Document of

**The World Bank**

**FOR OFFICIAL USE ONLY**

Report No: PAD4691

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT PAPER

ON A

PROPOSED RESTRUCTURING AND ADDITIONAL LOAN
IN THE AMOUNT OF US$100 MILLION

TO THE

DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

FOR A

# SRI LANKA COVID-19 EMERGENCY RESPONSE AND HEALTH SYSTEMS PREPAREDNESS PROJECT

SEPTEMBER 24, 2021

UNDER THE COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PROGRAM (SPRP),
USING THE MULTIPHASE PROGRAMMATIC APPROACH (MPA)

WITH A FINANCING ENVELOPE OF
UP TO US$ 6 BILLION APPROVED BY THE BOARD ON APRIL 2, 2020 AND
UP TO US$ 12 BILLION ADDITIONAL FINANCNG APPROVED BY THE BOARD
ON OCTOBER 13, 2020

Health, Nutrition & Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective August 31, 2021)

| | | |
|---|---|---|
| Currency Unit | = | LKR |
| LKR 210.00 | = | US$1 |

FISCAL YEAR
January 1 - December 31

| | |
|---|---|
| Regional Vice President: | Hartwig Schafer |
| Country Director: | Faris H. Hadad-Zervos |
| Regional Director: | Lynne D. Sherburne-Benz |
| Practice Manager: | Trina S. Haque |
| Task Team Leader(s): | Deepika Eranjanie Attygalle, Srinivas Varadan |

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ADB | Asian Development Bank |
| ADM | Accountability and Decision Making |
| AEFI | Adverse Event Following Immunization |
| AESI | Adverse Event of Special Interest |
| AF | Additional Financing |
| AMC | Advanced Market Commitment |
| APA | Alternate Procurement Arrangements |
| BCC | Behavior Change Communication |
| CBSL | Central Bank of Sri Lanka |
| CCE | Cold Chain Equipment |
| CERC | Contingent Emergency Response Component |
| CKD | Chronic Kidney Disease |
| COVAX | COVID-19 Vaccines Global Access |
| COVID-19 | Coronavirus Disease 2019 |
| CPF | Country Partnership Framework |
| CSIAP | Climate Smart Irrigated Agriculture Project |
| CSO | Civil Society Organization |
| DA | Designated Account |
| DP | Development Partner |
| DDG | Deputy Director General |
| DGHS | Director General of Health Services |
| DHIS2 | District Health Information Software 2 |
| DP | Development Partner |
| DPRU | Disaster Preparedness and Response Unit |
| DV | Domestic Violence |
| E&S | Environment and Social |
| EAP | Emergency Action Plan |
| eNIP | Electronic National Immunization Programme |
| EOHS | Environmental and Occupational Health and Safety |
| EPI | Expanded Program on Immunization |
| EPL | Environmental Protection License |
| ERD | Department of External Resources |
| ERHSP | COVID-19 Emergency Response and Health Systems Preparedness Project |
| ESCP | Environmental and Social Commitment Plan |
| ESF | Environmental and Social Framework |
| ESMF | Environmental and Social Management Framework |
| ESRS | Environmental and Social Review Summary |
| ESS | Environmental and Social Standard |
| ESSA | Environmental and Social Standards Advisor |
| EUL | Emergency Use Listing Procedure |
| FFCs | Friends of Facilities Committees |
| FI | Financial Intermediaries |
| FM | Financial Management |
| FTCF | Fast Track COVID-19 Facility |
| FY | Fiscal Year |
| GAVI | Global Alliance for Vaccines and Immunizations |
| GBV | Gender-Based Violence |
| GDP | Gross Domestic Product |
| GEM | General Education Modernization Project |

| | |
|---|---|
| GHG | Greenhouse Gas |
| GoSL | Government of Sri Lanka |
| Govt. | Government |
| GRM | Grievance Redress Mechanism |
| GRS | Grievance Redress Service |
| HCW | Health Care Worker |
| HCWMP | Health Care Waste Management Plan |
| HDU | High-Dependency Unit |
| HEIS | Hands-on Enhanced Implementation Support |
| HMIS | Health Management Information System |
| HNP | Health, Nutrition, and Population |
| HPB | Health Promotion Bureau |
| HSAHN | Health Nutrition and Population South Asia Region 1 |
| IBRD | International Bank for Reconstruction and Development |
| ICT | Information and Communications Technology |
| ICU | Intensive Care Unit |
| IDA | International Development Association |
| IDHs | Infectious Disease Hospitals |
| IEC | Information, Education and Communication |
| IFC | International Finance Corporation |
| IP | Implementation Progress |
| IPF | Investment Project Financing |
| ISR | Implementation Status and Results Report |
| IUFR | Interim Unaudited Financial Report |
| IVR | Interactive Voice Response |
| LDSP | Local Development Support Project |
| LKR | Sri Lanka Rupee |
| LMP | Labor Management Procedures |
| M&E | Monitoring and Evaluation |
| MLM | Middle Level Managers |
| MoH | Ministry of Health |
| MOH | Medical Officers of Health |
| MoU | Memorandum of Understanding |
| MPA | Multiphase Programmatic Approach |
| MRI | Medical Research Institute |
| MSI | Management and Science Institute |
| NACCD | National Advisory Committee on Communicable Diseases |
| NCC | National Coordination Committee |
| NCD | Non-Communicable Disease |
| NCPA | National Child Protection Authority |
| NDVP | National Deployment and Vaccination Plan for COVID-19 |
| NIID | National Institute of Infectious Diseases |
| NIP | National Immunization Programme |
| NITAG | National Immunization Technical Advisory Groups |
| NMRA | National Medicines Regulatory Authority |
| OECD | Organization for Economic Co-operation and Development |
| OHS | Occupational Health and Safety |
| OP | Operations Policy |
| PAD | Project Appraisal Document |
| PBCs | Performance-Based Conditions |
| PCR | Polymerase Chain Reaction |
| PDO | Project Development Objective |
| PEF | Pandemic Emergency Financing Facility |

| | |
|---|---|
| PHS | Public Health Services |
| PIE | Post Introduction Evaluation |
| PMU | Project Management Unit |
| PPE | Personal Protective Equipment |
| PPP | Purchasing Power Parity |
| PPR | Post Procurement Review |
| PPSD | Project Procurement Strategy for Development |
| PQ | Prequalification |
| PSSP | Primary Health Care Systems Strengthening Project |
| RDHS | Regional Director of Health Services |
| RF | Retroactive financing |
| RFB | Request for Bid |
| RFQ | Request for Quotation |
| SACSL | Sri Lanka Country Office |
| SEA | Sexual Exploitation and Abuse |
| SEP | Stakeholder Engagement Plan |
| SH | Sexual Harassment |
| SII | Serum Institute of India |
| SMoPCLGA | State Ministry of Provincial Councils and Local Government Affairs |
| SOP | Series of Projects |
| SPC | State Pharmaceuticals Corporation of Sri Lanka |
| SPRP | Strategic Preparedness and Response Program (also known as Global COVID-19 MPA) |
| STEP | Systematic Tracking of Exchanges in Procurement |
| SWL | Scheduled Waste License |
| UCC | Ultra-Cold Chain |
| ULT | Ultra-Low Temperature |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| UNOPS | United Nations Office for Project Services |
| VAC | Vaccine Approval Criteria |
| VIRAT | Vaccine Introduction Readiness Assessment |
| VRAF | Vaccine Readiness Assessment Framework |
| WB | World Bank |
| WBG | World Bank Group |
| WHO | World Health Organization |

**Sri Lanka**

**Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project**

**TABLE OF CONTENTS**


**I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING ..... 7**

A. Introduction ..... 7

B. Consistency with the Country Partnership Framework (CPF) ..... 8

C. Project Design and Scope ..... 8

D. Project Performance ..... 9

E. Rationale for Additional Financing ..... 10

**II. DESCRIPTION OF ADDITIONAL FINANCING ..... 21**

A. Proposed Changes ..... 21

B. Sustainability ..... 25

**III. KEY RISKS ..... 25**

**IV. APPRAISAL SUMMARY ..... 28**

A. Technical, Economic and Financial Analysis ..... 28

B. Financial Management ..... 28

C. Procurement ..... 30

D. Legal Operational Policies ..... 32

E. Environmental and Social ..... 32

F. Gender ..... 34

G. Climate Vulnerability and Resilience ..... 35

**V. WORLD BANK GRIEVANCE REDRESS ..... 35**

**VI SUMMARY TABLE OF CHANGES ..... 36**

**VII DETAILED CHANGE(S) ..... 37**

**VIII. RESULTS FRAMEWORK AND MONITORING ..... 40**

**ANNEX 1: SUMMARY TABLE ON VACCINE DEVELOPMENT AND APPROVAL STATUS ..... 48**

**AS OF SEPTEMBER 15, 2021 ..... 48**

**ANNEX 2: LATEST COVID-19 SITUATION IN THE COUNTRY ..... 49**

**ANNEX 3: SUMMARY OF THE PARENT PROJECT COMPONENTS ..... 51**

**LIST OF TABLES**

**Table 1: Summary of Vaccination Readiness Findings from the VIRAT/VRAF 2.0 Assessment.....12**

**Table 2: National Vaccine Coverage and Acquisition Plan .....19**

**Table 3: Priority Groups for Vaccination.....22**

**Table 4: Project Cost and Financing .....23**

**Table 5: Summary of COVID-19 Vaccine Sourcing and Bank Financing.....24**

## BASIC INFORMATION – PARENT (Sri Lanka COVID-19 Emergency Response and Health Systems Preparedness Project - P173867)

| Country | Product Line | Team Leader(s) | | |
|---|---|---|---|---|
| Sri Lanka | IBRD/IDA | Deepika Eranjanie Attygalle | | |
| Project ID | Financing Instrument | Resp CC | Req CC | Practice Area (Lead) |
| P173867 | Investment Project Financing | HSAHN (9321) | SACSL (7030) | Health, Nutrition & Population |

Implementing Agency: Ministry of Health, State Ministry of Samurdhi, Household Economy, Micro Finance, Self-Employment, Business Development,, Ministry of Finance

| Is this a regionally tagged project? |
|---|
| No |

| Bank/IFC Collaboration |
|---|
| No |

| Approval Date | Closing Date | Expected Guarantee Expiration Date | Environmental and Social Risk Classification |
|---|---|---|---|
| 02-Apr-2020 | 31-Dec-2023 | | Substantial |

### Financing & Implementation Modalities

| | |
|---|---|
| [✓] Multiphase Programmatic Approach [MPA] | [✓] Contingent Emergency Response Component (CERC) |
| [ ] Series of Projects (SOP) | [ ] Fragile State(s) |
| [ ] Performance-Based Conditions (PBCs) | [ ] Small State(s) |
| [ ] Financial Intermediaries (FI) | [ ] Fragile within a Non-fragile Country |
| [ ] Project-Based Guarantee | [ ] Conflict |
| [ ] Deferred Drawdown | [✓] Responding to Natural or Man-made disaster |
| [ ] Alternate Procurement Arrangements (APA) | [ ] Hands-on Expanded Implementation Support (HEIS) |

## Development Objective(s)

### MPA Program Development Objective (PrDO)

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

### Project Development Objectives (Phase 096)

To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Sri Lanka

### Ratings (from Parent ISR)

| | Implementation | | | Latest ISR |
|---|---|---|---|---|
| | 25-Apr-2020 | 11-Dec-2020 | 12-Aug-2021 | 01-Sep-2021 |
| Progress towards achievement of PDO | S | S | S | S |
| Overall Implementation Progress (IP) | S | MS | MS | MS |
| Overall ESS Performance | S | MS | MU | MS |
| Overall Risk | S | S | S | S |
| Financial Management | S | S | S | S |
| Project Management | S | MS | MS | MS |
| Procurement | S | MS | MS | MS |
| Monitoring and Evaluation | S | MS | MS | MS |

**BASIC INFORMATION – ADDITIONAL FINANCING (Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project - P177714)**

| Project ID | Project Name | Additional Financing Type | Urgent Need or Capacity Constraints |
|---|---|---|---|
| P177714 | Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project | Restructuring, Scale Up | Yes |

| Financing instrument | Product line | Approval Date | |
|---|---|---|---|
| Investment Project Financing | IBRD/IDA | 24-Sep-2021 | |
| Projected Date of Full Disbursement | Bank/IFC Collaboration | | |
| 30-Apr-2024 | No | | |
| Is this a regionally tagged project? | | | |
| No | | | |

## Financing & Implementation Modalities

| | |
|---|---|
| [✓] Multiphase Programmatic Approach [MPA] | [ ] Series of Projects (SOP) |
| [ ] Fragile State(s) | [ ] Performance-Based Conditions (PBCs) |
| [ ] Small State(s) | [ ] Financial Intermediaries (FI) |
| [ ] Fragile within a Non-fragile Country | [ ] Project-Based Guarantee |
| [ ] Conflict | [✓] Responding to Natural or Man-made disaster |
| [ ] Alternate Procurement Arrangements (APA) | [✓] Hands-on, Enhanced Implementation Support (HEIS) |
| [✓] Contingent Emergency Response Component (CERC) | |

## Disbursement Summary (from Parent ISR)

| Source of Funds | Net Commitments | Total Disbursed | Remaining Balance | Disbursed |
|---|---|---|---|---|
| IBRD | 89.00 | 54.06 | 34.94 | 61 % |
| IDA | 207.36 | 181.81 | 27.32 | 87 % |
| Grants | 1.72 | 1.72 | | 100 % |

## MPA Financing Data (US$, Millions)

| | |
|---|---|
| MPA Program Financing Envelope | 18,000,000,000.00 |

## MPA FINANCING DETAILS (US$, Millions)

| | |
|---|---|
| **Board Approved MPA Financing Envelope:** | 18,000,000,000.00 |
| **MPA Program Financing Envelope:** | 18,000,000,000.00 |
| **of which Bank Financing (IBRD):** | 9,900,000,000.00 |
| **of which Bank Financing (IDA):** | 8,100,000,000.00 |
| **of which other financing sources:** | 0.00 |

## PROJECT FINANCING DATA – ADDITIONAL FINANCING (Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project - P177714)

### FINANCING DATA (US$, Millions)

#### SUMMARY (Total Financing)

| | Current Financing | Proposed Additional Financing | Total Proposed Financing |
|---|---|---|---|
| **Total Project Cost** | 298.09 | 100.00 | 398.09 |
| **Total Financing** | 298.09 | 100.00 | 398.09 |
| **of which IBRD/IDA** | 296.36 | 100.00 | 396.36 |
| **Financing Gap** | 0.00 | 0.00 | 0.00 |

#### DETAILS - Additional Financing

**World Bank Group Financing**

| | |
|---|---|
| International Bank for Reconstruction and Development (IBRD) | 100.00 |

## COMPLIANCE

### Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [ ✓ ] No

Does the project require any other Policy waiver(s)?

