Unveiling Oversights and Under-reporting: A Rebuttal of Sri Lanka's COVID-19 Response Analysis

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Division of Labour

Although MS initiated and designed this response, ZI, TS, SU, DT, MMPMS, VT, and VV collaborated on data mining and curation. ZI specifically handled the section on ethnoreligious stigmatisation. MS and ZI jointly drafted the initial version of the manuscript, which was then improved with inputs from TS, SU, DT, MMPMS, VT, and VV. While all authors approved the final version, MS assumes full responsibility for any errors or omissions.

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Abstract

In response to an analysis of Sri Lanka's COVID-19 handling[1], this rebuttal delves into critical deficiencies in the data used and contextual factors influencing governmental decisions. It presents objective data showing Sri Lanka's poor performance in managing COVID-19 despite its healthcare infrastructure advantages. The initial success is attributed more to political motivations surrounding parliamentary elections rather than effective public health measures. Ethnoreligious stigmatisation exacerbated the crisis, impacting testing efforts and vaccination uptake, while economic mismanagement further worsened the situation, leading to the ousting of the Executive President in 2022. This rejoinder criticises the article for not explicitly recognising or downplaying these factors' significance. It concludes that while the study contributes to the lessons to be learned for the management of future pandemics in Sri Lanka, it overlooks crucial aspects, potentially skewing lessons for the future.

Introduction

Acknowledging the exhaustive analysis by the authors regarding Sri Lanka's responses to and management of COVID-19, this rebuttal endeavours to shed light on significant deficiencies in the objective data utilised and the contextual factors influencing specific governmental decisions. Through this endeavour, our aim is to offer a more profound and nuanced comprehension of the underlying causes and repercussions of COVID-19 mismanagement in Sri Lanka.

Our response enhances the ongoing discourse initiated by the authors and adds to the global body of literature concerning COVID-19.

Lack of objective data

The factual data compiled and presented by the authors of this rebuttal confirms that Sri Lanka ranked as the poorest performer in South Asia concerning COVID-19-related deaths per million people between January 2020 and December 2022 (see table). Specifically, Sri Lanka recorded 779 deaths per million, topping the list, followed by the Maldives with 622, India with 377, Nepal with 369, Afghanistan with 192, Bangladesh with 175, Pakistan with 133, and Bhutan with 26. The average number of COVID-19 deaths per million across South Asia stood at 330, significantly lower than Sri Lanka's figure (779) (see table).

Additionally, regarding COVID-19 cases/incidences per million, the Maldives reported the highest figure (371,356) during the same three-year period, trailed by Bhutan with 78,155, Nepal with 33,146, India with 31,764, Sri Lanka with 31,106, Bangladesh with 12,133, Pakistan with 6,866, and Afghanistan with 5,088. The average incidence of COVID-19 infection per million across South Asia was 26,567, notably lower than Sri Lanka's figure (31,764) (see table).

These objective statistics highlight a concerning trend: despite Sri Lanka and the Maldives boasting the highest levels of human development in South Asia according to the United Nations Human Development Index (UNHDI) in 2021[2]—0.783 for Sri Lanka and 0.753 for the Maldives—they experienced the highest number of COVID-19 deaths and cases/incidences, respectively. Moreover, both countries possess relatively robust healthcare systems and infrastructure. For instance, Sri Lanka boasts a hospital bed capacity of 4.2 beds per 1000 people, compared to the average of 2.3 beds in middle-income countries and a mere 0.6 beds in South Asian countries, as reported by the original authors.[3] Yet, despite these advantages, Sri Lanka fared poorly in handling the pandemic compared to other South Asian nations.

It's worth noting that the aforementioned data should be interpreted cautiously due to various factors. Globally, data on COVID-19 cases and deaths have faced scrutiny due to deficiencies[4], including lack of widespread testing[5] and underreporting in certain countries (see, for example, Richards, 2020).[6] Afghanistan's data may be

particularly unreliable due to the country's limited governance capacity resulting from decades of internal conflict and foreign occupation.

However, these objective findings contradict the broad assertion made by the original authors that "This study adds evidence on how one LMIC, Sri Lanka, leveraged a strong health system to SUBSTANTIALLY MITIGATE (emphasis ours) the impact of COVID-19 on its health services and healthcare access and at least initially control transmission." One notable flaw in their analysis is their use of absolute daily COVID-19 case numbers in Sri Lanka, rather than considering them relative to the country's population size, and comparing them to countries employing a "Zero COVID" strategy, such as Australia, Hong Kong, New Zealand, and Singapore, which have vastly different geographical and/or population sizes. Moreover, the total blackout of the number of deaths caused by COVID-19 is another major flaw in the study by the authors.

