample for the PCR test obtained and sent (not the patient) to the designated laboratories. Once the result is available, if positive, the patient (once stable) can be transferred to a designated COVID-19 treatment centre.
- In the case of **F**, all COVID-19 positive individuals will be admitted to a designated treatment facility.

Disposition of confirmed cases

All confirmed cases should be transferred to a COVID-19 Treatment Centre.

This is to be applied in all hospitals/ settings, including those in the private sector.

All suspected cases of COVID-19 shall be notified immediately to the Epidemiology Unit by the treating physician.

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Annexure-IV

Points of Entry

Mandatory pre departure and Day 1 PCR testing among travellers

If a passenger falls into the 'suspected case' category, he/she shall be escorted to the isolation area and arrangements will be made to transfer to a designated hospital. This will be informed to the Chief Epidemiologist.

If passengers are to be quarantined as per the policy decisions taken by the Ministry of Health depending on the COVID 19 global spread, such passengers will be transferred to quarantine centres with the coordination of the tri forces.

Regular Capacity building of the health staff including provision of latest updates of disease information, SOPs, and handling of sick passengers should be conducted.

Established assessment and isolation facilities to cater to ill passengers until they are transferred to designated hospitals.

Risk communication to all travellers.

Quarantine Unit

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PoE other stakeholders

Epidemiology Unit MoH, Department of Immigration & Emigration, Sri Lanka Ports Authority, Airport Aviation Sri Lanka Ltd, Civil Aviation Authority, Sri Lanka Customs

Annexure V

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National Health Laboratory Policy:

The Policy document is available online at,

http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/14_Health%20Laboratory.pdf

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Medical Research Institute

http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/14_Health%20Laboratory.pdf

Annexure VI

Infection prevention and control

Environmental and Occupational Health and Food Safety Unit

Deputy Director General-Environmental and occupational Health and Food Safety

Contact details:

Postal Address:

Dr. Thilak Siriwardhane,

DDG-ENOHFS (Act), Ministry of Health, 'Suwasiripaya' 385, Baddegama Wimalawansa Thero Mawatha, Colombo-10

Telephone: +94 112 112 720

E-mail: ddgenoh@health.gov.lk

CCP - Dr. (Mrs.) Inoka Suraweera

Tel. Office: +94 112112704, Mobile: +94 714809450

Hospital Infection Control Manual available at

<http://slmicrobiology.lk/download/IC-manual-2005.pdf>

Standard Precautions and Hand Hygiene in Health Care Settings available online at

<http://www.slkog.lk/img/guidelines/>

Minimum requirement for Infection Prevention and Control (WHO) available online at

https://www.who.int/infection-prevention/publications/MinReq-Manual_2019.pdf?ua=1

Disinfection and Decontamination: A Practical Handbook available

online at <https://www.crcpress.com/Disinfection-and-Decontamination-A-Practical-Handbook/Moldenhauer/p/book/9780815379010>

Health Waste care management in Sri Lanka available online at

<http://www.slkog.lk/img/guidelines/Other%20national%20Gidelines/Microbiologists/Book%203/Health%20Care%20Waste%20Management.pdf>

Hand hygiene:

Hand washing with soap and water or 70% alcohol-based hand sanitizers according to the procedures described in the National Infection Control Manual / Standard precautions and hand hygiene in health care settings.

Personal Protective Equipment (PPE)

Full PPE shall be worn by the staff. The standard steps in 'Donning' (Put the PPE on) and 'Doffing' shall be strictly practiced. After doffing, the used PPE shall be discarded according to the instructions provided in the Manual/ Guideline.

Disinfection and decontamination

Disinfection is not done to remove all contaminants, but instead reduces the amount of contamination. Certain surfaces cannot handle harsh cleaning over and over again, so disinfection suffices. Everyday surfaces are usually disinfected, which kills some bacteria and fungi while inactivating viruses.