[ ] Yes [ ✓ ] No

### Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

| E & S Standards | Relevance |
|---|---|
| Assessment and Management of Environmental and Social Risks and Impacts | Relevant |
| Stakeholder Engagement and Information Disclosure | Relevant |
| Labor and Working Conditions | Relevant |
| Resource Efficiency and Pollution Prevention and Management | Relevant |
| Community Health and Safety | Relevant |
| Land Acquisition, Restrictions on Land Use and Involuntary Resettlement | Not Currently Relevant |
| Biodiversity Conservation and Sustainable Management of Living Natural Resources | Not Currently Relevant |
| Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities | Not Currently Relevant |
| Cultural Heritage | Not Currently Relevant |
| Financial Intermediaries | Not Currently Relevant |

**NOTE**: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

## INSTITUTIONAL DATA

### Practice Area (Lead)

Health, Nutrition & Population

### Contributing Practice Areas

Social Protection & Jobs

### Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

## PROJECT TEAM

### Bank Staff

| Name | Role | Specialization | Unit |
|---|---|---|---|
| Deepika Eranjanie Attygalle | Team Leader (ADM Responsible) | | HSAHN |
| Srinivas Varadan | Team Leader | Co-TTL | HSASP |
| G. W. Anjali U. Perera Vitharanage | Procurement Specialist (ADM Responsible) | | ESARU |
| Dassanayake Mudiyanselage Anul Harasgama | Financial Management Specialist (ADM Responsible) | | ESAG2 |
| Nadeera Rajapakse | Environmental Specialist (ADM Responsible) | | SSAEN |
| Shanek Mario Fernando | Social Specialist (ADM Responsible) | | SSAS1 |
| Bushra Binte Alam | Team Member | | HSAHP |
| Hasanthi Shalika Subasinghe | Team Member | | HSAED |
| Hideki Higashi | Team Member | Co-TTL | HSAHN |
| Junko Funahashi | Counsel | | LEGAS |
| Martha P. Vargas | Team Member | | HSAHN |
| Mokshana Nerandika Wijeyeratne | Team Member | | SSAEN |
| Pablo Cardinale | Safeguards Advisor/ESSA | | SARDE |
| Priyantha Jayasuriya Arachchi | Team Member | | SACSL |
| Raadhika Gupta | Counsel | | LEGAS |
| Rene Antonio Leon Solano | Team Member | | HSADR |
| Sankha Maldeepa Gamage | Procurement Team | | SACSL |
| Satish Kumar Shivakumar | Team Member | | WFACS |
| Sybille Crystal | Team Member | | HSAHN |
| Yi Zhang | Team Member | | HSAHN |

# I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

## A. Introduction

1. ***This Project Paper seeks the approval of the World Bank's Regional Vice President[1] to provide a loan for US$100 million IBRD for an Additional Financing (AF)*** for the Sri Lanka COVID-19 Emergency Response and Pandemic Preparedness Project (ERHSP) (P173867) to support the costs of expanding activities for COVID-19 vaccines and deployment. This will be the third AF to the ERHSP (ERHSP-AF3). The project was prepared under the COVID-19 Strategic Preparedness and Response Program (SPRP) using the Multiphase Programmatic Approach (MPA), approved by the Board on April 2, 2020, and the vaccines AF to the SPRP approved on October 13, 2020.[2] The primary objectives of the proposed AF (ERHSP-AF3) are to accelerate affordable and equitable access to COVID-19 vaccines and help ensure effective vaccine deployment in Sri Lanka through vaccination system strengthening, and to further strengthen preparedness and response activities under the parent project. The Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project (ERHSP) in an amount of US$128.6 million equivalent (US$35 million IBRD loan under the Fast-Track COVID-19 Facility and US$93.60 million under the IDA Transitional regime) was approved on April 2, 2020, under the SPRP. A first AF (ERHSP-AF1) for US$87.24 million equivalent (US$45.34 million IDA blend terms and US$41.9 million IDA credit) was approved on June 22, 2020 to extend cash assistance and in-kind transfer of food packs. A US$1.72 million grant from the Pandemic Emergency Financing Facility Fund (PEF) was processed through the ERHSP-AF1. A second AF in the amount of US$80.5 million (US$54 million IBRD and US$26.51 million IDA credit) was approved on April 27, 2021, to support COVID-19 vaccine purchases and deployment (ERHSP-AF2).

2. ***The purpose of the proposed ERHSP-AF3 is to provide upfront financing to help the government of Sri Lanka (GoSL) purchase and deploy additional COVID-19 vaccines that meet the Bank's vaccine approval criteria (VAC).*** The proposed ERHSP-AF3 will support the GoSL's effort to scale up the vaccination program. It will finance the procurement of Pfizer vaccines and deployment of vaccines. The scale up will help vaccinate 26.5 percent of the country's population in addition to the currently effective ERHSP-AF2. The country provides free of cost vaccination to its population. The need for additional resources to expand the COVID-19 response was formally conveyed by the GoSL on August 18, 2021 for an amount of US$100 million to support the Ministry of Health (MoH) and the State Ministry of Provincial Councils and Local Government Affairs (SMoPCLGA) in their COVID-19 vaccination efforts.

3. ***Sri Lanka is currently at the peak of its third wave of the COVID-19 pandemic with the increased prevalence of the Delta variant.*** Case counts began to rise along with a growing prevalence of the Delta variant currently prevalent in the country. With growing case numbers and COVID-19 deaths being at an all-time high, an island-wide lockdown was imposed on August 20. As of August 31, 2021, the country has reported a total of 440,302 cases and 9,185 deaths from COVID-19.[3] The number of active cases is 56,961,

[1] On April 16, 2021, the Board decided to delegate the approval of COVID-19 Vaccine AF to the Regional Vice Presidents if the amount is less than or equal to US$100 million and the environmental and social risks are less than High.
[2] The World Bank approved a US$12 billion WBG Fast-Track COVID-19 Facility (FTCF or "the Facility") to assist IBRD and IDA countries in addressing the global pandemic and its impacts. Of this amount, US$6 billion came from IBRD/IDA ("the Bank") and US$6 billion from the International Finance Corporation (IFC). The IFC subsequently increased its contribution to US$8 billion, bringing the FTCF total to US$14 billion. The AF of US$12 billion (IBRD/IDA) was approved on October 13, 2020 to support the purchase and deployment of vaccines as well as strengthening the related immunization and health care delivery system.
[3] MoH Health Promotion Bureau COVID-19 live situational analysis dashboard of Sri Lanka. *https://hpb.health.gov.lk/covid19-dashboard/*.

while 383,341 patients have recovered. Sri Lanka's recovery rate is around 82 percent, and the fatality rate is over 2 percent. Approximately 15,000-20,000 PCR tests per day are being conducted with a positivity rate of 25-30 percent.[4] 70-80 percent of COVID-19-related deaths are among the unvaccinated population. Vaccination has had an impact on the severity of the disease, with only 4-5 percent of vaccinated individuals develop complications when infected. Accelerating the vaccination program could help reduce the severity of disease in more people, thereby reducing the need for hospitalization and relieving the burden on the health system. Given the current COVID-19 cases surge, the decision was taken at the National Task Force for COVID Management to expand its initial target of 60 percent of the population in Sri Lanka as outlined in the National Deployment and Vaccination Plan for COVID-19 (NDVP)[5] to at least 80 percent. The NDVP is expected to be updated to align with new developments of scientific evidence and knowledge surrounding the COVID-19 vaccine.

4. ***The World Bank (WB) in Sri Lanka through this and previous financings supports the procurement of Pfizer vaccines to cover an estimated 42.2 percent of population, of which an estimated 15.7 percent of population was covered by the ERHSP-AF2 and an estimated 26.5 percent of population will be covered by the proposed ERHSP-AF3.*** The WB-supported ERHSP-AF2 financed the first vaccines supply contract between Pfizer and GoSL. Furthermore, the GoSL has recently signed a second Pfizer contract for the purchase of vaccines to cover an estimated 31.1 percent of population, out of which an upfront payment was financed under the ERHSP-AF2 to cover an estimated 4.6 percent of the population. The remaining contract value will be financed by ERHSP-AF3 on October 1, 2021. All the supply of vaccines is expected to arrive to Sri Lanka by December 2021 in a staggered manner as per the agreed delivery schedule. In addition, the WB ERHSP-AF2 and AF3 together support the GoSL in their efforts for deployment of vaccines.

## B. Consistency with the Country Partnership Framework (CPF)

5. ***This proposed ERHSP-AF3 is consistent with CPF's Pillar 1 (Human Capital and Resilience) objectives of improving nutrition, hygiene, and reducing the still high under-five mortality rates.*** The need to invest in health systems to ensure the productive capabilities of the population is recognized, as is the challenge of overcoming a legacy of limited investment in human capital and social resilience systems. By building the strength of the health system and its resilience to shocks, it is aligned with the focus of the CPF Objective 2, which focuses on improving health services. The ERHSP-AF3, like the parent project and ERHSP-AF2[6], is also aligned with both global health priorities and IBRD/IDA priorities on improving pandemic preparedness. The current Sri Lanka CPF that initially covered the period from FY2016 to FY2020 (Report No. 104606-LK, dated March 31, 2016) has been extended to FY2021, which is aligned with the proposed ERHSP-AF3.

## C. Project Design and Scope

6. ***The ERHSP-AF3 is not adding new activities or components, but just a scale-up of subcomponent 1.3 Vaccine and Deployment.*** The main components of the ERHSP Project approved on April 2, 2020 are

[4] Our World in Data Coronavirus Pandemic. *https://ourworldindata.org/coronavirus*.
[5] Approved on January 18, 2021.
[6] See *Project Paper* of ERHSP-AF2.

described in the Project Appraisal Document of the ERHSP and Annex 3.[7] Since the beginning of the second wave of COVID-19 in Sri Lanka in October 2020, two additional financings and restructurings were approved to extend the ERHSP including: 1) expanding the scope of subcomponent 1.2 cash assistance to those who lost livelihoods during the lockdown and in-kind transfer of food packs to those under home quarantine[8]; and 2) creating subcomponent 1.3 to provide support for the national COVID-19 vaccination drive.[9] Implementation is on track with increased capacity in the Project Management Unit (PMU).

## D. Project Performance

7. ***The project's progress towards the achievement of the Project Development Objective (PDO) is satisfactory, and overall implementation progress is moderately satisfactory.*** Out of four PDO indicators, two are fully achieved and two are on track and the targets will be fully achieved by Dec 31, 2023. Six out of 18 intermediate results indicators have achieved their targets while the rest has shown varying degrees of progress (See Section VIII Results Framework). The PMU has been effectively coordinating project planning and implementation. The Environment and Social (E&S) Compliance performance have been upgraded to Moderately Satisfactory with the establishment of dedicated staff. The development of case management centers has shown satisfactory progress and preliminary work has been initiated in two hospitals. However, no major field activities could commence due to the earlier lockdown, intermittent travel restrictions, and now the recent lockdown. There is no major outstanding E&S commitment to date as per the latest Environmental and Social Commitment Plan (ESCP). The implementation of the social protection response has improved with the restructuring in January 2021. GoSL has recently announced a further cash transfer of LKR 2,000 to families for the loss of livelihood and it is expected that the remaining US$18 million under this subcomponent will be disbursed soon. As of September 23, 2021, overall project disbursement stands at 79.71 percent within sixteen months of implementation. As of 2nd September, a total of US$80.3 million out of US$80.5 million has been disbursed under the ERHSP-AF2 vaccine procurement and deployment activities. In addition, activities under the Pandemic Emergency Financing Facility (PEF) grant of US$1.7 million have been completed, and all funds have been utilized.

8. ***The US$80.5 million ERHSP-AF2 to support the purchase and deployment of safe and effective COVID-19 vaccines is implementing satisfactorily with a 99 percent disbursement ratio.*** The previous vaccine financing has supported the GoSL to purchase vaccines and the incremental service delivery cost during the initial stages of the vaccination drive. WB financing of US$29.5 million was initially disbursed to finance vaccine deployment activities for incremental operating costs for vaccination services, such as the development of micro plans at the community and institutional levels, conducting need-based rapid assessments on cold-chain requirements, conducting community awareness, operating vaccination centers, developing standard operating protocols and guidelines, and incremental service delivery costs supporting the benefits of clinical and non-clinical staff implementing subcomponent 1.3 of the project, including the provision of hazard pay and overtime allowance. The shipment of Pfizer vaccines is made in a staggered fashion to accommodate the limited ultra-cold-chain (UCC) storage capacity and the production capacity of the vaccine. Delivery of the first Pfizer vaccine contract has commenced in July, and first consignment of 664,560 doses have been delivered as of August 31, 2021. Most of the delivered Pfizer vaccines have been administered to an estimated 1.4 percent of the population. Further

[7] See *Project Appraisal Document* of the ERHSP parent project
[8] See *Project Paper* of ERHSP-AF1.
[9] See *Project Paper* of ERHSP-AF2.

consignments are expected to arrive by December 2021. The full consignment of the second Pfizer vaccine contract will also be expected to be delivered by December 2021. The balance for the procurement of vaccines, along with need-based deployment costs and systems strengthening, will be financed through the proposed ERHSP-AF3.

## E. Rationale for Additional Financing

9. ***The proposed ERHSP-AF3 will contribute to scale up the vaccine coverage.*** To this effect, it will be used to finance the remaining payment for the second vaccine contract of the Pfizer and to support costs associated with vaccine deployment efforts. Given the current surge of the pandemic recording high case fatality and transmissibility, the National Advisory Committee on Communicable Diseases (NACCD) recommended to expand the target population to include pregnant/lactating women and the 18-30-year age-group, and it is anticipated that children aged 12-17 will be included as evidence on the safety of vaccination in this age group is established. The upfront financing will enable the country to acquire the vaccine at the earliest.

10. ***Development partners including the World Bank, World Health Organization (WHO), United Nations Children's Fund (UNICEF), and Asian Development Bank (ADB) are supporting the GoSL in the COVID-19 vaccination drive***. In addition to financing COVID-19 vaccines, Gavi, the Vaccine Alliance, provides technical assistance to the government, UNICEF, and WHO for preparedness of COVID-19 vaccination and strengthening of cold chain capacity. ADB will provide financial support for vaccine procurement, deployment, transport system, and adverse event following immunization (AEFI) monitoring system (see Box 1 for details). The Bank is working closely with UNICEF and United Nations Office for Project Services (UNOPS) under the ERHSP project. UNICEF is implementing risk communication activities. The campaign carried out in collaboration with the Health Promotion Bureau, tracks and addresses the public perception of COVID-appropriate behavior, vaccine hesitancy, news, and possible misinformation. UNOPS is supporting the procurement of laboratory equipment, oxygen concentrators, and other medical commodities.

