

Perspective

## Ground Realities of COVID-19 in Sri Lanka: A Public Health Experience on Fear, Stigma and the Importance of Improving Professional Skills Among Health Care Professionals

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Public health is the organized effort by the entire society to prevent disease, restore health if damaged, and to promote health of the general public. As a team of medical professionals involved in public health in different capacities, we wish to share the experience gained by us, in our endeavour to control COVID-19 whilst working with the general public, health professionals, and other officials from government and non-government organisations. We hope this knowledge will contribute to broaden the perception about public health among medical professionals, thus contributing to improving public health services in the country especially in managing disease outbreaks.

This concept note is written on the 66<sup>th</sup> day (17<sup>th</sup> May 2020) following the confirmation of the 1<sup>st</sup> local patient with COVID-19. Many in the general public and the Health Care Professionals (HCPs) appear to be happy about the current COVID-19 control status of the country, achieved through organised efforts of all stakeholders. However, we would like to highlight a few important factors which we identified as obstacles to the effectiveness of outbreak control measures. Among the many obstacles we encountered, stigma attached to the disease and gaps in professional skills related to risk assessment for COVID-19 were high on the list.

The stigma attached to COVID-19 resulted in an unacceptable level of fear among the general public as well as HCPs. Stigma has led to HCPs not trusting patient's histories and patients not revealing their histories. Unethical use of the media was one of the main reasons for the stigma associated with COVID-19. A large proportion of the general public did not

receive enough scientific information about the disease and its preventive measures through the media. Instead, they were overloaded with emotionally provocative information. Many media reports were delivered in a judgemental manner, and frequently the fault was attributed to individuals who got the disease whilst some patients were labelled as to have hidden pertinent facts or lied about their symptoms. Frequent telecasting of patients' family members being taken to quarantine centres also would have contributed to creation of stigma and fear. This may in-turn have led some patients to hide their histories.

This reluctance to disclose details lead some HCPs to have a similar perception about the patients. In our day-to-day experience, it was not uncommon to observe that HCPs assumed patients would deliberately hide symptoms, contact history or other relevant information. Establishing the presence of symptoms in COVID-19 confirmed patients became an important task for the public health staff in order to assess the risk of disease transmission in the background of uncertainty associated with asymptomatic vs pre-symptomatic transmission. As a part of preparedness, we as a team were able to train almost all public health staff members and most of the staff in curative settings on COVID-19 outbreak control in the district. During our field investigations, we encouraged public health staff to use some techniques frequently used in counselling, for history taking. Once, during contact tracing in the field by a Public Health Inspector (PHI), careful attention to the history did not reveal the patient to have had any symptoms. However, later a cough syrup was found in

the house, and on subsequent inquiry a history of a cough was revealed. Sometimes, talking to neighbours gave more clues to the patient having symptoms. For example, a young person requesting a glass of warm water from a relative on a sunny day became a clue for further exploration of respiratory symptoms. Hiding symptoms was mainly due the fear of being blamed for deliberately transmitting the infection to others or fear of their loved ones being taken to quarantine centres.

Tracing close contacts of the patient during the symptomatic period is a priority for quarantine and testing procedures because of the relatively high probability of disease transmission during the symptomatic period compared to the asymptomatic or pre-symptomatic periods. We also observed that some COVID-19 suspected patients could not provide adequate information during history taking and the situation was mis-interpreted as deliberate withholding of information, whereas the exact reason was the language barrier which was not perceived by the HCPs. A skilled professional approach to history taking puts patients at ease. We found that after spending a few extra minutes to make patients and contacts comfortable and reassuring them that we were there to help, they tended to divulge their histories in full.

Fear and stigma interfere with health seeking behaviour of people. This leads to patients not seeking treatment or hiding their details. The portrayal on television of patients infected with COVID-19 as criminals has resulted in major damage to both public health control measures and hospital procedures. Enhancing professional skills of HCPs and training them to spend time in taking histories is essential to ensure that all information required to implement control measure are obtained from patients.

We feel that many of us HCPs, need to go back to basics, to re-train ourselves especially in communication skills such as respecting others irrespective of their differences, building rapport, empathy, active listening, and accepting what patients/clients say (until the facts are verified), etc. We emphasise that taking histories in the field to assess the risk of COVID-19, should be done by trained HCPs, and that all relevant field health staff such as Medical officers of health (MOH), Public health nursing sisters (PHNS), Public health nursing officers (PHNO), PHIs and Public health midwives (PHM) should be trained in this regard.