Decontamination is the process of decreasing antimicrobial presence in an area or on a surface.

The environment shall be cleaned with 0.1% Chlorine (aq) solution. For decontamination 0.5% Chlorine (aq) solution shall be used (Generally); as Chlorine solution is corrosive, Hydrogen peroxide is preferred to clean ambulances and metal surfaces.

Additional precautions

Shall be adopted for infections with highly transmissible pathogens. The guideline shall be referred for the specific precautionary measures.

Waste disposal

All waste generated, solid as well as liquid, shall be considered as infectious.

Shall be segregated at source, ward or IF, using colour coded bins and bags with Bio-hazard lining.

The solid waste bags shall be removed when it is $\frac{3}{4}$ full.

No spillage or leakage shall be ensured.

On transportation essential, PPE shall be donned and followed by hand hygiene.

Infectious solid waste shall be autoclaved or incinerated

Infectious liquid waste shall be treated to make it non-infectious before releasing it.

Disposal of dead bodies due to COVID-19

Provisional Clinical Practice Guidelines on COVID-19 suspected and confirmed patients. Sri Lanka College

of Physicians available online at

http://www.epid.gov.lk/web/images/pdf/Circulars/Corona_virus/covid-19-cpg_march-2020-moh-sl.pdf(Autopsy Practice and disposal of dead body; chapter 7, page 25)

Annexure VII

Intermediate care centres and ambulance services for COVID-19 patients available on paying basis as of 05 th May 2021

Services Available & Approximate cost							
Managed By	Contact number/s	Location	Single Room	Double Room	Triple Room	Shared Room (per person)	Remarks
Nawaloka Hospital	0770 066 006	Hotel Mirage - Mount Lavinia	17,000.00	22,000.00	27,000.00	Family Room	24/7 care by Medical officer/Nursing Staff & Consultants service (Fee 10,000/-)
	0771 181 856	Hotel Mount Lavinia Mount Lavinia	17,000.00	22,000.00	27,000.00	N/A	
	0777 256 555 0777 385 321						
Lanka Hospital	011 543 2015	Best Western Hotel - Colombo 5	18,000.00	24,000.00	36,000.00	12,000.00	Admission Fee - 5,000/- Consultant Fee - 10,000/-
	0752 273 383	Pearl Grand Hotel Colombo -04	17,000.00	22,000.00	33,000.00	11,000.00	
Ninewells	0716 784 451	Jetwing Beach Hotel- Negambo	17,000.00	22,000.00	25,000.00	N/A	Medical officer /Nursing Staff Service
Asiri Hospital	0763 074 235 0767 039 724	Anarva Hotel - Mount Lavinia	17,000.00	22,000.00	N/A	N/A	Medical officer /Nursing Staff Service. Consultants Fee 1,000/-
Durdans Hospital	0777 488 455	Ocean Edge Hotel - Marine Drive, Colombo-03	17,000.00	23,000.00	33,000.00	N/A	Medical officer /Nursing Staff Service
SL Army	0773 124 521	Koggala Beach Hotel- Koggala	13,000.00	19,000.00	26,000.00	N/A	Medical officer /Nursing Staff Service
Kings Hospital Colombo	0701 800 780 0772 327 190	Citrus Hotel Waskaduwa	17,000.00	22,000.00	30,000.00	N/A	Medical officer /Nursing Staff Service, Consultants Service & ICU facility available
Ministry of Health	0715 478 645 0718 440 225 0712 397 588	Cinnamon Citadel Kandy	16,000.00	22,000.00		N/A	Medical officer /Nursing Staff Service
Royal Ambulance Service	0718 320 320 0718 131 131 0718 711 711	The charge for the first 20km is Rs.12,500.00 and Rs.150/= will be charged for each additional kilometre. There will be no waiting charge for the first 30 minutes and a waiting charge of Rs.1,000/= will be charged for each additional 30 minutes of waiting.					