**Box 1: Potential Supportive Roles for Partner Agencies for Vaccines**

| **WHO's role** | **Financing amount** |
|---|---|
| Providing technical leadership for vaccine introduction, technical support for updating the NDVP, implementation of NDVP activities, developing guidelines, and conduct training on AEFI surveillance, monitoring, evaluation, and research on COVID-19 vaccine deployment. | US$620,497 as technical support through GAVI, German, Canada funding, and OCR (SEARO)<br>Planned US$460,000 through CDS jointly with UNICEF |
| **UNICEF role** | **Financing amount** |
| Supporting in procurement and distribution of vaccines, technical support for updating the NDVP, assistance for upgrading cold chain facilities, supporting rapid vaccine roll our developing materials for risk communication, and supporting in implementation of these. | US$6.5 million<br>(This includes COVAX TA support US$46,000 COVAX cold chain equipment (CCE) support - US$370,000 M & E support to WHO through UNICEF early access CDS US$462,680, Com strategies to enhance risk communication WB funding to UNICEF US$2.4 million). |
| **Gavi's role** | **Financing amount** |
| For 20 percent of the population through COVAX, vaccine and shipping costs up to the port of entry in Sri Lanka are covered by the COVAX grant. Besides, Gavi is providing technical assistance for preparatory activities through WHO and UNICEF, and cold chain support. | US$50,000 as technical support (through WHO/UNICEF) and US$360,000 for cold chain (through UNICEF) |
| **Other partners' role** | **Financing amount** |

| | |
|---|---|
| **ADB:** Financial support for procurement and deployment of vaccines, cold chain facilities, transport facilities, information management system, and healthcare waste management. | US$150 million |
| **Japan:** Budget support for COVID-19 vaccination and technical assistance | US$5 million grant through ADB |

### F. National Capacity and COVID-19 Vaccination Plan

11. ***The GoSL was able to accelerate the vaccination program using its strong public health network.*** GoSL has decided to consider the 30 years and above population engaged in economically important industries along with the 60+ category. There have been some difficulties in achieving full vaccination coverage of the 60+ category as many people in this age group are homebound, face mobility issues and are unable to come to vaccination centers on their own. Though the government has now identified tailor-made specific measures, including mobile vaccination programs to target the 60+ age group, the country could have benefitted from introducing intensive targeting measures and strategies during the early stages of the vaccination drive. Since July 2021, the GoSL has enlisted the support of the military medical corps and other logistical groups to carry out mobile vaccination programs to vaccinate population groups who are unable to come to centers. No transfer of funds is envisaged to military corps. The GoSL also opened several 24/7 vaccination centers to mop up campaigns and to provide second doses to the eligible population as soon as possible. In addition to the routine vaccination centers, community centers were set up in some areas to increase vaccination drive. To date, over 50 percent of the population has been fully vaccinated and over 60 percent has received at least the first dose of vaccine.[10]

12. ***The January 2021 vaccine readiness assessment has been updated***. The Vaccine Readiness Assessment Framework (VRAF)/Vaccine Introduction Readiness Assessment Tool (VIRAT) will continue to be updated based on new findings and lessons learned (see Table 1 below).

[10] Our World in Data Coronavirus Pandemic. *https://ourworldindata.org/coronavirus*.

**Table 1: Summary of Vaccination Readiness Findings from the VIRAT/VRAF 2.0 Assessment**

| | Readiness of government | Key gaps to address and actions taken since the inception of the COVID-19 vaccination program |
|---|---|---|
| **Planning and coordination** | • Sri Lanka has established the NCC for COVID-19 vaccination. The NCC has three technical subcommittees: COVID-19 vaccines, prioritization and targeting; logistics for COVID-19 vaccination; and costing for COVID-19 vaccination. The sub-committees contributed to the development of NDVP.<br>• Coordination among different stakeholders, such as ministries, universities, hospitals, and development partners, is conducted through this committee.<br>• A district-level micro plan for vaccination has been developed for each district, including waste management. | • The NDVP is expected to be updated with new developments of scientific evidence and knowledge surrounding the COVID-19 vaccine. Only new thematic guidelines have been developed. |
| **Budgeting** | • The GoSL has endorsed the COVID-19 vaccination program as a national priority.<br>• The Ministry of Finance (MoF) has allocated separate budget lines for the vaccination program, and any special allocation is approved through consultation with the Cabinet of Ministers.<br>• In addition, the External Resource Department (ERD) of the MoF has approved the utilization of external donor support. In case additional financing is required, the possibility of accepting private and donor contributions to the account of the National Health Development Fund is also being considered.<br>• A detailed budgeting exercise was completed as part of the NDVP (different financing scenarios and investments on cold chain).<br>• The ERHSP-AF2 was utilized for the procurement of Pfizer vaccines and to finance the deployment costs between December 2020 and April 2021. The proposed ERHSP-AF3 will add US$100 million to finance additional Pfizer vaccines with deployment costs. The rest will be covered by the GoSL and other sources, particularly ADB. | • While the total costs of COVID-19 vaccination have been estimated, the situation has been evolving and the budget needs to be updated accordingly together with the NDVP update.<br>• National Health Development Fund is also being actively contributing to support the COVID-19 related activities, mainly communication and other logistics aspects of the program. The GoSL is also accepting private donations to finance the COVID-19 vaccination program. |
| **Regulatory** | • Sri Lanka has a well-functioning National Medicines Regulatory Authority (NMRA) and has standard systems for regulatory approvals and registration of new vaccines.<br>• Emergency decision-making provisions for the registration of new vaccines/medicines for special circumstances, such as pandemics and other emergencies, are clearly articulated in section 109 of the NMRA Act No 5 of 2015.<br>• The Government of Sri Lanka has already issued the indemnification and liability agreement through a Cabinet decision on January 7, 2021, and the same has been shared with COVAX.<br>• A high-level task force has been appointed to coordinate the implementation of the COVID-19 vaccination program.<br>• The MoH convened the National Coordination Committee (NCC) for the COVID-19 vaccine in | • No gaps identified.<br>• NCC for the COVID-19 vaccine meets monthly with supplementary meetings based on the need. |

| | | |
|---|---|---|
| | November 2020, including various health and non-health stakeholders with different expertise. The technical oversight, including the choice of candidate vaccines to be deployed in the country, priority population groups, safety monitoring, AEFI, surveillance, etc. is provided by the NACCD and the National Immunization Technical Advisory Group (NITAG). | |
| **Prioritization, targeting, surveillance** | • As described in the NDVP in January 2021, the MoH intended to vaccinate at least 60 percent of the Sri Lankan population in phases.<br>• The NDVP lays out priority orders of different groups based on the availability of vaccine supplies. Initially, up to 20 percent of the population had been prioritized for vaccination, and this group included health workers and frontline staff, elderly people aged 60 years or more, and other high-risk groups.<br>• Children under 18 years of age are still medically contraindicated for the vaccination while the vaccination for pregnant/lactating women and individuals between 20 and 30 years old has commenced in June 2021 as scientific evidence accumulated on their safety. | • Prioritization between different target groups has been laid out.<br>• Initially, the target population was set at 60 percent of the population excluding the pregnant/lactating mothers and children under 18. However, some changes have been introduced based on the epidemiological profiles, new scientific evidence.<br>• The GoSL has/will include the pregnant/lactating mothers and 18- 30 age group and next will consider children between 12-17 for vaccination[11] to cover a minimum of 80 percent of the population. |
| **Service delivery** | • Sri Lanka has identified a time-limited "campaign mode" vaccination strategy as opposed to a "routine vaccination" strategy for achieving high coverage through targeted vaccination in a short period. Approximately 1,500 sites are available for COVID-19 vaccination, and each vaccine clinic is staffed by a minimum of seven health staff and supportive non-health staff (following the standard guidelines for COVID-19 vaccination centers issued by the MoH).<br>• Waste management plans (distribution plan to incinerators) for each vaccination center are included as part of district-level micro plan development and being implemented. Hospital Directors, Provincial and Regional Directors of Health Services take the responsibility to ensure proper waste management and provide guidance to each vaccination center.<br>• Incinerator facilities available at non-health sectors, private health and private organizations have been mapped out, and mechanisms have been identified for additional requirements for incineration facilities during the campaign through the identified waste management network within the health sector. | • An online registration system has been developed and is in progress. People are able to check available time slots/pre-registration for vaccination. Further, the Vaccine Tracker is established in all 25 districts, through which real-time data on the coverage, vaccine waste age, and AEFI is being monitored at the national level. This has increased the efficiency of the vaccination program and this may lead to minimizing wastage at around 10 percent. Based on the available information, real-time monitoring and supervision are done at the national/provincial level on the vaccine wastage, and specific interventions/recommendations are directed to the related vaccination centers accordingly. Close communication between public health inspectors and recipients could mitigate the risk. There is also an option for walk-in registration at the vaccination centers.<br>• Equipment requirements such as sharp shredders, on-site autoclaves, sharp bins, and means of transport to disposal centers, capacity/functionality of incinerators has been addressed to handle the increased number of vaccination centers. |

[11] Since September 20, children aged 15-17 with comorbidities have been included as target (Pfizer vaccine only).

| | | |
|---|---|---|
| | | • Each vaccination center is equipped with the basic waste equipment and infrastructure to areas / center specific arrangements to facilitate proper hazardous medical waste management.<br>• In order to assure equitable access to vaccination, mobile vaccination teams, selected community vaccination centers, available for 24/7, have been established to reach the remote and unreached population. |
| **Training and supervision** | • Already trained public health staff, and hospital staff engaged in routine vaccination programs were given refresher training on adult vaccination, vaccine management, and AEFI surveillance focusing on the COVID-19 vaccination.<br>• Supervisory staff in both preventive and curative care sectors were mobilized for the COVID-19 vaccination program to ensure effective, timely, and supportive supervision.<br>• The Epidemiology Unit has been identified as the focal point for training, has been identified by MoH with experience in training of immunization program including surveillance and management of AEFI by the MoH.<br>• A cascade training approach has been used to achieve a maximum number of training within a short period during the pandemic. A Middle-Level Managers (MLM) training has been conducted for the district level staff, who in turn conducted the training programs for the divisional level staff. Specific tailor-made training programs were carried out by the Epidemiology Unit, based on the different vaccine types available to the country.<br>• A virtual platform was also used for staff training while facilitating the problem-solving process during the rolling out of the vaccination program.<br>• All health personnel involved in the vaccination program in the MoH, and the supportive staff of the triforces medical services, community assistants, volunteers, non-health workforce were informed and trained to provide the required assistance. | • The gaps previously identified have been addressed.<br>• The Epidemiology Unit has been identified as the focal training center for the COVID-19 vaccination program. It has trained and mobilized around 15,000 public health staff. This led to maintain a high rate of vaccination at 500,000 per day. |
| **Monitoring and evaluation** | • Informed written consent for vaccination is obtained from all eligible individuals, and consent forms have been developed adhering to a specific legal framework.<br>• A special COVID-19 vaccination card was developed for vaccine receivers (a home-based record) for follow-up of the 2nd dose and subsequent vaccinations.<br>• The officers from the Epidemiology Unit and the Regional Epidemiologist conduct random field supervision.<br>• Monitoring and evaluation of the program have been conducted through supervisions and the Vaccine Tracker established for the COVID-19 vaccination and is functional in all 25 districts. This will help to identify vaccine uptake, coverage for each dose, and to identify dropout rates. Final completed coverage will be identified as the monitoring indicator for vaccinating the expected target priority population. | • Data updates in the eNIP are daily rather than in real-time. While it is sufficient for monitoring purposes, further improvement in efficiency could be expected with real-time updates. Given the limitation, WHO and MoH have developed an “Immunization Tracker” system to allow for real-time tracking of COVID-19 vaccine related information. It allows for real-time updates of data related to vaccination. The system was initially introduced in the Western Province and has been scaled up in all provinces. Eventually, it is expected that the system will be integrated into the eNIP.<br>• The serosurvey and the effectiveness of vaccination is |

| | | |
|---|---|---|
| | • The modification of the "eNIP" web-based system for vaccination data entry is done through the immunization information system at the Epidemiology Unit, MoH. Regional Epidemiologists will be responsible for all immunization data at the district level from all sites. The Medical Officers of Health (MOH) offices are to ensure the timely submission of data to Regional Epidemiologists and will enter data into the web-based immunization data system (eNIP).<br>• Data will be analyzed to identify the vaccination, coverage for each dose, coverage in districts, and coverage for target population categories.<br>• The serosurvey and the effectiveness of vaccination will be assessed appropriately with field-level vaccine efficacy studies (effectiveness) to be conducted in the future. The country will plan a post-introduction evaluation (PIE) after one year, together with the next campaign cycle. | underway by the University of Sri Jayawardenapura, and results are expected to be published by end of the 2021.<br>• MoH is in the process of linking vaccination data system with other systems (e.g., testing) ensuring interoperability of information management systems. |
| **Vaccine, cold chain, logistics, infrastructure** | • Sri Lanka already has an established and well-functioning system for vaccination programs requiring cold chain facilities for 2-8 degree Celsius. An assessment has been conducted, and available transport and storage facilities have been reviewed and identified. The estimated spare capacity at all levels, defined as 62,712 L is adequate for vaccines with 2-8-degree Celsius requirement supplied through COVAX Facility (assuming only 60 percent of refrigerator capacity can be used for vaccine storage, including routine expanded program on immunization (EPI) vaccines).<br>• UNICEF supported the Epidemiology Unit of MoH in conducting a CCE gap analysis using the WHO-Sizing tool. Prior to this exercise, the Epidemiology Unit updated the National CCE Inventory which formed the baseline for the gap analysis. The gap was calculated based on the space required to store all the routine vaccines in the immunization program, any future inclusion of Rota and Pneumococcal vaccines and COVID-19 vaccines to increase the capacity for additional 20% of the population (this was deemed sufficient for the whole vaccination drive as vaccines are received in batches rather than all at once). Identification of the gaps in CCE inventory enabled replacement of all refrigerators/freezers more than 10 years old, all cold/freezer rooms more than 15 years old, all non-WHO/PQS CCE and additional five 30$m^3$ Walk in Cold Rooms to the Central Vaccine Store. With this, the capacity of cold chain facilities at national and provincial/district levels was strengthened to ensure uninterrupted cold chain.<br>• For COVID-19 vaccines requiring ultra-cold chain (UCC) (e.g., Pfizer), the existing capabilities in the country have also been identified. The central blood bank has a spare capacity to store 4 million doses of Pfizer vaccine at -70 degree Celsius. Additional 3.8 $m^3$ volume usable spare capacity for UCC has been identified in key universities.<br>• There is a spare capacity of 14.5L for -20-degree Celsius vaccine storage, should the need arise (e.g., Moderna), and storage and transport facilities for vaccines requiring -20 degree | • Though sufficient capacity of fridges and cool rooms for +2 °C to + 8°C temperature is available both at the central and Regional Director of Health Services (RDHS) levels, gaps, and excess capacities exist between RDHSs. This will be managed by sharing the excess capacity between neighboring RDHS.<br>• Sri Lanka has a -20-degree Celsius cold chain capacity dedicated for vaccine storage only at the Central Cold Stores. The vaccine storing -20-degree Celsius cold chain capacity at the district level store is not available. Yet there are ample -20-degree Celsius transport facilities which can be converted to plug-in storage facilities in case the need arises.<br>• Currently, the vaccination program does not have adequate UCC vaccine storage facilities (capable of accommodating 4 million doses). Therefore, vaccines that require UCC, such as Pfizer, have been received in multiple tranches of small lots to manage within the existing capacity and deploy in a staggered fashion.<br>• MoH is planning to do the next EVM by November/ December 2021 to update the cold chain situation.<br>• Internet is not available in most of the smaller facilities. Adequate connections, such as 4G, must be provided for vaccination data to be transferred to the eNIP daily.<br>• Storage of vaccines should be avoided in facilities that do |