In our training programmes conducted for public health staff we frequently highlighted the fact that as HCPs, we should not divulge any personal information to the media. We actively discouraged the presence of the media during contact tracing, specimen collection and quarantine procedures in the community. Furthermore, we discouraged taking photographs without consent and exhibiting these on social media. Initially this approach was not popular mainly because the media and social media frequently practised the opposite. Our experience is that, continuous efforts to train HCPs on professional handling of information and communication with people, with hands on training at the community level is of use to prevent stigma while improving professional conduct.

Ensuring patient confidentiality is mandatory when history taking is done by any HCPs. Liaising with other stake holders such as the police, regional administrators and the military should be done in a way that this confidentiality is not breached. It is the duty of HCPs to ensure that patients and their contacts are treated with dignity and that the highest ethical standards are maintained. Public health teams should assess any risk exposure in detail and be confident about the data gathered prior to communicating with other authorities involved. We found that this approach helped to build the confidence of the people about HCPs and encouraged them to adhere to disease prevention practices during quarantine processes.

Assessing the risk of getting COVID-19 in people who present with respiratory symptoms, pregnant women, and contacts of confirmed COVID-19 confirmed patients etc, require an updated, broad understanding on interim guidelines and case definitions. This became a challenge in a scenario where case definitions and guidelines were updated in quick succession. HCPs had to learn ways to gather and disseminate knowledge on the frequently updated guidelines.

Epidemiology (frequency and distribution of cases) of COVID-19 is very dynamic. In this background HCPs are expected to be very up to date about the disease situation in the country and their locality. They must be aware of the evidence-based preparedness and response practices in the institutional and community settings. However, the Sri Lankan health system lacks a proper process to update health care professionals during such dynamic situations. Updating HCPs, at provincial, district and divisional levels were mostly dependent on a few self-

motivated professionals rather than through a process. A lack of understanding about the disease dynamics and guidelines led to panic among HCPs. Panic in turn, hindered proper risk assessment and risk communication resulting in unnecessary testing, irrational use of personal protective equipment (PPE), unnecessary travel restrictions (local lock downs) and problems related to handling dead bodies etc. Sri Lanka does not have a mandatory continuous professional development (CPD) requirement for any health care professional category. This pandemic illustrated the need for such a programme for all categories of HCPs. Had such a system been in place, we could have had ways and means to train people from December 2019.

COVID-19 control activities spanned throughout various disciplines in addition to healthcare. The panic created during the initial period meant that these other categories also had to be re-trained on how to adjust their work during the pandemic, without contributing to further panic while adequate precautions were being taken. We conducted awareness programmes to many stakeholders including police, district officers, educational officers, complementary and traditional medical practitioners and owners of funeral parlours.

According to the technical guidance given by World Health Organization, the use of non-scientific methods on disease prevention such as the use of disinfectant chambers, direct spraying on humans, spraying on roads and open public places was not advised. However, these practices rapidly gained ground in local communities as these created an atmosphere of perceived protection. This has created an undue pressure on public health staff because local politicians and some government officials demanded the same practice that were frequently shown by the media. The amount of chemicals wasted and subsequently added to the environment may contribute to environmental health problems in the future. As there were no guidelines available during the initial few weeks, it was a difficult task to resist such request, coming from various stake holders, from health care workers themselves to politicians.

Another new challenge for us and other public health officers was to acquire the skill of specimen collection from quarantine centres and the

community. This procedure always drew much interest from the general public and the media, adding to the challenge. Further, collecting a large number of samples from different places in the community and from quarantine centres, while ensuring that the quality of samples was not compromised, and PPE use was minimised, was a challenge. From in-house preparation of triple packs for sample transportation to training staff on donning and doffing of PPE in the community were all skills that we had to learn rapidly. All this work needed contributions by all categories of public health staff. This outbreak showed us that every member of the public health team needed to work as one, and learn from each other, for successful execution of a public health intervention.

We noted that awareness among HCPs about the disease was mostly dependent on the information gleaned through social media and television news rather than through scientific communications. This was a challenge and myth busting required additional effort. Knowledge on the evidence hierarchy and its applicability for scientific decision making was lacking. Reorienting the health system to prepare and practice evidence-based epidemiological interventions in any outbreak situation is a timely need of the country.

If lessons learnt from this outbreak are used in a productive manner, the Sri Lankan public health system would be better prepared to face outbreaks of emerging infections in the future. We feel that practically oriented training sessions on medical communication, risk assessment, risk communication and risk management during outbreaks and pandemics should be done for HCPs. Medical ethics, ethics of social media use, information gathering, and fact-checking should be included in CPD programmes for all categories of HCPs. Further, these should also be included in their basic, post basic and postgraduate training programmes.