Annexure-VIII

List of COVID 19 treatment centres prepared for COVID 19 response as of 5th of May 2021.

Serial No.	Name of the Centre
1	IDH
2	BH Mulleriyawa
3	BH Homagama
4	DGH Hambanthota
5	BH Galgamuwa
6	BH Kattankudy
7	BH Teldeniya
8	DGH Ampara
9	Methsirisewana
10	DH Divulapitiya
11	DH Rambukkana
12	DH Galenbinduna wewa
13	DH Dankotuwa
14	DH Lunawa
15	DH Abanpola
16	NFTH
17	DH Ingiriya
18	DH Minuwangoda
19	BH Welikanda
20	BH Laggala Pallegama
21	DH Periya Kallar
22	BH Kamburugamuwa
23	DH Dompe
24	BH Pimbura
25	DH Karandiyanaru
26	DH Eachchalampaththu
27	DH Radawana

28	DH Kosgama
29	NHRD Welisara
30	DH Kuchchaweli
31	DH Mathugama
32	DH Iththepana
33	DH Palamunei
34	DH Nochchiyagama
35	DH Narammala
36	DH Undugoda
37	Iranawila
38	DH Bandaragama
39	DH Arachchikanda
40	BH Warakapola
41	DH Marathamunei
42	DH Nawagamuwa
43	BH Hanguranketha
44	DH Walapane
45	BH Marawila
46	DH Bandarawela
47	DH Damana
48	DH Polwaththa
49	DH Karandeniya
50	DH Kebithigollewa
51	DH Beligala
52	DH Padiyathalawa
53	DH Katugasthota
54	DH Madagaa
55	BH Hingurakgoda
56	DH Mawathagama
57	Kopai ITC
58	Yakkala ITC
59	Pasdunrata ITC

60	Dharga town ITC
61	Agunakolapelassa ITC
62	Pallekele ITC
63	Krishnapuram ITC
64	Giriulla ITC
65	Ambilipitiya YC ITC
66	Bindunawewa ITC
67	Kahagolla ITC
68	Bingiriya ITC
69	Punani Campus ITC
70	Bagawanthalawa ITC
71	Weligama ITC
72	Gallella ITC
73	Maliban ITC
74	Wathupitiwala ITC
75	Polgolla ITC
76	Punani Brandix ITC
77	Dambadeniya ITC
78	Penideniya ITC
79	Kandakadu ITC
80	Pinnawala ITC
81	Kahawatta ITC
82	Hotel Christema and J/leaf ITC
83	Hotel Kaya ITC
84	Hotel Jetwin Beach ITC
85	Hotel Long Beach Koggala ITC
86	Hotel Anarwa ITC
87	Hotel Supercoral Hikkaduwa ITC
88	Hotel Pearl Grand ITC
89	Hotel Mount Lavinea ITC
90	Hotel Best Western ITC

91	Hotel Citrus ITC
92	Hotel Pearlcity ITC
93	Hotel Nirai ITC
94	Kundasale ITC (Police)
95	BH Panagoda (SL Army)
96	Hanthana ITC (Police)
97	Iyakachchi (Prison)
98	BH Katunayake (SL Air Force)

BH- Base Hospital. DGH- District General Hospital, DH- Divisional Hospital, PGH- Provincial General Hospital, TC- Training College, TTC- Teachers Training College, PTC- Police Training College & NH- National Hospital, ITC-Intermediate Treatment Centre