| | | |
|---|---|---|
| | Celsius are available. The country has enough supplies of dry ice with trained staff to replace dry ice in the transport box of Pfizer vaccine. Hence, the shipping box (thermal Shipper) provided by Pfizer can be used as a temporary storage facility till it is transported to the points of vaccine delivery.<br>• From a health facility service readiness assessment, improved water supply and primary power supply are available in virtually all public facilities. Back-up power sources are not available in about 9 percent of facilities, primarily in smaller facilities. | not have adequate backup power. |
| **Safety surveillance** | • Sri Lanka has a well-established, targeted, time-tested AEFI surveillance system. This system includes hospital AEFI surveillance (government and private), public health institutions (MOH offices) and community detected cases through routine passive surveillance of spontaneous reporting to hospitals, and community-based active surveillance through an organized process of actively identifying, recording, and reporting of AEFI and Adverse Events of Special Interest (AESI).<br>• Skilled and competent EPI and related staff are available for causality assessment in the country.<br>• An expert committee on AEFI regularly reviews all AEFI situations in the country.<br>• The NIP, Epidemiology Unit takes all measures regularly in addressing all preventable AEFI, maintain the quality of the program, developing competencies and skills in immunization staff on emergency AEFI management and AEFI investigation process. AEFI guidelines are available for the country. The country's existing guidelines can be implemented for the AEFI and AESI detection and reporting and management of such events but adequate training of AEFI – AESI is identified as a requirement for COVID-19 vaccine deployment. Surveillance activities will be continued to assess the COVID-19 disease status based on the vaccination status.<br>• Eligibility screening will be done by competent health staff capable of identifying contraindications for vaccination. Readiness for AEFI is ensured by developing adequate competencies through training and by ensuring proper screening for AEFI before vaccination. Emergency readiness is assured through observation for a minimum of 20 minutes post-vaccination, the availability of emergency trays with essential medicines together with oxygen facilities for proper management, and specialized care arrangements at all vaccination centers. | • With the expansion of digital immunization tracker in all 25 districts, related information on vaccination and AEFI are available. All the vaccination centers are provided with emergency management facilities, including portable oxygen. No serious AEFI was identified to date as to trigger the indemnification clauses. |
| **Demand generation and communication** | • Advocacy and communication, including risk communication, have been carried out by the HPB, together with relevant program stakeholders of the Epidemiology Unit, MoH, other health officers, and other partners including UNICEF.<br>• The communication is focusing on NIP standards and COVID-19 vaccination. It conveys government commitment for the vaccination program, generates demand for vaccines, disseminates timely, accurate and transparent information about the vaccine(s), including information about preparedness, and manage misinformation in order to alleviate | • Vaccine hesitancy existed in some selected groups at the initial stage of the vaccination drive. Periodic assessment is ongoing to capture community perception on vaccination. Based on the findings, necessary measures have been taken at the national and grassroot level to address the contributing factors to vaccine hesitancy (knowledge sharing in local languages through print and social media and mobile |

| | | |
|---|---|---|
| | apprehension about the vaccine, ensuring its acceptance and encouraging uptake.<br>• The health promotion bureau, with the civil society and United Nations (UN) agencies (WHO and UNICEF), is conducting formative implementation research to assess the situation. The findings from the first survey were presented to the policymakers and a Social Listening tool through social media to receive real-time public perception is under development. | public health education measures). Recent research has found 20 percent increase of vaccine acceptance from March to July.<br>• The project has supported the national communication campaign through UNICEF: establishing/ facilitating multiple platforms through social and mainstream media, including live public forums on radio and television channels, outreach interventions and hotlines for the public to raise questions about the vaccine program. In addition, community groups such 'Friends of Facilities Committees (FFCs)' and Grama Niladari officers visit homes sharing information about the COVID-19 vaccination program especially, in hard-to-reach areas.<br>• The GRM is now in place. |

13. ***Based on the gaps identified in the VIRAT/VRAF assessment, remedial actions have been taken***. Regarding the *risk communication campaign*, a survey revealed that lower coverage of vaccination and high vaccine hesitancy were seen in selected communities. Measures are being taken to reach out with more information in local languages and mobile clinics where access limitations have been identified. The digital information system has been upgraded, with vaccination data entered into the web-based "eNIP" system of the Epidemiology Unit at the end of each day. A digitalized real-time "Immunization Tracker" system for COVID-19 vaccination has been developed on DHIS2 by the MoH/WHO and is currently functional in all 25 districts. This enables authorities to obtain real-time data on vaccination centers, availability of vaccine stocks and wastage, and incidence of AEFI. Eventually, the tracker is expected to be integrated into the eNIP system.

14. ***One of the issues that have evolved since the initiation of the vaccination drive is the growing demand for UCC facilities.*** The GoSL has already initiated administering the mRNA vaccines that require UCC facilities for -70 degree Celsius. The available ultra-low temperature (ULT) facilities at National Blood Transfusion Center can only accommodate about 4 million doses of Pfizer vaccines requiring UCC. Thus, the MoH decided to obtain additional containers of ULTs to accommodate the expected doses of Pfizer vaccines requiring UCC during the 4th Quarter of 2021. As per the latest evidence, mRNA vaccines can be kept at 2-8 degree Celsius up to 30 days. The GoSL is leveraging this new evidence to deliver mRNA vaccines as well as others in accelerating the vaccination drive ensuring equitable access to vaccination for the hard-to-reach population. Mobile vaccination outreach with door-to-door services has been identified as a key strategy to address this unmet need. Expansion of cold chain facilities and capacity of 2-8 degree Celsius at field level will help to ensure the last-mile delivery of the vaccination drive.

15. ***Disruptions to vaccine supply chain and distribution and storage from unexpected disasters, climate change impacts, transport disruptions and power outages will be closely managed.*** Alternative routes and alterative power supplies will be used as back up to minimize the risk of deterioration of the vaccines. Measures in vaccine supply and distribution chains will improve energy efficiency or resource efficiency upstream or downstream, leading to an overall reduction in greenhouse gas (GHG) emissions. Impact from potential extreme weather/climate events and variability in temperatures and rainfall will be addressed through targeting and improving health care interventions as well as the surveillance monitoring and preparedness.

16. **To accommodate the accelerated vaccination drive, the cold chain facilities were strengthened. More ULT facilities were added to store mRNA vaccines such as Pfizer requiring UCC. The number of refrigerators for 2-8 degree Celsius at national and provincial level vaccination centers were increased.** Pfizer vaccines requiring UCC arriving at the Bandaranaike International Airport are initially transported to the UCC at the Blood Bank in Colombo to be stored at -70 degree Celsius. The vaccines are then delivered by refrigerated container to the regional cold stores at the regional medical supply divisions to be stored at 2-8 degree Celsius. Main hospitals and the MOH units also have refrigerators to store the vaccines. From there, the vaccines will be transported to the vaccination centers in cold boxes and administered to the population. If there are some unused vials at the end of the day, they will be transported back to the respective storage facilities. The quantity of vaccines delivered to each regional/district facility is determined so that all vaccines will be administered within 30 days after they were dispatched from the UCC at the Blood Bank. The capacity of cold chain facilities was also enhanced at national and provincial/district level to ensure uninterrupted cold chain and accommodate the storage of mRNA vaccines up to 30 days in the refrigerators until they are administered to the population.

## Table 2: National Vaccine Coverage and Acquisition Plan

| Source of financing[12] | Pop'n targeted (out of 22.5 million pop'n) | | Vaccines | | | | Number of doses needed | Estimated total US$ (millions) | WB's VAC status of the vaccine | Contract status | Vaccines already arrived in the country | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Percent | Number | Source | Name | Price ($/dose) | Deployment ($/dose)[13] | | | | | Name | Dose |
| **Stage 1: 20.06 percent (frontline health workers, army and police, age 60+, international travelers and outbound migrant workers/ students, etc.)** | | | | | | | | | | | | |
| IND; **IBRD/IDA** | 1.11 | 250,000 | India | Astra Zeneca | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $2.25 | Approved | Delivered | Astra Zeneca | 500,000 |
| GoSL; **IBRD/IDA** | 1.11 | 250,000 | Direct purchase | Astra Zeneca | $5.25 | $4.5 | 2 | Vaccine $2.63<br>Deploy $2.25 | Approved | Delivered | Astra Zeneca | 500,000 |
| COVAX; **IBRD/IDA** | 0.59 | 132,000 | COVAX allocation | Astra Zeneca | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $1.19 | Approved | Delivered | Astra Zeneca | 264,000 |
| **IBRD/IDA**; **IBRD/IDA** | 1.48 | 332,280 | Direct purchase | Pfizer | N/A* | $4.5 | 2 | Vaccine -<br>Deploy $2.99 | Approved | Delivered | Pfizer | 664,560 |
| CHN; GoSL | 2.44 | 550,000 | China | Sinopharm | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $4.95 | Approved | Delivered | Sinopharm | 1,100,000 |
| GoSL; GoSL | 13.33 | 3,000,000 | Direct purchase | Sinopharm | N/A** | $4.5 | 2 | Vaccine -<br>Deploy $27.00 | Approved | Delivered | Sinopharm | 6,000,000 |
| **Stage 2: 41.10 percent (age 18-59 and eligible people in Stage 1 who have not received the vaccines)** | | | | | | | | | | | | |
| COVAX/JPN; GoSL/**IBRD/IDA** | 3.23 | 727,500 | COVAX dose share | Astra Zeneca | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $6.55 | Approved | Delivered | Astra Zeneca | 1,455,000 |
| COVAX/USA; GoSL/**IBRD/IDA** | 3.33 | 750,000 | COVAX dose share | Moderna | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $6.75 | Approved | Delivered | Moderna | 1,500,000 |
| COVAX/USA; GoSL/**IBRD/IDA** | 0.22 | 50,000 | COVAX dose share | Pfizer | $0.00 | $4.5 | 2 | Vaccine $0.00<br>Deploy $0.45 | Approved | Delivered | Pfizer | 100,000 |
| **IBRD/IDA;** GoSL/**IBRD/IDA** | 9.63 | 2,167,720 | Direct purchase | Pfizer | N/A* | $4.5 | 2 | Vaccine -<br>Deploy $19.51 | Approved | Signed | - | - |

[12] The first row within each cell of the first column provides the source of funding for procurement of vaccines, and the second row for deployment of vaccines.
[13] Deployment costs include activities and items that strengthen the health and vaccination systems such as planning and programming, expansion of storage capacity and purchase of additional cold chain equipment, full PPE, sanitizer, syringes, other consumables, transport, risk communication, training, monitoring and evaluation, and incremental service delivery costs that supports the benefits of clinical and non-clinical staff implementing subcomponent 1.3 of the project, including the provision of overtime and additional/special allowance. Details of calculation of per dose cost is provided in the *Project Paper* of the ERHSP-AF2.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GoSL; GoSL | 0.47 | 105,000 | Direct purchase | Sputnik V | N/A** | $4.5 | 2 | Vaccine - Deploy $0.95 | Not approved | Delivered | Sputnik V | 210,000 |
| CHN; GoSL; | 4.22 | 950,000 | China | Sinopharm | $0.00 | $4.5 | 2 | Vaccine $0.00 Deploy $8.55 | Approved | Delivered | Sinopharm | 1,900,000 |
| GoSL; GoSL | 20.00 | 4,500,000 | Direct purchase | Sinopharm | N/A** | $4.5 | 2 | Vaccine - Deploy $40.50 | Approved | Delivered | Sinopharm | 9,000,000 |
| **Stage 3: 31.11 percent (all other eligible population including age 12-17 and eligible people in Stage 1&2 who have not received the vaccines)** | | | | | | | | | | | | |
| **IBRD/IDA;[15] GoSL/IBRD** | 31.11 | 7,000,000 | Direct purchase | Pfizer | N/A* | $4.5 | 2 | Vaccine - Deploy $63.00 | Approved | Signed | - | - |
| | | | | | | | | | | | | |
| **National Total** | 92.29[16] | 20,764,500 | | | | | | | | | | 23,245,200 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Potential additional doses[17]** | | | | | | | | | | | | |
| COVAX/ ADB/GoSL | 4.44 | 1,000,000 | COVAX cost share | Sinopharm | - | $4.5 | 2 | Vaccine - Deploy $9.00 | Approved | Signed with COVAX | - | - |

*Information has been provided to the Bank in confidence and remains restricted from public access unless and until there is prior written consent to disclose.
**Information is not available.

**Box 2: Liability and Indemnification Issues in Vaccine Acquisition**

**Background**

- The rapid development of vaccines increases **manufacturers' potential liability** for adverse effects following immunization ("AEFI").
- Manufacturers want to protect themselves from this risk by including immunity from suit and liability clauses, **indemnification** provisions and other **limitation of liability** clauses in their supply contracts.
- **Contractual provisions and domestic legal frameworks** can all operate to allocate that risk among market participants, but **no mechanism will eliminate this risk entirely**.

**For COVAX-financed vaccines for Advanced Market Commitment (AMC) countries**

- COVAX has negotiated model indemnification provisions with manufacturers for vaccines purchased and supplied under the COVAX AMC.
- In providing vaccines through COVAX AMC, COVAX requests COVAX AMC participants to have in place an indemnity agreement directly with manufacturers, and the necessary indemnity and liability frameworks for that purpose – either in the form of the COVAX model indemnification arrangements or prior bilateral arrangements with manufacturers.
- The COVAX Facility will have a no-fault compensation mechanism to provide compensation for AMC countries as part of its risk mitigation strategy. This will cover vaccines supplied only through COVAX AMC.
- The GoSL, through a Cabinet decision dated January 7, 2021, has agreed to enter into indemnification and liability agreements with manufacturers for vaccines through the COVAX Facility and the same has been shared with COVAX.

**For vaccines purchased outside of COVAX**

- Sri Lanka does not currently have legislation in place to provide statutory immunity for manufacturers.
- Sri Lanka does not have a national no-fault compensation scheme.
- Adoption of any such indemnification provisions or compensation scheme would have to follow Sri Lanka's own national strategy and framework.
- The GoSL, through the State Pharmaceuticals Corporation of Sri Lanka, has entered into vaccine purchase agreements with multiple manufactures, including the Serum Institute of India for Covishield, Sinopharm, Sputnik V, and Pfizer.

**Possible World Bank support to Sri Lanka, depending on needs, may include**:

- Information sharing on (i) statutory frameworks in OECD countries and other developing countries; and (ii) overall experience in other countries.
- Providing training and workshops for government officials to familiarize them with the issues.
- For World Bank-financed contracts, providing Hands-on Expanded Implementation Support (HEIS).

The project operational documents will specify clearly that the country's regulatory authority is responsible for its own assessment of the project COVID-19 vaccines' safety and efficacy and is solely responsible for the authorization and deployment of the vaccines in the country.

