

3rd Independent Expert Group Meeting
Brainstorming on streamlining the vaccination program in Sri Lanka
Convened by WHO Sri Lanka, 28 May 2021

PREAMBLE

The most important intervention to reduce deaths and to enable the health services to continue functioning is to vaccinate healthcare workers and vulnerable populations against COVID-19. This is because the highest deaths are recorded among those having other diseases and/or above 60 years of age; and we need the contributions by each and every healthcare worker to overcome this crisis. This can avoid the need for repeated “lockdowns” in the future. The current vaccination strategy apparently focused primarily on blocking transmission seems injudicious and is scientifically flawed.

KEY POINTS

1. Have a national strategy to identify priority groups, e.g. healthcare workers, >60 years group, those having identified diseases (such as diabetes, heart disease, renal failure, liver failure, asthma, stroke or taking immunosuppressive drugs) . This should be based on mortality data which will be periodically publicized. Then key economic sectors could also be included.
2. Accelerate the administration of vaccinations. The process could include:
 - a national mobilization programme to rapidly administer the available stocks*
 - improvements in efficiency and speed of vaccination roll-out at the facility level(e.g. methods to select patients, issue appointments, floor plans, notices and posters to direct people in each of the vaccination facilities).
3. Have regular communications through the media by a high level and credible person with expert knowledge at a predefined time, daily. This is essential to keep the public informed, stabilize the system and give confidence to the public on the vaccination programme.
4. Organize an effective social support programme that involves the state sector, civil society, philanthropists, and private sector.

*We could also use medical students who have done clinicals: 4th year, 5th year and those who have finished the exams. This will amount to about 6000 island-wide. At least some of the centers could run 24/7 hours.

The recommendations from the initial two brainstorming meetings among health experts were well received and widely shared. Thus, the expert group, convened by WHO Sri Lanka, met for the third time to review the situation and offer considered insights regarding COVID-19 vaccination in Sri Lanka.

The key observations and recommendations indicated below represent the consensus achieved by the national experts at the meeting and do not necessarily reflect those of WHO. Global WHO guidance is available if needed.

Vaccines are a global public good: everyone benefits when anyone is vaccinated. There will be no true health or economic recovery unless all parts of the country and the world reduce COVID-19

morbidity and mortality. Sri Lanka's recent strategy on prolonged restrictions on travel and assembly aim to reduce transmission, prevent deaths and unburden the health system. This will buy some time for the vaccine campaign to be progressively rolled out over the next few months to gradually get control over the epidemic.

The scientific basis of COVID-19 vaccination is prevention of severe disease and death, thereby avoiding the capacity of the health care system being exceeded. Therefore, the national vaccination plan should be geared to achieve these objectives. The national vaccine deployment plan (NVDP) was not developed only for COVAX but as an overall plan for the country.

Targeted and systematic immunization of vulnerable populations against COVID-19 will be the most important intervention to reduce deaths and severe disease over the next 6 -8 weeks in Sri Lanka, and allow the health care system to function effectively.

Trying to suppress transmission by targeting vaccines to small areas with clusters / high number of cases is unlikely to work because:

- we are deploying vaccines long after the peak period of transmission, given detection and testing delays;
- **Sinopharm vaccine, which seems to be more accessible at present, has minimal effect until a few weeks after the 2nd dose, i.e. over 6 weeks after vaccination (see point below).**
- the sero-prevalence in such high transmission areas is already increasing and vaccine is not being deployed to maximal effect (you are probably vaccinating a good proportion of people who are already infected and immune and doing it too late to have an additional impact on transmission).

Recommendations:

1. Review the national vaccination plan, particularly the chapters on prioritization and vaccination delivery strategies, taking into consideration the strained and unpredictable global supply chain.

1.1. Commit to vaccinating priority groups first. With limited supply chains, doses must be disseminated deliberately and equitably. WHO's Strategic Advisory Group of Experts on Immunization (SAGE) recommends prioritizing frontline workers, older people, and people with comorbidities for the following reasons:

- Protecting high-risk frontline workers has three primary benefits: (i) protects the individual, (ii) ensures the continuation of essential non-COVID-19 services, and (iii) prevents onward transmission to vulnerable people. Frontline workers should include groups like Grama Nilhadari officers and other public officials.
- Vaccinating older people and people with comorbidities will have the greatest public health impact by reducing deaths. This global trend is reflected in national mortality data, which shows that 73% of people who have died from COVID-19 in Sri Lanka were more than 60 years old, while 25% were between 30 - 60 years old. It will also reduce the number of people who experience severe disease, which will lessen the burden on the healthcare system, especially in terms of intensive care units.