Annexure IX

List of Hospitals prepared for COVID 19 response as of 23rd of December,2020

Serial No	Hospital
1.	NIID – National Institute of Infectious Diseases (Angoda, Colombo)
2.	NHSL- National Hospital of Sri Lanka (Colombo)
3.	TH Ragama – (Gampaha)
4.	TH Karapitiya – (Galle)
5.	TH Anuradhapura - (Anuradhapura)
6.	TH Kurunegala- (Kurunegala)
7.	TH Jaffna-(Jaffna)
8.	NH Kandy- (National Hospital, Kandy)
9.	TH Batticaloa-(Batticaloa)
10	DGH Gampaha- (Gampaha)
11	DGH Negombo- (Gampaha)
12	TH Rathnapura- (Rathnapura)
13	PGH Badulla- (Provincial General Hospital, Badulla)
14	LRH- (Lady Ridgeway Hospital for Children, Borella, Colombo)
15	DMH (De Zoysa Hospital for Women, Borella, Colombo)
16	DGH Polonnaruwa- (Polonnaruwa)
17	TH Kalubowila- (Colombo South Teaching Hospital, Colombo)
18	Castle St TH (For Women, Colombo)
19	DGH Hambantota- (Hambantota)
20	DGH Monaragala- (Monaragala)
21	BH Welikanda- (Polonnaruwa)
22	DGH Kaluthara- (Kaluthara)
23	Chest H. Welisara (Gampaha)
24	Colombo East Base Hospital (Mulleriyawa, Colombo)
25	BH Homagama- (Colombo)
26	Dr Neville F. Hospital- (Malabe, Colombo)
27	DGH. Chilaw- (Puttalam)

28	DGH Matara-(Matara)
29	KDU Hospital- (Kothalawala Defense University)
30	DGH Vavunia- (Vavunia)
31	BH Marawila (Puttlam)
32	TH S.J.Pura- (Colombo)
33	BH Theldeniya(Kandy)
34	BH Tangalle- (Hambantota)
35	National Institute of Mental Health (Colombo)

BH- Base Hospital. DGH- District General Hospital, DH- Divisional Hospital, PGH- Provincial General Hospital & NH- National Hospital

Annexure X

List of Quarantine Centres established and under the care of Sri Lankan Tri-forces

Following Quarantine Centres (QC) were established and maintained under the care of Sri Lanka Army, Sri Lanka Navy and Sri Lanka Air Force (Source: Epidemiology Unit) as of 25.12.2020.

1. Biyagama village QC
2. Airport Garden QC
3. SL.Navy QC
4. Brandix QC
5. Waskaduwa QC
6. Pasdunrata QC
7. Avani Kalutara QC
8. Club Dolphin Hotel QC
9. Carolina Beach Hotel QC
10. Peradeniya QC(Panideniya)
11. Kundasale QC
12. Police (Hanthana) QC
13. Suisse QC
14. Hanthana Sisila QC
15. Araliya Hotel QC
16. Ashford Hotel QC
17. Vidathapillai QC
18. Welankulam QC
19. Navy QC Mulankavil,
20. Mullaitivu QC
21. SLAF, Mullaitivu QC
22. Vavuniya QC
23. SLAF Vavuniya QC
24. Addalachchnai Teachers Training School (Prison) QC
25. Vidura Camp QC
26. Navy Nochchiyagama QC

27. Boralanda Police QC
28. Ranthambore QC
29. Fairway sunset QC
30. Koggala QC
31. Boossa Navy Camp QC
32. Habaraduwa QC
33. Nilwala QC
34. Ranminithanna QC
- 35. Koggala Beach Hotel QC**

Annexure XI

Case management, clinical operations, and therapeutics

DDG MS I

Deputy Director General of Medical Services

Contact details:

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Director /Medical Tchnology Coordinator in Charge of Covid-19

Contact details:

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Telephone: +94 112 693 674

E-mail:ddgms1@health.gov.lk

All necessary information is provided in the following publications

3. Provisional Clinical Practice Guidelines on COVID-19 suspected and confirmed patients;In collaboration with Ceylon College of Physicians Coordinated by Epidemiology Unit: 27th March, 2020; available online at http://www.epid.gov.lk/web/images/pdf/Circulars/Corona_virus/covid-19-cpg_march-2020-moh-sl.pdf
4. Revision to interim summary guidelines for clinical management of patients with novel coronavirus COVID – 19; available online at http://www.epid.gov.lk/web/images/pdf/Circulars/Corona_virus/revisionsummary.pdf