## II. DESCRIPTION OF ADDITIONAL FINANCING

### A. Proposed Changes

17. ***The changes suggested for the proposed ERHSP-AF3 entail scaling-up of activities in the ERHSP-AF2 (P176422).*** The ERHSP-AF3 will cover the procurement of additional Pfizer vaccines, additional cold chain equipment, and any incremental transport costs and service delivery costs required for the deployment of vaccines to the target populations such as overtime and additional/special allowance for clinical and non-clinical workers for implementation of subcomponent 1.3 of the project. As the proposed

activities to be funded under the ERHSP-AF3 are aligned with the original PDO, the PDO will remain unchanged.

18. ***The content of component 1 and the Results Framework of the parent project are adjusted to reflect the increase in financing for vaccination, and target of the vaccination coverage has revised accordingly.*** Subcomponent 1.3 will be adjusted to reflect the scale-up of financing vaccination, including the acquisition, planning, management, and deployment of COVID-19 vaccines. The institutional arrangements for the ERHSP-AF3 will remain the same. All activities under the subcomponent 1.3 will be implemented by the PMU under the MoH in coordination with the SMoPCLGA, the State Ministry of Production, Supply and Regulation of Pharmaceuticals and other relevant stakeholders to identify and facilitate related deployment activities. The PMU will work in close consultation with a technical team appointed under the MoH to carry out the activities. The project closing date will remain unchanged as December 31, 2023.

**(i) Proposed Scale-Up Activities**

19. ***The proposed AF will finance additional Pfizer vaccine doses and deployment of vaccines to scale-up the vaccination campaign.*** Vaccine purchasing will be done through subcomponent 1.3 (COVID-19 Vaccine and Vaccine Deployment) of the ERHSP.

20. ***The GoSL is expanding the population to be vaccinated to go beyond the initially set target of 60 percent as summarized in Table 3 below***. Of this, vaccination acquisition for 26.5 percent of the population and deployment and service delivery cost to cover approximately 10 percent of the population will be supported by the proposed ERHSP-AF3. The priority order of different groups has been determined based on the WHO Fair Allocation Framework.

**Table 3: Priority Groups for Vaccination**

| Ranking of Vulnerable Group | Population Group | Number of Additional Individuals to be Vaccinated | % of Population |
|---|---|---|---|
| 1 | Frontline health workers | 155,000 | 0.7 |
| 2 | Front line military and police | 127,500 | 0.6 |
| 3 | Above 60 | 3,159,800 | 14.0 |
| 4 | International travelers and outbound migrant workers/ students, other vulnerable, cleaning, ports, essential, immune-compromised | 225,700 | 1.0 |
| 5 | 50 – 59 with comorbidities | 1,241,350 | 5.5 |
| 6 | 40 – 49 with comorbidities | 1,151,070 | 5.1 |
| 7 | 30 – 39 with comorbidities | 835,090 | 3.7 |
| 8 | 50 – 59 without comorbidities | 1,286,490 | 5.7 |
| 9 | 40 – 49 without comorbidities | 1,828,170 | 8.1 |
| 10 | 30 – 39 without comorbidities | 1,218,780 | 5.4 |
| 11 | All other eligible (12 – 29) with and without comorbidity* | 6,771,050 | 30.2 |
| Total | | 17,845,000 | 80.0 |

*Based on WB staff calculation

**(ii) Financing Arrangements**

21. ***The increased financing will be reflected under component 1 (Emergency COVID-19 Response) with the full of the ERHSP-AF3 being dedicated for vaccine purchase and deployment under subcomponent 1.3***. This includes the procurement of Pfizer vaccines and procurable items and incremental operating costs. Front end fee capitalized would be financed. Project financing for vaccine purchase will continue to include shipping costs to the country if included in the vaccine purchase price and for deployment costs activities and items that strengthen the health and vaccination systems such as planning and programming, expansion of storage capacity and purchase of additional cold chain equipment, full personal protective equipment (PPE), sanitizer, syringes, other consumables, transport, risk communication, training, and incremental service delivery costs that supports the benefits of clinical and non-clinical staff implementing subcomponent 1.3 of the project, including the provision of overtime and additional/special allowance. There will be no allocation for components 2, 3 and 4. The allocation for component 5 (CERC) will be maintained at zero. Table 4 presents the indicative allocation for each component by financing source.

**Table 4: Project Cost and Financing**

| Project Components | Parent Project Cost including AF1 +AF2 (US$ million) | Parent + AF3 Cost (US$ million) | IBRD or IDA financing | Trust Funds (PEF) | Co-Financed with |
|---|---|---|---|---|---|
| Component 1: Emergency COVID-19 response | 247.76 | 347.76 | IBRD+IDA | 1.72 | _ |
| - *Subcomponent 1.1: Strengthening health system response* | *80.00* | *80.00* | *IBRD+IDA* | *1.72* | _ |
| - *Subcomponent 1.2: Social and financial support to vulnerable households* | *87.24* | *87.24* | *IDA* | _ | _ |
| - *Subcomponent: 1.3 COVID-19 Vaccination* | *80.52* | ***180.52*** | ***IBRD+IDA*** | **_** | **_** |
| Component 2: Strengthening national and sub national institutions for prevention and preparedness | 35.0 | 35.0 | IBRD+IDA | _ | _ |
| Component 3: Strengthening multi-sectoral, national institutions and platforms for one health | 8.6 | 8.6 | IBRD+IDA | _ | _ |
| Component 4: Implementation management and monitoring and evaluation | 5.0 | 5.0 | IBRD+IDA | _ | _ |
| Component 5: Contingent emergency response | 0.0 | 0.0 | _ | _ | _ |
| **Total cost** | **296.36** | **396.36** | **US$189 million IBRD + US$207.36 million IDA** | **US$1.72 million** | **_** |

**Table 5: Summary of COVID-19 Vaccine Sourcing and Bank Financing**

| | National plan target (pop percent) | Source of vaccine financing and population coverage | | | | Specific vaccines and sourcing plans | Doses purchased with Bank finance (2 doses assumed) | Estimated allocation of Bank financing |
|---|---|---|---|---|---|---|---|---|
| | | COVAX grant | Bank-financed | | Other | | | |
| | | | Through COVAX | Through direct purchase | | | | |
| This AF (ERHSP-AF3) | A minimum of 80 percent* | 7.38 percent | - | Vaccine to cover an estimated 26.50 percent (and deployment of approximately 10 percent) | GoSL: 34.9 percent India: 1.1 percent China: 6. 7 percent ADB: 4.4 percent | Vaccines to cover 52 percent of population have arrived, which leaves WB financing of Pfizer vaccines the dominant source for the rest | N/A** | **Purchase:** N/A** **Deployment**: N/A** **Other:** N/A** |
| Previously approved vaccine operation for this country | | | - | Vaccine to cover an estimated 15.72 percent (and deployment of approximately 16 percent) | | | N/A** | **Purchase:** N/A** **Deployment**: N/A** **Other:** N/A** |

*Decision was made by the National Task Force for Covid Management to aim beyond the original target of 60 percent vaccination coverage. The 80 percent coverage includes pregnant/lactating women and children aged 12-17.
**Information has been provided to the Bank in confidence and remains restricted from public access unless and until there is prior written consent to disclose.

### (iii) Results Framework

22. ***The target of the percentage of the population vaccinated will be adjusted to reflect the increased financing for vaccination.*** The target will be increased to 56.8 percent for both males and females. The changes proposed to the results framework indicator reflecting modifications to the new ERHSP-AF3 components are reflected below.

| Indicators | Baseline | Target | Current status | New target |
|---|---|---|---|---|
| ***PDO level indicator*** | | | | |
| Percentage of the population vaccinated, which is included in the priority population targets defined in the NDVP, disaggregated by gender. | 0.01 (210,000 people) * | 20 | 14.6 | 56.8 ** |
| ***Intermediate indicators*** | | | | |
| National Deployment and Vaccination Plan for COVID-19 vaccines with input from relevant bodies are updated by the government, as needed | No | Yes | No | Yes |
| Number of districts with functional vaccination tracking system/HMIS collecting sex and age disaggregated data on COVID-19 vaccines at district level | 3 districts | 25 districts | 25 districts | 25 districts |

*Both male and female, Epidemiology Unit, MoH.
** The target will be equally set for males and females.

### B. Sustainability

23. ***There is a strong political commitment from the GoSL to mobilize additional financial resources for COVID-19 response, including for vaccine purchase and deployment.*** The funds through the proposed ERHSP-AF3 for vaccine purchase and deployment will establish an enabling environment for other donors, multilateral development banks, and UN agencies to also support efforts in the country. Investments under the parent project and the ERHSP-AFs are expected to strengthen the health system in the country, ensuring institutional sustainability to deal with infectious diseases.

## III. KEY RISKS

24. ***The overall risk to achieving the PDO with the expanded scope of the project for vaccination is High.*** The ratings for all risk categories remain the same as those of the parent project and the first two ERHSP-AFs. The large-scale acquisition and deployment of COVID-19 vaccines entail certain significant risks. Given the new changing patterns of the pandemic with the new variant, high demand for new vaccines with greater efficacy or different vaccination regime for different age groups may become the global need in the future. Acquisition of multiple types of vaccines would reduce the risk of delays in vaccine supplies due to production capacity but also increase options to vaccinate faster.

25. ***The political risk remains Substantial.*** Political commitment for the COVID-19 response remains high. Appropriate targeting of the ERHSP-AF3-supported vaccines needs continued monitoring. Prioritization and targeting are based on objective public health criteria. However, the message needs to be communicated properly down to the vaccine centers and population to ensure the target population receives the vaccines at each stage. The UN/DPs technical committee at the MoH oversees the deployment process of the vaccination on a bi-weekly basis. The oversight mechanism is backed by a digitalized real-time immunization tracking system for the COVID-19 vaccination is fully functional in all 25 districts and the hotline operated on the National Grievance Management System for Health Services at MoH. This enables the MoH to obtain data on population coverage disaggregated by age/sex providing information to ensure equitable administration of vaccines and opportunities to address any breach of the deployment criteria such as elite capture and exclusions. The WHO and the Sri Lanka medical expert committee are closely monitoring.

26. ***The macroeconomic risk remains Substantial.*** Macroeconomic vulnerabilities remain high due to weak fiscal buffers, high indebtedness, and large refinancing needs. The GDP growth was -3.6 percent in 2020, severely affected by restricted travel and economic activities due to the pandemic. A prolonged outbreak that leads to prolong and frequent lockdowns could severely hamper growth and place further strain on fiscal sustainability, limiting additional fiscal space for the purchase of vaccines for deployment at scale. In this context, the proposed ERHSP-AF3 specifically aims to mitigate this risk by providing financing for vaccine purchase and deployment that will help curb the community transmission of the COVID-19 pandemic. This in turn could develop confidence in revitalizing economic activities, particularly in the tourism sector that was most affected in the pandemic.

27. ***The ERHSP-AF3 is designed to address key institutional capacity risks related to vaccine deployment and distribution, but residual risks remain Substantial.*** Vaccine deployment cold-chain and distribution capacity are relatively strong in Sri Lanka, especially for the anticipated scale and population

group coverage for COVID-19 vaccination. This risk will be mitigated by this ERHSP-AF3 financing and technical support for immunization system strengthening needs, conducting capacity assessments, and coordinating with WHO, UNICEF and other partners in the provision of systems strengthening support. The residual institutional capacity risk is Substantial considering the inherent risk, and the mitigation via the system strengthening supported under the ERHSP-AF3 and by partners.

28. ***Technical risk remains Substantial.*** There are uncertainties related to the COVID-19 vaccine market, including trial, approval, availability, and pricing, which require flexibility. Whilst the project focuses on vaccines meeting the Bank's VAC, there is a risk that in some cases other vaccines procured by the recipient under its national vaccination program might end up being deployed through systems financed under the Project. These risks will be closely monitored during implementation. In addition, through robust monitoring, any risks related to improper storage of vaccines, delays in delivery, and administration of vaccines caused by a shortage of needed inputs/supplies will be identified and addressed. Developing plans for the potential acquisition of other types of vaccines, when they become available and receive the necessary regulatory approvals, would spread the risk of delays in vaccine supplies due to production capacity. In addition, the project operational manual will make clear that the country's regulatory authority is responsible for its assessment of the project COVID-19 vaccines' safety and efficacy and is solely responsible for the authorization and deployment of the vaccines in the country.

29. ***Institutional capacity risk remains Substantial.*** Sri Lanka has a well-developed logistic and cold chain system through its reputable EPI program. However, COVID-19 vaccine rollout efforts remain challenging. The NDVP provides a calculation of the existing cold chain capacity (+2 to +8 °C) at different levels that is sufficient to accommodate a large number of COVID-19 vaccines without crowding out spaces needed for the routine immunization program. Nonetheless, the capacity in managing the COVID-19 vaccines varies between districts. The GoSL has strategized to utilize the excess capacity of a district to accommodate vaccines for other districts with insufficient storage capacity so that sufficient quantities can be stored for all districts within the province. Detailed planning of vaccine storage with sound backup plans in case logistic issues arise will help mitigate the risk of cold chain interruption. Additional measures have been taken by the GoSL to expand the national cold room capacity, including two selected provincial cold stores. Further, GoSL is in the process of purchasing two ULT containers to enhance the storage facilities for vaccines requiring ULT (-60 to -80 degree Celsius) requirements.

30. ***Fiduciary risk remains Substantial***. The key procurement risk is that the market for COVID-19 vaccines is uncertain and complex. Key risks include the likely inability of the market to supply adequate quantities of vaccines to meet global demand, limited market access by GoSL due to advance orders by other countries, and potentially insufficient bargaining power for purchasers given the significant market power enjoyed by vaccine manufacturers. Recent appointment of designated fiduciary staff in the PMU may help to mitigate the key constraints in FM-related institutional and implementation capacity at the MoH, and the attendant delays in the implementation of procurement due to slow decision making.

31. ***The environmental and social risks remain Substantial.*** Key environmental risks are related to the collection, transport, and disposal of hazardous medical waste generated by the COVID-19 vaccination program across a large number of vaccination centers. In addition, there is a risk of exposure to COVID-19 for a range of communities and individuals, including frontline health care workers and others involved in the vaccination campaign. These risks will be mitigated by the ERHSP-AF3 by fulfilling existing gaps in health care waste management in the proposed centers and adhering to strict measures in infection

prevention and controls, as emphasized under the parent project. So far, no evidence has emerged of significant material impact due to poor occupational health and safety (OHS) or mismanaged HCW from the ongoing vaccination program. The predominant social risks revolve around the challenges in ensuring distribution of the vaccines inclusively and equitably, inadequate public engagement and spread of misinformation which could lead to social tensions, people feeling pressured to receive vaccination against their will, risks of sexual exploitation and abuse and sexual harassment (SEA/SH) for females, and risk of use of excessive force by the military. To mitigate against these risks, operational guidelines for vaccination centers have been developed to ensure that everyone will be treated equally and in a dignified manner including paying attention to specific, culturally determined concerns of minority and vulnerable groups. The project will also promote the avoidance of SEA/SH by adopting the WHO Code of Ethics and Professional Conduct for all health workers, including for community groups and military personnel.

