https://doi.org/10.22502/jlmc.v8i1.347

Perspective

COVID-19 in the West Indies: Trinidad and Tobago Experience

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Trinidad and Tobago (T+T) is a small twin-island state in the Caribbean, eight miles off the coast of Venezuela. It has an area of approximately 5431 square kilometres and population of 1.4 million. At the present time, there are 116 corona virus disease (COVID-19) cases and eight deaths, with no new cases or deaths for the last 21 days (May 17, 2020).

Its COVID-19 story is one of the prompts, with early control and great success. There has been no such instance where the health services were stretched or unable to cope. Even before the first case was identified, the T+T Government restricted entry to travellers from China, Japan, Singapore, South Korea and several European countries.

The first case of COVID-19 identified in T+T was on March 12, 2020. The patient had returned from Switzerland. The next day, a second positive case was a person who had returned from USA.

On March 13, 2020, T+T started progressive lockdown. Cruise ships were not allowed to dock, schools and universities were closed and people were advised not to congregate. By March 16, most businesses were closed except for pharmacies and supermarkets. Food outlets were allowed to operate but no in-house dining was permitted - one had to order, pick-up and take away. Even these were completely closed 24 days after diagnosis of the first case.

Wearing of face masks was strongly and repeatedly advised by the Chief Medical Officer and Minister of Health on their twice-daily public briefings on national television.

On March 22, churches, mosques and temples stopped congregations. Hindus cancelled Phagwa, Ram Navami and Hanuman Jayanti celebrations. Just 10 days after the first case, all ports were closed. The government stuck fairly rigid to these restrictions despite numerous protests and appeals from citizens stranded abroad. Very few exceptions were made. In one case, 68 citizens, returning from a cruise were stranded on *Gaudeloupe* island, just after the borders were closed. After much protest and appeals to the concerned authorities, they were allowed on the condition of strict institutional quarantine for 14 days and COVID-19 testing as deemed necessary. This turned out to have magical beneficial consequences as 49 of them turned to be COVID-19 positive. Had they entered the country and gone home, even on 'voluntary home isolation', the outbreak could have been massive and uncontrollable.

Although no cases were identified locally, the government had already started making preparations for the epidemic in January 2020. By mid-February, the Regional Laboratory (CARPHA), based in T+T was equipped to do PCR testing.

Sites were identified, completely separate from the present active hospitals, to quarantine and manage COVID-19 cases. Thus, a parallel 'new' system was set up where neither the beds, wards, institutions nor health care personnel dedicated to COVID-19 patients, mixed with the usual hospital population. This was possible by utilizing two existing unused hospitals, modifying two sporting

Submitted: 19 May, 2020
Accepted: 25 May, 2020
Published: 27 May, 2020

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How to cite this article:
Naraynsingh V, Harnanan D, Maharaj R, Naraynsingh R. COVID-19 in the West Indies: Trinidad and Tobago Experience. Journal of Lumbini Medical College. 2020;8(1):2pages. DOI: https://doi.org/10.22502/jlmc.v8i1.347 Epub: 2020 May 27.

complexes, an unoccupied University campus and a Church camp. This 'new' parallel system provided about 500 beds, 24 ICU beds, 24 ventilators and also quarantine facilities for those who were positive; these were not allowed home until they had a 14-day quarantine and two negative tests. Patients who went to the general hospitals with COVID-19 like symptoms were screened in a tent outside the main building and transferred to one of the COVID-19 centres if tested positive.

All the elective surgeries and non-emergency clinic services were halted from March 13. This served the important purposes of minimizing human traffic as well as keeping hospital facilities and staff as additional available resource if the designated centres were overwhelmed; fortunately, this never happened.

The total number of cases remains at 116 with eight deaths. At no time was any hospital or quarantine site saturated. Although provision existed for 24 ICU patients with ventilators, the maximum number on any day was three for ICU cases and 70 for non-critical cases.

Now that we are resuming elective surgeries from 18th May, there is much debate about the 'safest' way to achieve this. The usual hand sanitizing, face masks, social distancing, minimal visitors are already in place.

The more difficult decisions are:

a. Should all patients be tested pre-operatively?

b. Should health care workers, especially operating theatre staff be tested, and how often?

c. How elaborate should the personal protective equipment (PPE) be for these surgeries?

d. Should high risk procedures involving the airway, nose, eyes be introduced later?

e. Should laparoscopy, in which there may be aerosolization of body fluids, be postponed?

These are important questions since the operating theatre is a high-risk environment as patients often cough, splutter and aerosolise their respiratory tract secretions in a relatively closed space with many staff present.

The other high-risk decision, in our protective island setting, is reopening the borders to air and sea travel.

The success of our measures, thus far, is due mainly to early lockdown of entry ports, strict institutional isolation (not allowing 'home quarantine'), no community gatherings, early closure of businesses, no prayer congregations, twice daily national briefings and instructions as well as the utilization of two parallel health care staff and institutions.

Our testing has been quite inadequate - about 2,000 people tested in a population of 1.4 million. This demonstrates that other measures could be highly effective even with minimal, focused testing.

Conflict of interest: Authors declare that no competing interest exists.

Funding: No funds were available for the study.