Plausible reasons for the initial success

In early March 2020, Gotabaya Rajapaksa, then-President of Sri Lanka, made a bold statement, saying, “Even during the civil war when we faced numerous deaths daily, we never shut down the country or economy.” However, by March 20, 2020, he had imposed an indefinite curfew, confidently asserting, “We will defeat the coronavirus pandemic just as we defeated terrorism.”[7] Despite Rajapaksa's defiant remarks, the government did take decisive action within the first month (March 10th–April 10th 2020), exempting the agriculture sector and export manufacturing from total lockdown beginning mid-April 2020.

Sri Lanka initially stood out as a success story in South Asia during the early stages of the pandemic in 2020.[8] However, this success wasn't merely luck or a reflection of a robust health system. Instead, it was largely attributed to the impending parliamentary elections. These elections, originally slated for April 25, 2020, became a significant factor in the government's response to the crisis. With a new Executive

President elected on November 16, 2019, and the dissolution of parliament on March 2, 2020, the timing of the pandemic's emergence and the subsequent actions taken by the government were intricately tied to political considerations.

The urgency to control the pandemic was heightened by the looming parliamentary elections. The new President, elected with 52% of the vote, aimed to secure his party's control over parliament as soon as possible. However, constitutional restrictions prevented the dissolution of parliament until within six months of its five-year term.

Although originally scheduled for April 25, 2020, the parliamentary elections were indefinitely postponed in late March 2020, much to the frustration of the ruling party. Eventually, they were rescheduled for June 20, 2020, and later pushed to August 5, 2020, when they finally took place.[9]

The government's swift response to lockdown measures was largely driven by the electoral imperative to minimise COVID-19-related casualties. Any delay or negligence in implementing these measures could have had dire electoral consequences. However, this aspect of the government's strategy has been totally overlooked by the original authors.

Despite claims of controversies surrounding data transparency and accessibility, particularly regarding COVID-19 death tolls (see page 7 of the article), the political motivations behind such actions have not been explicitly acknowledged. Pressure from businesses, particularly export and tourism sectors, to avoid prolonged lockdowns existed from the beginning but was balanced against electoral concerns.

After the August 5, 2020, parliamentary elections, the government became complacent about the pandemic's impact, leading to a decline in vigilance and responsiveness. This shift, coupled with a reluctance to conduct extensive testing (see pages 4-5), contributed to a surge in COVID-19 cases and deaths in Sri Lanka, particularly from October 2020 onwards. Thus, the removal of electoral and political pressures post-August 5, 2020, played a significant role in Sri Lanka's unfortunate distinction of

having the highest number of deaths per million population among South Asian countries during the pandemic's first three years.

Ethnoreligious stigmatisation and polarisation amidst COVID-19

The silence of the original authors on the ethnoreligious stigmatisation of COVID-19 in their recent work has left us perplexed. They seem to have overlooked or chosen NOT to address the issue of ethnoreligious minority groups being unjustly targeted as spreaders of the coronavirus. This disturbing trend has been perpetuated by various stakeholders including the government, military, and a powerful faction within the medical community.

For instance, back in March 2020, when the first COVID-19 cases emerged in densely populated areas of Colombo largely inhabited by Muslim and Tamil minorities (Grandpass and Bandaranaike Mawatha), the Sri Lankan authorities swiftly resorted to a policy of stigmatisation. Patients' privacy rights were blatantly disregarded as the state embarked on a campaign of naming and shaming. The armed forces, accompanied by government-aligned media personnel, conducted intrusive operations like disinfecting residents in public and broadcasting these actions without consent.[10]

Similarly, when a cluster emerged among evangelical Christians in Jaffna (Ariyalai), the response was marked by the same stigmatisation, particularly by state media. A Tamil pastor who had come from Switzerland to preach this congregation on March 15, 2020, had tested positive for COVID-19 on his return to Switzerland.[11] Subsequently, the military had rounded up several participants of the congregation and put them on forcible quarantine. These instances of ethnoreligious scapegoating were evidently orchestrated to rally support from the majority Sinhalese Buddhist population ahead of parliamentary elections.

Interestingly, when COVID-19 cases were detected within a naval camp in Welisara (in the outskirts of Colombo city) in April 2020[12], media access was restricted under the guise of protecting privacy—a stark departure from earlier practices.