32. ***As the military is involved in the vaccination program, the project conducted a risk assessment in August 2021 to ensure that adequate measures, meeting World Bank's Policy requirements on the use of security personnel, are in place***. The findings from the risk assessment concluded that the overall E&S risk of involving military is 'low', given the measures in place to address the associated risks. The army personnel involved in the vaccination program are professional cadres in the army medical team with similar educational backgrounds as their MoH counterparts and have been trained by the Epidemiology unit of the MoH on the processes and guidelines to follow during vaccinations. In addition, the army personnel have been trained on codes of conduct governed by the Sri Lanka Army Act 1949 (also in line with WHO Code of Ethics and Professional Conduct) and on human rights (HR) principles, International Humanitarian Law (IHL) & IHL Universal Code trained by the 'Directorate of HR and IHL' established within the army. In addition to the codes of conduct in place, the army is required to abide by the standing order on instructions to be followed by army personnel involved in the vaccination program issued by the Commander-In-Chief of the Army Infantry Unit. Further, at all vaccination centers operated by the army, complaint reporting hotlines and recording books are made available, both female and male military health cadres are deployed, and the presence of military police is mandatory as army personnel involved in public activities. Additional findings from the risk assessment and mitigation measures are already included in the revised Environmental and Social Management Framework (ESMF) which was disclosed on September 22, 2021 in the MoH website and on September 23, 2021 in the World Bank website. The additional findings are also included in the Stakeholder Engagement Plan (SEP) and the Labor Management Procedures (LMP) disclosed on September 12, 2021 in the MoH website and on September 17, 2021 in the World Bank website, and also in the Environmental and the Social Commitment Plan (ESCP) disclosed on September 24, 2021 in the World Bank website.

33. ***The risk rating for stakeholder and community engagement remains Moderate***. Inadequate public engagement, misinformation, and spread of rumors may create confusion and anxiety, and concerns regarding Covid-19 vaccination in general. These risks will be mitigated through several measures to ensure vaccine delivery will target and prioritize frontline workers and the most vulnerable populations such as the elderly and people with co-morbidities by criteria identified by MoH. The community-based health officials, Grama Niladari's, and community groups will also support the identification of vulnerable populations in remote locations to access information and support access to vaccination centers. Multiple outreach platforms will be used for information sharing, including messaging through radio programs, television, social media, information hotlines, mobile phones, and community-based platforms to address any questions the public may have about the vaccination and its risks. The existing GRM is available for the public to raise any complaints.

## IV. APPRAISAL SUMMARY

### A. Technical, Economic and Financial Analysis

34. ***The economic case for investing in the COVID-19 vaccine for Sri Lanka is very strong, considering the losses incurred due to the pandemic.*** The real GDP growth rate for 2020 was -3.6 percent, the second worst in the region after the Maldives. The country's economy was hard hit in 2020 especially due to its high dependence on tourism that had virtually dried up due to the COVID-19 pandemic. The poverty rate measured using the $3.20 poverty line (in 2011 PPP) increased from 9.2 percent in 2019 to 11.7 percent in 2020. The recent surge of the pandemic has impacted health service capacity significantly and caused increased rates of case fatality and infection. The pandemic further poses a significant risk of indirect morbidity and mortality from other diseases due to limited access to essential health services. Without a higher population coverage with fully vaccinated, the country will continue to face both health and economic losses as the pandemic continues.

35. ***The proposed ERHSP-AF3 and the parent project will yield substantial economic returns to the investment through the revitalization of economic activities, reduced morbidity and mortality, and accumulation of human capital.*** The effective launch of a COVID-19 vaccine will have direct benefits in terms of reduced pressure on the health system and averted treatment costs as well as strengthened health systems. In addition to the immediate health benefits, COVID-19 vaccination could speed up the reopening of the economy that will likely yield more return than its investments, particularly through building confidence in the tourism sector. It can also reverse human capital losses by ensuring schools are reopened. Global experience with immunization against diseases shows that vaccines are one of the best buys in public health.

36. ***The proposed ERHSP-AF3 will finance vaccine procurement for 26.5 percent of the population, and deployment and service delivery to cover approximately 10 percent of the Sri Lankan population as part of the GoSL's aim to vaccinate all eligible population.*** Given the externality of vaccination, the benefit in protecting the people's safety and health will go beyond the covered population. Other benefits not quantified here include poverty alleviation and psychological benefits of a healthy population. Healthier people can work more productively and thus earn a higher return in the labor market. The ERHSP-AF3 will contribute to human capital development and increase productivity directly by reducing incapacity. The project and the ERHSP-AF3 will therefore contribute to inclusive and sustainable economic growth in Sri Lanka.

### B. Financial Management

37. ***Financial Management (FM) arrangements*** are in line with fiduciary requirements of OP 10.00. The PMU is already established under the MoH with the designated staff for the ERHSP and the ERHSP-AF3 is the main implementing agency. It will be responsible for overall FM coordination, monitoring, and FM arrangements for the activities managed under the proposed additional financing including the compliance with the financial covenants of the legal agreement. In line with the guidelines as stated in the Financial Management Practices Manual issued by the Financial Management Sector Board on March 1, 2010, a FM assessment was conducted for the parent project. The overall financial management

arrangements established for the parent project are satisfactory and will be replicated for the ERHSP-AF3.[14] A full-time Finance Manager and senior accounts officer appointed for the PMU of ERHSP will continue to be responsible for managing FM activities. The World Bank will provide guidance to manage and coordinate the overall FM arrangements related to the activities managed by the MoH.

38. ***Budgeting.*** The fund requirement for the additional financing of the project will be budgeted with a separate budget line for the MoH in the GoSL annual estimates.

39. ***Disbursements*** will be report-based using Interim Unaudited Financial Reports (IUFRs). The Project will open a separate US dollar-denominated dedicated Designated Account (DA) at the Central Bank of Sri Lanka (CBSL) in the name of Deputy Secretary to Treasury (DST) for disbursement purposes under the ERHSP-AF3. This DA will be operated and managed by the PMU housed at MoH. Advances to the DA will be made based on six months of projected expenditure and these funds will be solely used to finance eligible expenditure. Actual expenditure incurred will be tracked and recorded in the IUFR prepared by the PMU and will be submitted quarterly to WB within 45 days from the end of the quarter. For vaccine purchases, Direct Payment and/or Special Commitment disbursement methods including UN Commitment/Advance may be used. Withdrawal of funds is to be made first under the ERHSP-AF2 before the withdrawal of funds is made from this ERHSP-AF3. Separate books of accounts will be maintained by the PMU to track payments made under each ERHSP-AF. Any World Bank funds received for project activities that are not fully utilized by the closing date of the project will be refunded to the World Bank. In addition, when the advance method of disbursements is to be followed, the PMU at the MoH will open a separate Sri Lanka Rupee (LKR) account for the ERHSP-AF3 at a state commercial bank that will be operated by the PMU to receive funds from the DA and make payments for eligible project expenditures following the country system. This account will be operated to track payments being made using WB finances.

40. ***Audit arrangements.*** The Project will be subjected to internal and external audits. The external audit of the project will be carried out by the Auditor General of Sri Lanka, which is acceptable to the Bank. The audited financial statements for the ERHSP-AF3 will be required to be submitted by the MoH to the Bank within 6 months of the end of the financial year. There are no outstanding audit reports for the project. Audit report for the FY20 was received and found to be acceptable to the Bank.

41. ***Internal Audit.*** Internal audit of the ERHSP-AF3 will also be carried out by the internal auditor of the Primary Health Care Systems Strengthening Project (PSSP) for activities managed by the MoH. The PMU will share the internal audit reports with the Bank within 60 days of the end of each quarter.

42. ***Retroactive financing.*** Retroactive financing (RF) of 20 percent (US$20.0 million equivalent) is eligible for this ERHSP-AF3. RF will apply to eligible expenditures incurred by the GoSL during the period December 1, 2020, and the Financing Agreement signing date. Such RF limit would enable the GoSL to reimburse procurement of Bank approved vaccines and deployment costs such as expansion of storage capacity and purchase of additional cold chain equipment, full PPE, sanitizer, syringes, other consumables, transport, risk communication, training, monitoring and evaluation, and incremental service delivery costs that support the benefits of clinical and non-clinical workers implementing subcomponent 1.3 of the project, including the provision of overtime and additional/special allowance. The MoH will prepare IUFRs

[14] See *Project Paper* of ERHSP-AF2

for the eligible expenditure incurred by the MoH under the ERHSP-AF3 and submit them to the Bank for reimbursement. Transactions carried out to incur eligible expenditure under RF can be submitted to the World Bank for reimbursement as soon as the ERHSP-AF3 is declared effective.

43. ***Financial Covenants.*** The financial covenants are: (i) audited annual project financial statements to be submitted to the Bank no later than six months of the following fiscal year; and (ii) project IUFRs to be submitted to the Bank no later than 45 days following the end of the reporting quarter.

44. ***FM risks remain Substantial.*** FM-related risks and the mitigation measures outlined in the parent project remain relevant for the ERHSP-AF3 as well. FM risk will be monitored during periodic implementation missions and effective implementation of proposed mitigation measures will be reassessed based on the action taken.

| Risks | Mitigation Measures |
|---|---|
| Poor FM capacity will lead to delayed and inaccurate reporting, and weaknesses in the preparation of Interim Unaudited Financial Reports (IUFRs) may be encountered. | Hand holding support by the Bank and the provision of clear guidelines/ formats for financial reporting. The MoH will maintain separate books of accounts for the project, as per existing practices, based on an agreed chart of accounts. The project financial management arrangements have been documented in the Project Operations Manual and being followed-up. |
| Delayed finalization of annual financial statements which leads to delayed submission of Audited Financial Statement to auditors which in turn delays the submission of audit reports. | With the new recruitment of the designated FM staff at the PMU, FM capacity has been enhanced. It is expected that the overall audit process will improve including finalizing the annual accounts and submission to auditors on time. |

## C. Procurement

45. ***Procurement under the proposed ERHSP-AF3 will be carried out by the World Bank Procurement Regulations for IPF Borrowers***, Fourth Edition, November 2020 ("Procurement Regulations"). As for the ERHSP and ERHSP-AF2, the ERHSP-AF3 will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and July 1, 2016. The ERHSP-AF3 will continue to use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record, and track procurement transactions.

46. ***This ERHSP-AF3 will finance the procurement of additional doses of the Pfizer vaccine subject to the same conditions as in the previous vaccine procurement.*** The Pfizer vaccine being purchased has not been affected by delays; however, other related procurements may encounter delays due to high demand for the product. In parallel, the GoSL acquires vaccines from other major suppliers. Contracts for vaccines will be subject to the World Bank's prior review irrespective of value and procurement approach. In addition to the procurement of vaccines, the non-vaccine procurement may include, among others: (a) additional capacity or refurbishment of facility-based and mobile energy-efficient cold chain equipment and supplies including cold rooms, ice lined refrigerators, refrigerator vehicles, and vaccine carriers; (b) technical assistance for risk communication and advocacy, assessments of effective vaccine management capacity and training of front-line delivery workers; and (c) vaccine logistics and information management systems and information systems to monitor adverse effects from immunization.

47. ***The overall procurement arrangement will remain the same with the availability of flexibilities under fast-track procurement.*** In addition to direct selection method, particularly for vaccines, other options for procurement include: (i) streamlined competitive procedures with shorter bidding time; (ii) use of framework agreements including existing ones; (iii) procurement from UN agencies enabled and expedited by World Bank procedures and standard agreements; and (iv) increased thresholds for "Requests for Quotations" and Open National Completive Procurement. Each procurement will be evaluated on a case-by-case basis considering the value and complexity of the job, and the prevailing market conditions, as well as the associated risks. The State Pharmaceutical Corporation (SPC) has been carrying out the procurement of vaccines and other vaccine deployment-related supplies under the ERHSP-AF2 and will continue to do the vaccine procurements in this ERHSP-AF3 as well. Procurement for some items required for vaccine deployment will continue to be carried out by the COVID-19 PMU under the MoH. To expedite procurement, amendments to existing MoUs with UNICEF and UNOPS may be considered. The institutional arrangements within MoH have been further strengthened by identifying a Project Director and a dedicated Procurement Officer who have experience working in World Bank funded projects and other International Funding Agencies.

48. ***The project procurement strategy for development (PPSD) and the Procurement Plan has been updated to reflect the modifications under this ERHSP-AF3.***

49. ***Procurement risks remain Substantial.*** The procurement risks and the mitigation measures are summarized in the table below.

| Risks | Mitigation Measures |
|---|---|
| The market for COVID-19 vaccines is uncertain and complex due to growing demand. Key risks include the likely inability of the market to supply adequate quantities of vaccines to meet global demand; limited market access by the GoSL due to advance orders by other countries; and potentially insufficient bargaining power for purchasers given the significant market power enjoyed by vaccine manufacturers. | The procurement of vaccines using the direct selection method with the option to purchase through the major vaccine manufacturers will in part mitigate this risk. There will be supply chain and logistics risks that will need to be managed through close monitoring of the cold chain and storage capacities not only for the vaccines financed by the Bank, but potentially vaccines acquired through COVAX 20, ADB, or other International Funding Institutes. |
| Lack of previous experience of the SPC in implementing WB financed procurement. | The SPC has long-standing experience in the procurement of medical supplies, although it has not conducted procurement under WB financing. The SPC has adequate procurement staff. All staff in the procurement department were trained locally and some of them have been offered International pieces of training. The risk has been mitigated by providing detailed training on the World Bank Procurement Regulations and STEP to the staff of SPC through ERHSP-AF2. Since the Project is mainly based on one contract for the vaccine, it is envisaged that there will not be any major issues during the contracting process. |
| Delays in procurement. | The GoSL has instituted Emergency Procurement Procedures for the procurement of health-related supplies and equipment. These procedures streamline approvals processes, raise delegation of authorities, and reduce bidding periods for such procurements. The Bank will ensure that these procedures will |

| Risks | Mitigation Measures |
|---|---|
| | continue to be followed and seek confirmation during appraisal. In addition, flexibilities in the Bank's Procurement Regulations and streamlined procedures, use of existing arrangements with UN Agencies, and enhanced thresholds for request for quotation (RFQ) and request for bid (RFB) will further ensure timely procurement. |
| The HNP sector is susceptible to critical risks posed by shortcomings in the procurement systems, particularly for the international market approach. | The World Bank's procurement oversight will be ensured through increased implementation support. The World Bank's prior and post review arrangements will apply as specified in the procurement plan. All contracts for vaccines will be subject to prior review. Post procurement review (PPR) will be conducted at least once annually or more frequently based on need. |

## D. Legal Operational Policies

| | Triggered? |
|---|---|
| Projects on International Waterways OP 7.50 | No |
| Projects in Disputed Areas OP 7.60 | No |

## E. Environmental and Social

50. ***Activities under the ERHSP-AF3 will have net positive impacts as they will improve capacity for surveillance, monitoring, and containment of COVID-19.*** The key risks of the ERHSP-AF3 remain the same as the previous ERHSP-AF2 for vaccines. They include (i) potential environmental pollution and community health and safety issues from handling, transportation, and disposal of HCW. Wastes will be generated in significant quantities. These added quantities of HCW can stretch the existing system in the country being used for the safe disposal of HCW such as the incinerators. It will require special handling and awareness as it could pose a huge risk to HCWs from occupational infections and the communities if not disposed of properly; and (ii) OHS issues related to potential infection of health care workers as well as communities through the handling of patients, supplies, vaccination and, if deemed required, the installation of cold chain facilities. Incinerator facilities available at non-health sectors, private health and private organizations have been mapped out, and mechanisms have been identified for additional requirements for incineration facilities during the campaign through the identified waste management network within the health sector. The safety of these front-line workers would need to be ensured via proper infection control procedures and the provision of adequate PPEs. There will be no new civil works funded under the ERHSP-AF3. The project may support strengthening the cold chain for vaccine storage and deployment if needed, and if so the specifications for such equipment will ensure energy efficiency and low GHG footprint through necessary equipment specifications. Occupational COVID-19 infection risks will be mitigated with OHS standards and site-specific infectious-control and health care waste management plans as recommended by WHO.