Annexure XII

Operational support and logistics

1. Medical Supplies Division

The Medical Supplies Division (MSD) of Ministry of Health and Indigenous Medical Services is the main organization responsible for providing all *Pharmaceuticals, Surgical items, Laboratory Items, Radioactive Items, Printed materials*, etc. for Government sector healthcare institutions throughout the country. In addition, MSD is also responsible for supplying dangerous drugs and essential medical items, which are not available to the private sector in the open market.

MSD is the central organization where the medical supplies are stored until they are distributed among healthcare institutions. It has a network of stores comprising of a central Medical Stores in Colombo (MSD) and there are 26 Regional stores at district level (RMSD). In the chain of central medical stores, there are 18 Bulk warehouses at the main building, 3 Bulk warehouses in Angoda, 5 bulk warehouses in Wellawatta, one warehouse in Digana and one warehouse in Welisara. More information is available online at <https://www.msd.gov.lk/>

2. Bio-medical Engineering Services (BES)

Provide appropriate state of art medical equipment technologies for the government hospitals in the country while achieving the highest standards of Safety, Quality, Reliability, and Accuracy.

Main functions of the BES are, Technology Assessment, Equipment Planning, Procurement Maintenance Management & Training of End-users & Maintenance Staff.

Contact details:

Postal Address

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Annexure XIII

The composition of the committee and subcommittees of National Coordination of Covid-19 (as of 18/11/2020)

1. The Composition of the National Coordinating Committee (NCC) for Covid-19 Vaccine

National Coordinator:

Dr. Lakshmi C. Somathunga - Additional Secretary (Public Health Services)

Name	Designation	Institute
Dr S.H Munasinghe	Secretary	Ministry of Health
Dr R.M.S.K Rathnayake	State Secretary	State Ministry of Production, Supply and Regulation of Pharmaceuticals
Dr. Sunil De Alwis	Additional Secretary (MS)	Ministry of Health
Dr. Asela Gunawardena	DGHS	Ministry of Health
Dr. H.D.B Hearth	DDG (PHS)I	Ministry of Health
Dr. Susie Perera	DDG (PHS)II	Ministry of Health
Dr. Sudath Samaraweera	Chief Epidemiologist	Ministry of Health
Dr. Dammika Jayalath	PDHS	Western Province
Dr. J.C.M Tennakoon	PDHS	Uva Province
Dr. Kapila Kannangara	PDHS	Sabargamuwa
Dr. Vijith Gunasekara	Director, Lab service	Ministry of Health
Dr. P.L Athapaththu	Director, PCS	Ministry of Health
Dr. A.D.U Karunarathna	RDHS	Matara
Dr. Pramitha Shanthilatha	RDHS	Kurunegala
Dr. H.M.K Wikramanayake	Director, MSD	Ministry of Health
Dr. P. Gunasena	Chairman	SPC
Prof. Asitha De Silva	Chairman	NMRA
Prof. Priyadarshani Galappaththi	Professor of Pharmacology	University of Colombo
Prof. Neelika Malawige	Immunologist	USJ
Prof. Pujitha Wikramasinghe	Paediatrician	University of Colombo
Dr. Kanthi Nanaykkara	Virologist	MRI

Dr. Rohitha Muthugala	Virologist	TH Kandy
Dr. Annada Wijewickrama	Physician	NIDH
Dr. Nihal Abeysinghe	President	CCPSL
Dr. Shirani Chandrasiri	Microbiologist	TH Kalubowila
Dr. Mizaya Cader	NPO	WHO
Dr. Sofina Abdullewa	CSC Chief	UNICEF
Dr. D. Rowel	Health and Nutrition Officer	UNICEF
Dr. Anil Dissanayake	Project Director	ADB
Dr. Deepika Atigala	Senior Health Specialist	World Bank
Mr. Hideki Higashi	Senior Economist	World Bank

Three subcommittees and their members are listed as follows,

1. Technical subcommittee for Prioritization, Targeting and Surveillance for Covid-19 Vaccine.
2. Technical subcommittee for maintenance of cold chain and logistics Covid-19 vaccine.
3. Technical Subcommittee for costing for implementation of Covid-19 vaccine program.