We will likely experience more waves in this pandemic for several reasons, such as the clustering of asymptomatic cases, the introduction of new variants, etc. Therefore, people who have not been immunized are at high risk of getting infected, and vulnerable groups such as older people and people with comorbidities are more likely to die or require intensive care.

- 1.2. Collate demographically-disaggregated mortality and morbidity data at the national level. The MOH Vaccine Tracker, based on DHIS 2 platform should be utilized in all vaccination sites for data collection and analysis and ensure that vaccines have the intended impact in reducing deaths and disability.
- 1.3. Given known delays in the supply chain and the possibility that unplanned disruptions may occur from every consignment of vaccines received, the second dose of vaccines should be reserved or confirmed before the rest is distributed.

Sinopharm, unlike the AstraZeneca vaccine or Sputnik, does not provide significant protection after the first dose. Therefore, when the Sinopharm vaccine is rolled out, it should be done with the assurance that the 2nd dose is available.

- 1.4. Considering the high level of uncertainty associated with the pandemic, it may not be possible to implement the plan with complete compliance. Therefore, the plan should be flexible enough to allow for changes while adhering to the basic principle of prioritizing vulnerable groups to reduce morbidity and mortality.
- 1.5. Review the NVDP immediately; a sub-group from Advisory Committee on Communicable Diseases should be appointed to do this. Mechanisms should be in place to minimize undue external influence. The Epidemiology Unit should communicate the plan to decision-makers and share information on prioritization with the public.

2. A clear and transparent communication strategy is essential

- 2.1. Develop a strong communication strategy that places the public at the center and incorporates the following:
 - Regular and transparent updates and explanations of the current situation, supported by data.
 - A rationale for decisions taken, especially on vaccination plans, including realistic estimates of which supplies will be available and the best way to utilise them considering available scientific evidence.
 - Justify and explain changes to control strategies based on evolving scientific evidence or local data.
 - An authorized and credible spokesperson who regularly provides updates, including the actions being taken to address current issues, potential outcomes, and the rationale for these decisions. The spokesperson may be a high-level administrator or a political leader. Updates should occur daily at a predefined time. This is essential to stabilize the system and raise the public's confidence in the vaccination programme.
 - Establish a designated hotline to provide information on COVID-19 vaccination.

- Engage the media on their role and responsibilities. Encourage a self-assessment of their professional conduct during the pandemic and develop a special code of conduct for emergencies like the pandemic. Responsible reporting is key to controlling the pandemic.
- 2.2. Do not announce a change in policy without having a communication package or an official communique ready. When a new policy or guideline is announced, it should be accompanied by an official written statement that transparently explains what the change is, why it was made (the rationale), what it will achieve (the intended impact), and how it will affect individuals.
 - 2.3. Emphasize the fact that public health and social measures must continue even after vaccination. So far, currently available vaccines appear to be efficacious against developing severe disease, but we do not know their impact on preventing transmission. Therefore, everyone who gets the vaccine must continue to take necessary precautions to protect everyone in the community. We need to stay the course and continue practicing physical distancing, wearing masks, practicing hand hygiene, increasing ventilation, avoiding crowds, disinfecting surfaces, and staying home if asked.

3. Promote a more efficient and systematic process to accelerate vaccination

- 3.1. Improve the efficiency and speed of the vaccination roll-out at the facility level. Identify groups to be vaccinated, give appointments, and set up an organized floor plan, including notices and posters to direct people.
- 3.2. Organize a national mobilization programme to administer the available vaccine stocks rapidly. The programme can be supported by medical students who have done their clinicals (4th and 5th year students and those who have finished their exams), about 6,000 people islandwide, allowing some centers to operate continuously (24/7). Support of the GPs in the area also can be solicited.
- 3.3. Establish a streamlined and simple appointment system to implement islandwide. This will reduce confusion and decrease inappropriate vaccination (e.g., people who already received a dose of another vaccine).
- 3.4. Develop and enforce protocols to follow-up with people after vaccination; to support the monitoring of adverse events and ensure everyone receives both doses as needed.
- 3.5. Build on established local vaccination programmes to properly set up vaccination sites that operate efficiently and meet realistic targets. These can be initiated at nearby hospitals and Medical Officers of Health sites where quality can be assured, including Ayurveda hospitals and other Health and Government institutions.

4. Continue and intensify efforts to obtain vaccine doses

- 4.1. A clear statement on the second dose of AstraZeneca should be provided to the public as soon as possible.
- 4.2. Explore all possible avenues to obtain the additional 600,000 doses of the AstraZeneca vaccine for the second dose.

If additional doses of the AstraZeneca are not forthcoming, we may, as a last resort, have to consider another type of vaccine for those who received the first dose; WHEN/IF solid evidence to support this becomes available. However, currently, [WHO recommends](#) countries wait for more evidence before introducing a mix and match schedule. Sri Lanka may consider a rapid small clinical trial of its own to inform policy for the country.