51. ***In compliance with the ESF and line with WHO and national guidelines, the parent project developed a comprehensive ESMF that includes a detailed generic Health Care Waste Management Plan (HCWMP).*** The ESMF of the ERHSP has undergone several revisions. After the approval of ERHSP-AF2, the MoH updated the ESMF and the generic HCWMP to specifically include mitigation of risks from COVID-19 vaccination. As such, the April 2021 ESMF adequately covers the requirements of this ERHSP-AF3. The ESMF would only require minimum

adjustments to reflect the financial top-up for vaccine delivery and to reflect a few gap fillings on fire and safety associated with some medical equipment under procurement.

52. ***The key social risks for this ERHSP-AF3 will be the risks of social exclusion of prioritized groups, including those from high-risk and vulnerable categories and those in remote locations from accessing the vaccine and inadequate public engagement, misinformation, and spread of rumors creating confusion and anxiety, and concerns regarding COVID-19 vaccination.*** Operational guidelines for vaccination centers will ensure that everyone will be treated equally and in a dignified manner, including paying attention to specific, culturally determined concerns of minority and vulnerable groups. The GoSL does not have mandatory and forced vaccination policies. Accordingly, policies and procedures will be in place to ensure informed written consent is obtained before vaccinating eligible individuals ensuring that no forced vaccinations will take place. Hence the proper application of the Bank's stakeholder engagement standard as described in the SEP of the project will be especially important to mitigate these risks.

53. ***To ensure equitable and unbiased access to vaccination, the following mechanisms will be used to monitor the vaccination process:*** (i) a digitalized real-time immunization tracking system for the COVID-19 vaccination which is functional in all 25 districts.[15] The GoSL is reviewing the current deployment criteria and will soon lay out the national criteria, reflecting the evolving global recommendations and new epidemiological pattern; and (ii) UN/DPs technical committees on COVID-19 vaccination deployment will provide the opportunity to share and analyze available information and unify policy dialogue with the government and stakeholders.

54. ***The community engagement approach, detailed in the national COVID-19 vaccine deployment plan and described in the SEP, focuses on demand generation in communities, clarifies target groups, and removes misconceptions related to vaccinations while ensuring a community feedback loop***. the objectives of the community engagement strategy includes: (i) disclosure of criteria and justification of the identification of priority populations; (ii) building trust and awareness on COVID-19 vaccines, using data and evidence to dispel rumors and public misperceptions and to address vaccine hesitancy; (iii) development and provision of context specific IEC/behavior change communication (BCC) materials targeted to priority groups, details on available services at the vaccination centers catering to needs of women and other high-risks groups and measures in place to manage Adverse Effects Following Immunization (AEFI); (iv) training of front line workers, including 'Field Health Facilitators' about the COVID-19 vaccine, its importance and measures to promote safety and wellbeing of the public; (v) promoting the COVID-19 vaccine through use of different channels, including mass and social media and community and public outreach interventions; and (vi) citizen engagement, feedback and grievance redressal mechanisms. Accordingly, the parent project's SEP has been updated with these actions related to communications, outreach, and stakeholder engagement. The parent project also includes a stakeholder engagement indicator "Percentage of received grievances that are addressed within 30 days" which will be used for the ERHSP-AF3 component as well.

55. ***The project will also take measures to avoid and mitigate issues and risks of SEA/SH during vaccine deployment in communities.*** These include having separate rooms/vaccine areas and toilets for females, having at least one female staff in place, a Code of Conduct for all the staff, and accessible and functioning GRM ensuring that it is accessible by female beneficiaries. In addition, the project will adopt the WHO Code of Ethics and Professional Conduct for all health workers including community groups and military personnel supporting

[15] Assessment of the immunization tracking system could also be included in the independent periodic assessment of the ERHSP-AF2 and 3.

the vaccination program. Accordingly, the project's ESMF, LMP and SEP have been updated with these additional measures to address SEA/SH risks during the implementation of ERHSP-AF2.

## F. Gender

56. ***The ERHSP parent project was gender-tagged, and it will apply to the proposed ERHSP-AF3.*** Pandemics can create or exacerbate vulnerabilities that especially put women and girls at increased risk of gender-based violence (GBV). The lockdown and additional economic stresses have increased the risks of GBV among women and girls in Sri Lanka***.*** With the 3rd wave of the pandemic, Sri Lanka has seen more curfews and extended lockdowns which increase the vulnerability of women and children experiencing prolonged incidences of domestic violence (DV) and GBV. With the support of the parent project, the GoSL outlined plans to strengthen programs for the prevention of GBV and provide mental health support to survivors through the existing program of Mithuru Piyasas under the public health department. Activities focused on (a) developing public messaging on prevention of GBV and creating awareness about the services available to survivors of GBV, (b) developing standard operating procedures for quarantine facilities to prevent GBV and child abuse as well as include GBV screening so survivors can be referred to support services, (c) strengthening and digitalizing data management systems and integrating GBV into the health management information system, (d) refurbishing and strengthening GBV care centers and counseling services at public hospitals and training hospital staff on GBV management, and (e) strengthening GBV and child protection service provision through the increase of hotline services.

57. ***Enhanced the SEA/SH risk mitigation activities to address the rising GBV issues especially in the pandemic context are ongoing.*** The project will continue the following activities: (a) training of health workers at vaccination centers with the basic skills to respond to disclosures of GBV and to whom they can make referrals for GBV service provision; b) development of public messaging on the prevention of GBV and creating awareness about the services available to survivors of GBV. The GRM will be an entry point to strengthen the GBV referral system; and (c) targeting of high-risks groups for GBV such as female headed households, women with disabilities, elderly women or women of ethnic minority groups by working with Public Health midwives and CSOs which work on women's rights and these vulnerable groups to encourage uptake in GBV and child protection services.

58. ***The indicator for measuring progress towards gender intervention*** will remain as the "number of women utilizing gender-based violence services through the Mithuru Piyasas". The increase in the number of women utilizing services from the Mithuru Piyasa since the implementation of the parent project to this phase of the project can be captured through this indicator.

59. ***The COVID-19 pandemic can exacerbate existing gender gaps in women's access to information and healthcare services.*** To increase proper outreach and vaccination of women, the project supports targeted communication, as outlined in the NDVP, to disseminate information regarding the COVID-19 vaccination, particularly to dispel misconceptions about vaccines. Furthermore, the project mobilizes 'Field Health Facilitators' especially females to play a critical role in communicating with women about the vaccine and managing misinformation regarding COVID-19 vaccination. It also works with CSOs working with high-risk groups to ensure information around the vaccines reaches them and increases their access to the vaccine by conducting sessions with families, religious leaders and community leaders to educate them on the importance of gender-equitable access to the vaccine.

### G. Climate Vulnerability and Resilience

60. ***The ERHSP-AF2 had been screened for short and long-term climate change and disaster risks, and there is no significant change since the ERHSP-AF2.***[16] The climate co-benefit for the ERHSP-AF2 was 6.67 percent, which corresponds to total climate finance of US$5.4 million of which US$2.7 million is adaptation co-benefits and another US$2.7 million is mitigation co-benefits. ERHSP-AF3 was submitted for climate co-benefits assessment.

61. ***The ERHSP-AF3 will address identified vulnerability to climate change and disaster risks in the design and implementation of activities under subcomponent 1.3 in the same manner as ERHSP-AF2.***[17]

62. ***The proportion of subcomponent 1.3 financed through COVAX not only accounts for the cost of the vaccines but also includes safety boxes for disposal of syringes, syringes, international freight, and procurement fees.*** To protect vaccines from exposure to extreme temperatures, per WHO requirement, the vaccines are kept cool during transport with non-energy consuming coolant packs inside shipping units. This is both a climate adaptation and mitigation measure as (i) it ensures a reduction in possible vaccine wastage due to exposure to climate-related extreme heat events, and (ii) the vaccine is kept in non-energy-consuming cool packs thereby reducing GHG through reduced energy use. Further, WHO also requires temperature monitoring devices in all vaccine shipments which is another climate adaptation measure to prevent wastage, and which the project includes in its design. Concerning safety boxes for the disposal of syringes, this is also an adaptation and mitigation measure as (i) it reduces the risk of exposure to medical waste during flooding and another climate-related extreme event, and (ii) disposal of syringes in this manner does not require incineration and hence would reduce GHG emissions. The total estimate for climate adaptation for these measures, as part of the vaccine price, is estimated at 20 percent of subcomponent 1.3.

## V. WORLD BANK GRIEVANCE REDRESS

*63.* ***Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS).*** The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*

64. ***World Bank Sri Lanka received two grievances related to the Bank-financed COVID-19 vaccination program.*** Both grievances were related to the delay in receiving the second dose of the AZ vaccine. WB

[16] See *Project Paper* of ERHSP-AF2 for screening results.
[17] See *Project Paper* of ERHSP-AF2.

responded to the query explaining that the WB supported health project follows the national vaccine deployment plan of the GoSL and also shared the contact details of the MoH GRM hotline with the complainants. The Project management unit and the GRS were also kept informed about the complaint. Going forward, in the WB website, links will be provided to the MoH websites where the public could access information about the WB financed vaccine rollout plans, including hotlines/contacts to raise queries/complaints directly with the MoH about the vaccine program.

65. ***Grievance redress mechanism (GRM).*** The parent project incorporates a comprehensive project GRM which will eventually evolve into the National Grievance Management System for Health Services. This GRM is operated by the office of the Additional Secretary of Medical Services at the national level. Since the establishment of the GRM, 1,552 grievances have been received and 1,314 have been resolved. Awareness of GRM has been created in 63 hospitals. A 'Beneficial Feedback' indicator was introduced in the project's Results Framework.

## VI SUMMARY TABLE OF CHANGES

| | Changed | Not Changed |
|---|---|---|
| Results Framework | ✓ | |
| Components and Cost | ✓ | |
| Implementing Agency | | ✓ |
| Project's Development Objectives | | ✓ |
| Loan Closing Date(s) | | ✓ |
| Cancellations Proposed | | ✓ |
| Reallocation between Disbursement Categories | | ✓ |
| Disbursements Arrangements | | ✓ |
| Legal Covenants | | ✓ |
| Institutional Arrangements | | ✓ |
| Financial Management | | ✓ |
| Procurement | | ✓ |
| Implementation Schedule | | ✓ |
| Other Change(s) | | ✓ |

## VII DETAILED CHANGE(S)

### MPA PROGRAM DEVELOPMENT OBJECTIVE

#### Current MPA Program Development Objective

The Program Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness

#### Proposed New MPA Program Development Objective

### EXPECTED MPA PROGRAM RESULTS

#### Current Expected MPA Results and their Indicators for the MPA Program

Progress towards the achievement of the PDO would be measured by outcome indicators. Individual country-specific projects (or phases) under the MPA Program will identify relevant indicators, including among others:

- Country has activated their public health Emergency Operations Centre or a coordination mechanism for COVID-19;
- Number of designated laboratories with COVID-19 diagnostic equipment, test kits, and reagents;
- Number of acute healthcare facilities with isolation capacity;
- Number of suspected cases of COVID-19 reported and investigated per approved protocol;
- Number of diagnosed cases treated per approved protocol;
- Personal and community non-pharmaceutical interventions adopted by the country (e.g., installation of handwashing facilities, provision of supplies and behavior change campaigns, continuity of water and sanitation service provision in public facilities and households, schools closures, telework and remote meetings, reduce/cancel mass gatherings);
- Policies, regulations, guidelines, or other relevant government strategic documents incorporating a multi-sectoral health approach developed/or revised and adopted;
- Multi-sectoral operationalmechanism for coordinated response to outbreaks by human, animal and wildlife sectors in place;
- Coordinated surveillance systemsin place in the animal health and public health sectors for zoonotic diseases/pathogens identified as joint priorities; and
- Mechanisms for responding to infectious and potential zoonotic diseases established and functional; and
- Outbreak/pandemic emergency risk communication plan and activities developed and tested

Proposed Expected MPA Results and their Indicators for the MPA Program

## COMPONENTS

| Current Component Name | Current Cost (US$, millions) | Action | Proposed Component Name | Proposed Cost (US$, millions) |
|---|---|---|---|---|
| Component 1: Emergency COVID-19 Response | 249.48 | Revised | Component 1: Emergency COVID-19 Response | 349.48 |
| Component 2: Strengthening National and Sub-national Institutions for Prevention and Preparedness | 35.00 | | Component 2: Strengthening National and Sub-national Institutions for Prevention and Preparedness | 35.00 |
| Component 3: Strengthening Multi-sectoral, National institutions and Platforms for One Health | 8.60 | | Component 3: Strengthening Multi-sectoral, National institutions and Platforms for One Health | 8.60 |
| Component 4: Implementation Management and Monitoring and Evaluation | 5.00 | | Component 4: Implementation Management and Monitoring and Evaluation | 5.00 |
| Component 5: Contingent Emergency Response Component | 0.00 | | Component 5: Contingent Emergency Response Component | 0.00 |
| **TOTAL** | **298.08** | | | **398.08** |

## Expected Disbursements (in US$)

| Fiscal Year | Annual | Cumulative |
|---|---|---|
| 2020 | 51,750,946.00 | 51,750,946.00 |
| 2021 | 129,390,413.00 | 181,141,359.00 |
| 2022 | 140,000,000.00 | 321,141,359.00 |
| 2023 | 70,000,000.00 | 391,141,359.00 |
| 2024 | 6,928,641.00 | 398,070,000.00 |

## SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

| Risk Category | Latest ISR Rating | Current Rating |
|---|---|---|
| Political and Governance | Substantial | Substantial |
| Macroeconomic | Substantial | Substantial |
| Sector Strategies and Policies | Moderate | Moderate |
| Technical Design of Project or Program | Substantial | Substantial |
| Institutional Capacity for Implementation and Sustainability | Substantial | Substantial |
| Fiduciary | Substantial | Substantial |
| Environment and Social | Substantial | Substantial |
| Stakeholders | Moderate | Moderate |
| Other | | |
| Overall | Substantial | High |