Another contentious policy imposed by the Sri Lankan government in March 2020 mandated the immediate cremation of suspected COVID-19 victims, disregarding burial practices of Muslim and Christian communities.[13] Despite international pressure, this mandate was only rescinded in March 2021, after causing significant distress and fostering mistrust. This unscientific and arbitrary regulation imposed only in a handful of countries in the world (such as Argentina and Sri Lanka) did cause immense distress to Muslim and Christian communities in Sri Lanka, who bury their dead (as opposed to Buddhists and Hindus who cremate). This unscientific policy also led to underreporting of deaths caused by COVID-19, as a considerable number of Muslims refrained from reporting deaths in their family until religious rites/rituals were performed and the body buried to avoid forcible cremation by the authorities.[14]

While Rannan-Eliya, Ghaffoor, Amarasinghe, and colleagues acknowledge the slow response of health authorities to combat misinformation and stigmatisation, they curiously omit specific mention of responsible parties such as the Government Medical Officers' Association (GMOA), led by Dr. Anuruddha Padeniya at the time.[15] This raises questions about the authors' intentions regarding the medical profession's involvement.

The systemic stigmatisation of minority religious groups during a global health crisis not only violates medical ethics but also exacerbates societal divisions, especially in a country scarred by decades of civil war. Even professional bodies like the GMOA played a crucial role in enforcing discriminatory policies, further deepening societal rifts.

This targeted stigmatisation undoubtedly hindered testing and vaccination efforts among Sri Lanka's Muslim population, as highlighted by the authors (see page 12).

Implications of the mismanagement of COVID-19 in Sri Lanka

Since early 2022, there has been a significant interplay between the impact of COVID-19 on public health and the economy in Sri Lanka, culminating in an economic crisis and sovereign default in April of the same year. While efforts to curb the spread of the virus through Non-Pharmaceutical Interventions (NPIs) took a toll on the country's economy, underlying weaknesses in Sri Lanka's economic framework exacerbated the situation. As noted by the original authors, factors such as limited fiscal resources hindered effective responses to the pandemic.

This rebuttal argues that the mishandling of both the pandemic and the economy, particularly exacerbated by issues like ethnoreligious tensions and economic mismanagement following the election of a new President in October 2019, led to the unprecedented removal of the Executive President from power in July 2022, despite their recent electoral success. One criticism of the original authors is its failure to explicitly recognise this cause-and-effect relationship.

COVID-19 had far-reaching consequences beyond its epidemiological impact, influencing economic, social, and political dynamics worldwide. The removal of leaders like Donald Trump in the USA and Boris Johnson in the UK underscores the political ramifications of the pandemic, a trend similarly observed in Sri Lanka.
The main argument of this rebuttal is that the mismanagement of the responses to COVID-19 (especially ethnoreligious stigmatisation and polarisation) along with the mismanagement of the economy (which was long running, but intensified after the election of a new President in October 2019) resulted in the unprecedented peaceful ouster of the Executive President from power in July 2022 who was duly elected just two-and-half years ago with a comfortable majority. The major failure of the study by original authors is not to explicitly identify this cause and effect. Globally, COVID-19 was not just an epidemiological outbreak, it had profound economic, social, and political ramifications, which continues to date.[16]

Conclusion

The conclusion drawn from this rebuttal is that while the study by the original authors offers considerable contributions to the future management of pandemics in Sri Lanka, it fails to adequately address certain critical factors or events. This oversight and underreporting may have skewed the lessons that could be gleaned for the future.

References & Endnotes

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Those contentions by the President of Sri Lanka revealed his ignorance about the difference between a visible enemy (human-made disasters such as civil war) and an invisible enemy (coronavirus). Even natural disasters (such as floods, cyclones, hurricanes, tsunamis, drought, or famine) are predictable in advance due to technological advancements and are short in its duration, but not epidemics or pandemics. Moreover, while the impacts of natural- or human-made disasters are confined to certain geographical regions within countries or to certain countries of the world, epidemics affect many countries in a certain region/s of the world, and pandemics affect almost the entire world. In short, combating a virus is a different ball game altogether than a civil war, and therefore same or similar strategies such as asymmetrical warfare would not work. Similarly, as in the case of 'foot and mouth disease' in the UK in 2001 when over 6 million cattle, pigs & sheep were culled, millions of diseased or suspected to be diseased humans cannot be killed.

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