Technical subcommittee for Prioritization, Targeting and Surveillance for Covid-19 Vaccine.

Name	Designation	Role
Dr. H.D.B Hearth	DDG (PHS)I	Chair
Dr. Chithramali De Silva	Director	Convener
Dr. Priyantha Athapaththu	Director, PCS	Member
Dr. Deepa Gamage	CCP	Member
Dr. Chinthana Perera	CCP	Member
Prof. Neelika Malavige	Immunologist	Member
Dr. Rohitha Muthugala	Virologist	Member
Dr. Nihal Abeysinghe	CCP	Member
Dr. Ananda Wijewickrama	VP	Member
Prof. Pujitha Wikramasinghe	Pediatrician	Member
Prof. Priyadarshani Galappaththi	Pharmacologist	Member
Representative	WHO	Member

Technical subcommittee for maintenance of cold chain and logistics Covid-19 vaccine.

Name	Designation	Role
Dr. Susi Perera	DDG (PHS)II	Chair
Dr. Vijith Gunasekara	Director, Lab service	Convener
Dr. H.M.K Wikramanayake	Director, MSD	Member
Dr. Kapila Kannangara	PDHS- Sabaragamuwa	Member
Dr. Dammika Jayalath	PDHS- Western	Member
Dr. J.C.M Thennakoon	PDHS-Uva	Member
Dr. A.D.U Karunarathna	RDHS -Matara	Member
Dr. Pramitha Shanthilatha	RDHS- Kurunegala	Member
Prof. Asitha De Silva	Chairman, NMRA	Member
Dr. P. Gunasena	Chairman, SPC	Member
Dr. Manjula Kariyawasam	CCP	Member

Technical Subcommittee for costing for implementation of Covid-19 Vaccine programme

Name	Designation	Role
K.R Uduwawala	Secretary, State Ministry of Production, Supply and Regulation of Pharmaceuticals	Chair
Dr. Palitha Karunapema	Director, HPB	Convener
Dr. S. Sridharan	DDG (Planning)	Member
Mr M.R.H. Swarnathilaka	DG (Finance)	Member
Dr. S.M Arnold	Director, Quarantine	Member
Representative	World Bank	Member
Representative	WHO	Member
Representative	UNICEF	Member
Representative	ADB	Member

Annexure XIV

List of essential biomedical equipment for patient care

Se.No.	Item	Quantity to be purchased
1	Adjustable Bed	2442
2	Pulse Oximeter finger type	785
3	Digital BP	386
4	Anaroid BP	440
5	Pulse Oximeter	316
6	Nebulizer	780
7	ECG	398
8	IR Thermometer	710
9	Multipara Monitor Basic	702
10	High Flow Nasal Oxygen Therapy	400
11	Mini Autoclave	125
12	HDU Bed	375
13	Multipara Monitor Advanced	152
14	BIPAP Machine	67
15	Suction Apparatus	47
16	Defibrillator	35
17	Ventilator Transport	12
18	X-ray portable	40
19	ICU Bed	33
20	Ventilator ICU	15
21	Dialysis	7
22	RO Plants Portable	7
23	CRRT	5
24	Spot Lamp	13
25	Ventilator Neonatal	7
26	CTG	25
27	Infant Incubator	17
28	Infant Warmers	17
29	Phototherapy machine Double	17
30	Hand Held Dopler Machine	34
31	Oxygen concentrators	505
32	Oxygen Cylinders (Jumbo)	1605
33	Connectors	255