- 4.3. Many of the vaccines have a short life span. By the time they reach Sri Lanka, the expiry may be within the next two months. Accordingly, if we receive large batches of vaccines, we must ensure country preparedness for roll-out to avoid wastage.

5. Community education, engagement, and empowerment

The Ministry of Health should engage and empower communities by involving them in the vaccination campaign. Community-based organizations and volunteers can play a significant role in raising awareness and mobilizing communities, leading to positive behavior change.

Conclusion

Given that vaccines are in short supply and likely to be for the foreseeable future, prioritizing target groups with clarity is of utmost importance. A vaccine roll-out plan based on prioritization criteria, accompanied by a sound communication strategy, is essential, deploying standard, district, and community level support systems, as was done in previous successful vaccination programs in Sri Lanka.

A streamlined vaccination process is crucial to controlling this situation and reducing preventable deaths as part of the overall COVID-19 control strategy. We strongly recommend the Government to strictly follow the NDVP and transparently share relevant information with the public as early as possible. The Ministry of Health should support the 352 Medical Officers of Health areas to conduct the vaccination campaign and request all other stakeholders to facilitate the MOH's plans without interference.

Vaccination is essentially a public health matter; the decision-making and implementation of the NVDP should rest with the country's public health system. Decisions should be based on sound scientific and epidemiological principles, as recommended by the Advisory Committee on Communicable Diseases, chaired by the Director General of Health Services and supported by all other stakeholders.

Annex 1 -List of Experts and Participants – 28 May 2021

Name	Designation/Organization
1. Dr. Palitha Abeykoon (Facilitator)	WHO Consultant and WHO Director-General's Special Envoy For COVID-19 Preparedness and Response for SEAR
2. Prof. Malik Peiris	Chair/Professor – School of Public Health, The University of Hong Kong, Faculty of Medicine, Hong Kong
3. Prof. Kamini Mendis	Professor Emeritus, University of Colombo; Public Health Expert and former WHO Malaria expert
4. Prof. Asita de Silva	Senior Professor of Pharmacology, University of Kelaniya and President, Sri Lanka Association of Clinical Pharmacology & Therapeutics
5. Prof. Indika Karunathilake	Prof. in Medical Education, Department of Medical Education, Faculty of Medicine and Former President – SLMA
6. Dr. Vinya Ariyaratne	Public Health Specialist , President- Sarvodaya (CSO)
7. Dr Ananda Wijewickrama	Consultant Physician and Past President of the College of Physicians
8. Prof. Manuj Weerasinghe	Prof in Community Medicine, Faculty of Medicine, Univ of Colombo
9. Dr. Lakkumar Fernando	Consultant Pediatrician and President, Association of Medical Specialists
10. Dr. Nihal Abeysinghe	Consultant in Community Medicine and Former Chief Epidemiologist in Sri Lanka and President of the College of Community Physicians in Sri Lanka
11. Prof. Saroj Jayasinghe	Consultant Physician and Prof. of Medicine, University of Colombo
12. Dr. Padma Gunaratne	Consultant Neuro Physician and President, Sri Lanka Medical Association
13. Prof Lalini Rajapaksa	Emeritus Professor of Community Medicine, University of Colombo
14. Dr Rajiva de Silva	Consultant Immunologist and Head of the Department of Immunology-MRI
15. Prof Athula Sumathipala	Professor of Psychiatry, Keele University, UK.; Emeritus Professor of Global Mental Health, Kings College London, and Chair, NIFS

WHO

1. Dr Alaka Singh	WHO Representative, WHO Sri Lanka
2. Dr Risintha Premaratne	WHO SEARO Technical Officer
3. Dr Paba Palihawadana	WHO Indonesia Medical Officer
4. Dr Olivia Nieveras	Public Health Administrator, WHO Sri Lanka
5. Dr Sapumal Dhanapala	WHO Sri Lanka
6. Dr Padmal de Silva	WHO Sri Lanka
7. Prof. Nalika Gunawardena	WHO Sri Lanka
8. Dr Virginie Mallawarchi	WHO Sri Lanka
9. Mr T Suveendran	WHO Sri Lanka
10. Dr Preshila Samaraweera	WHO Sri Lanka
11. Ms Sahani Chandraratna	WHO Sri Lanka
12. Dr Mizaya Cader	WHO Sri Lanka
13. Ms Sadhani Rajapakse	WHO Sri Lanka
14. Dr Shreenika de Silva	WHO Sri Lanka
15. Dr Roshan Sampath	WHO Sri Lanka
16. Dr Priyanga Senanayaka	WHO Sri Lanka
17. Dr Anjalee de Silva	WHO Sri Lanka