## LEGAL COVENANTS – Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project (P177714)

| Sections and Description |
|---|
| No information available |

### Conditions

## VIII. RESULTS FRAMEWORK AND MONITORING

### Results Framework

COUNTRY: Sri Lanka

Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project

### Project Development Objective(s)

To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Sri Lanka

### Project Development Objective Indicators by Objectives/ Outcomes

| Indicator Name | PBC | Baseline | End Target |
|---|---|---|---|
| **To prevent, detect and respond to the threat posed by COVID-19** | | | |
| Emergency Operations Centre for COVID-19 and pandemic responses established (Yes/No) | | No | Yes |
| Percentage of health districts with a tertiary or secondary care hospital with isolation capacity (Number) | | 8.00 | 100.00 |
| Percentage of population vaccinated, which is included in the priority population targets defined in the NDVP, disaggregated by gender (Percentage) | | 0.01 | 56.80 |
| ***Action: This indicator has been Revised*** | | | |
| **To strengthen national health systems for preparedness in Sri Lanka** | | | |
| Number of designated laboratories with COVID-19 diagnostic equipment, test kits, and reagents (Number) | | 5.00 | 17.00 |

## Intermediate Results Indicators by Components

| Indicator Name | PBC | Baseline | End Target |
|---|---|---|---|
| **Emergency COVID-19 Response** | | | |
| Number of ICU beds in tertiary and secondary hospitals against planned (Number) | | 560.00 | 750.00 |
| Number of health staff trained in infection prevention and control per MoH approved protocols (Number) | | 100.00 | 1,000.00 |
| Number of secondary and tertiary care hospitals with environmental protection license (EPL) and Scheduled waste license (SWL) (Number) | | 20.00 | 81.00 |
| Guidelines to engage private health facilities in supporting pandemic response (Yes/No) | | No | Yes |
| Number of secondary and tertiary hospitals with solar energy backup to overcome electricity outages (Number) | | 0.00 | 20.00 |
| Number of field staff engaged in elder care, homes for the people with special needs and orphanages trained and equipped for prevention and care measures (Number) | | 100.00 | 1,000.00 |
| Number of beneficiaries provided with cash transfers in response to COVID-19 (Number) | | 0.00 | 600,000.00 |
| Risk communication plan implemented (Yes/No) | | No | Yes |
| Number of individuals utilizing GBV services through the Mithuru Piyasas (Number) | | 9,000.00 | 12,000.00 |
| Number of women utilizing gender-based violence services through the Mithuru Piyasas (Number) | | 8,500.00 | 11,000.00 |
| Number of children and men utilizing gender-based violence services through the Mithuru Piyasas (Number) | | 500.00 | 1,000.00 |
| National Deployment and Vaccination Plan for COVID-19 vaccines with input from relevant bodies is updated by the government, as needed (Yes/No) | | No | Yes |

| Indicator Name | PBC | Baseline | End Target |
|---|---|---|---|
| Number of districts with functional vaccination tracking system/HMIS collecting sex and age disaggregated data on COVID-19 vaccines at district level (Number) | | 3.00 | 25.00 |
| ***Action: This indicator has been Revised*** | | | |
| **Strengthening National and Sub-national Institutions for Prevention and Preparedness** | | | |
| Number of individual isolation rooms established within the National Institute of Infectious Diseases established (Number) | | 0.00 | 27.00 |
| Number of secondary and tertiary care hospitals with networked laboratory information system in place (Number) | | 0.00 | 50.00 |
| Number of sub-national emergency operational centers with an established quarantine mechanism (Number) | | 8.00 | 26.00 |
| Number of secondary and tertiary care hospitals with classified accredited labs (Number) | | 0.00 | 50.00 |
| **Strengthening Multi-sectoral, National institutions and Platforms for One Health** | | | |
| National protocols for detection, surveillance, and response systems for animal and human health infections (Yes/No) | | No | Yes |
| **Implementation Management and Monitoring and Evaluation** | | | |
| Number of peer-reviewed publications from Research Institutions supported to undertake research and monitor progress and capacity of the health system for pandemic preparedness (Number) | | 0.00 | 5.00 |
| Percentage of received grievances that are addressed within 30 days (Percentage) | | 0.00 | 80.00 |

| Monitoring & Evaluation Plan: PDO Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Emergency Operations Centre for COVID-19 and pandemic responses established | | Annual | National Coordinator of Emergency Operations Centre | Report from the National Coordinator | National Coordinator, MoH |
| Percentage of health districts with a tertiary or secondary care hospital with isolation capacity | | Six-monthly | Hospital directors | Reports from relevant hospital directors | DDG, MS, MoH |
| Percentage of population vaccinated, which is included in the priority population targets defined in the NDVP, disaggregated by gender | The target comprises 42.2% coverage of the population through procurement of vaccines financed by the WB and an additional 14.6% population coverage through financing the deployment of vaccines procured by other funding sources. | Annual | Epidemiology Unit, MoH | Report | Chief Epidemiologist, National Coordinator for MoH |
| Number of designated laboratories with COVID-19 diagnostic equipment, test kits, and reagents | | Six-monthly | Hospital Directors | Reports from relevant hospital directors. | DDG, Laboratory Services, MoH |

| Monitoring & Evaluation Plan: Intermediate Results Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Number of ICU beds in tertiary and secondary hospitals against planned | | Six-monthly | Hospital Directors | Reports from relevant hospital directors | DDG, MS, MoH |
| Number of health staff trained in infection prevention and control per MoH approved protocols | | Six-monthly | Epidemiology Unit, MoH | Quarterly report on the number of health staff trained on infection and control measures | DDG (PHS), MoH |
| Number of secondary and tertiary care hospitals with environmental protection license (EPL) and Scheduled waste license (SWL) | | Six-monthly | Directorate of Environment and Occupational Health | Quarterly report from provinces and line ministry institutions on the number of secondary and tertiary care hospitals with EPL and SWL | DDG/ E&OH, MoH |
| Guidelines to engage private health facilities in supporting pandemic response | | Annual | MoH website | Availability of guidelines on the website including a list of private health facilities empanelled to provide support | MoH |
| Number of secondary and tertiary hospitals with solar energy backup to overcome electricity outages | | Six monthly | HMIS | Monthly report from provinces and all line ministry institutions on the number of facilities that have set up solar energy backup systems | DDG, MSI, MoH |

| | | | | | |
|---|---|---|---|---|---|
| Number of field staff engaged in elder care, homes for the people with special needs and orphanages trained and equipped for prevention and care measures | | Six-monthly | MoH | Monthly report on the number of social welfare staff trained on COVID prevention and care measures | MoH |
| Number of beneficiaries provided with cash transfers in response to COVID-19 | | Monthly | MoWCS | Monthly Report on number of beneficiaries provided cash transfers | MoWCS |
| Risk communication plan implemented | Risk communication refers to communication focused on promoting preventive actions to reduce risk of contracting COVID-19 - not only at an individual level, but also for institutions.<br><br>Implementation refers to (1) costed risk communication plan developed (2) expenditures made against the plan; and (3) report outlining progress against the plan, including reporting against output indicators.<br><br>The indicator will be considered achieved if at | Quarterly | MoH | Quarterly report on implementation of risk communication plan | Health Promotion Bureau |

| | | | | | |
|---|---|---|---|---|---|
| | least two out of the 3 criteria are met. | | | | |
| Number of individuals utilizing GBV services through the Mithuru Piyasas | | Quarterly | MoH | Reports from Mithuru Piyasas | Public Health Department |
| Number of women utilizing gender-based violence services through the Mithuru Piyasas | | Quarterly | MoH | Reports from Mithuru Piyasas | Public Health Department |
| Number of children and men utilizing gender-based violence services through the Mithuru Piyasas | | Quarterly | MoH | Reports from Mithuru Piyasas | Public Health Department |
| National Deployment and Vaccination Plan for COVID-19 vaccines with input from relevant bodies is updated by the government, as needed | | Annually | Epidemiology Unit, MoH | Report | Chief Epidemiologist, National Coordinator for MoH |
| Number of districts with functional vaccination tracking system/HMIS collecting sex and age disaggregated data on COVID-19 vaccines at district level | | Annually | Epidemiology Unit, MoH | Report | Chief Epidemiologist, National Coordinator for MoH |
| Number of individual isolation rooms established within the National Institute of Infectious Diseases established | An isolation unit established and functional for at least one month | Six-monthly | Director NIID, MoH | Report on use of the isolation unit, based on number of in-patients and use of the facility. | Director NIID, MoH |
| Number of secondary and tertiary care hospitals with networked laboratory information system in place | | Six-monthly | HMIS | Number of secondary and tertiary care hospitals that are networked as visible on the online laboratory information system | DDG Laboratory Services, MoH |

| | | | | | |
|---|---|---|---|---|---|
| Number of sub-national emergency operational centers with an established quarantine mechanism | | Six-monthly | Reports from DPRU, MoH | Monthly progress report | National Coordinator, DPRU, MoH |
| Number of secondary and tertiary care hospitals with classified accredited labs | | Six-monthly | HMIS | Quarterly Report on the number of hospitals that received the certification of accreditation from the national accreditation team | DDG Laboratory Services, MoH |
| National protocols for detection, surveillance, and response systems for animal and human health infections | (a) One-health protocols for detection, surveillance, and response systems for animal and human health infections developed; and (b) a mechanism to implement the protocols in place (as evidenced by an assigned unit responsible for it and financing of the same) | Six-monthly | MoH | Protocols are available online; and quarterly report on the implementation of the protocol from the responsible unit. | DDG PHS I, MoH |
| Number of peer-reviewed publications from Research Institutions supported to undertake research and monitor progress and capacity of the health system for pandemic preparedness | Count of publications in peer-reviewed journals produced with support of the project funding | Once, at the end of the project period. | MoH | Govt. report listing peer review publications (which can be accessed online) from research supported by them. | DDG ET&R, MoH |
| Percentage of received grievances that are addressed within 30 days | Total number of grievances resolved within 30 days as a percentage of the total number received | Monthly | National GRM system | Report | Office of Additional Secretary - MoH |

## ANNEX 1: SUMMARY TABLE ON VACCINE DEVELOPMENT AND APPROVAL STATUS AS OF SEPTEMBER 15, 2021

| Vaccine | Stringent Regulatory Authority Emergency Use Approval | WHO PQ/EUL |
|---|---|---|
| BNT162b2/COMIRNATY Tozinameran (INN) - Pfizer BioNTech | United Kingdom: December 2, 2020<br>Canada: December 9, 2020<br>United States of America: December 11, 2020<br>European Union: December 21, 2020<br>Switzerland: December 19, 2020<br>Australia: January 25, 2021 | WHO Emergency Use Listing (EUL): December 31, 2020 |
| mRNA-1273 - Moderna | USA: December 18, 2020<br>Canada: December 23, 2020<br>EU: January 6, 2021<br>Switzerland: January 12, 2021<br>UK: January 8, 2021 | WHO EUL: April 20, 2021 |
| AZD1222 (also known as ChAdOx1_nCoV19/ commercialized as COVISHIELD in India) - AstraZeneca/Oxford | UK: December 30, 2020<br>EU: January 29, 2021<br>Australia: February 16, 2021 (overseas manufacturing); March 21, 2021 (for local manufacturing by CSL – Seqirus)<br>Canada: February 26, 2021 | WHO EUL: February 15, 2021, for vaccines manufactured by SK Bio and Serum Institute of India |
| Ad26.COV2.S - Johnson & Johnson | USA: February 27, 2021<br>Canada: March 5, 2021<br>EU: March 11, 2021<br>Switzerland: March 22, 2021<br>UK: May 28, 2021<br>Australia: June 25, 2021 | WHO EUL: March 12, 2021 |
| BBIBP-CorV - Sinopharm | | WHO EUL: May 7, 2021 for vaccines manufactured by Beijing Institute of Biological Products Co Ltd<br>E-Town Vaccine Industry Base<br>No. 6 &9 Bo'xing 2nd Road<br>Economic-Technological Development Area<br>Beijing, China |
| CoronaVac - Sinovac | | WHO EUL: June 1, 2021 for vaccines manufactured by Sinovac Life Sciences Co., Ltd. No. 21, Tianfu Street, Daxing Biomedicine Industrial Base of Zhongguancun Science Park, Daxing District, Beijing, China |

## ANNEX 2: LATEST COVID-19 SITUATION IN THE COUNTRY

1. Sri Lanka is experiencing the 3rd wave of the COVID-19 pandemic with the increased prevalence of Delta variants found in all parts of the country. The second wave of the pandemic began in October 2020, with the detection of a major cluster in a garment factory in the outskirts of Colombo. Despite the significantly wider spread associated with the second wave, the country did not experience an exponential increase in the number of cases at the time. Daily case numbers fluctuated between 500-800 since October 2020 and began to decline in mid-March 2021 to 150- 200.

2. The third wave came with a massive surge in of numbers from April to July (attributable to the Alpha variant) and led to a 30-day lockdown in May/June. Case counts began to rise along with a growing prevalence of the Delta variant that is currently prevalent in the country. With growing case numbers and COVID-19 deaths being at an all-time high, an island-wide lockdown was imposed on August 20th, initially for 10 days, but has since been extended by an additional week.

3. The country has reported a total of 440,302 cases and 9,185 deaths from COVID-19 as of August 31, 2021. 56,961 cases were active while 383,341 patients had recovered. Sri Lanka's recovery rate is around 82 percent, and the case fatality rate is over 2 percent. Approximately 15,000-20,000 PCR tests per day are being conducted per day as of the end of August 2021. In the current context, six main hospitals have reportedly exceeded their capacity to treat COVID patients. With hospitals and treatment centers at maximum capacity, the government is now allowing home-based care of COVID-19 patients.

4. Within the current situation, Sri Lanka is continuing to make progress with the COVID-19 vaccination drive. Vaccination began in late January 2021, and despite a slow start due to the unavailability of vaccines, the program has accelerated since July and is currently being administered throughout the island. As of August 31, 2021, 57.8 percent of the population has received at least one dose of the vaccine.

5. During the month of August 2021, there has been a significant increase in the number of COVID-19 related deaths in the country. An average of 200 deaths are being recorded per day, and deaths per million population is at 9.20. With the spread of the Delta variant most hospitals in the country have been overburdened, and the health service delivery capacity is at tipping point. This in turn has resulted in disruptions in routine health service delivery, and people are unable to access necessary treatment for other serious health conditions.

6. Analyses of the death trend show that 70-80 percent of deaths have been among unvaccinated or partially vaccinated individuals, and there have been relatively few deaths among fully vaccinated individuals. Vaccination has also had an impact on the severity of the disease, and evidence suggests that only 4-5 percent of vaccinated individuals develop complications when infected. Even with the Delta variant, the need for hospitalization and intensive care has been significantly less among the fully vaccinated population. In light of the heavy case load, Sri Lanka has already permitted and provided guidelines for the home-based care of COVID-19 patients showing mild to moderate symptoms. The increase in home-based care has helped reduce the burden on the hospital system. Accelerating the vaccination program could help reduce the severity of disease in more people, thereby reducing the need for hospitalization and relieving the burden on the system. The data also shows an increase in infection and mortality rates among pregnant women and young children, with the spread of the Delta Variant,

suggesting that the vaccination of these groups should also be accelerated. As of September 2, 2021, 700 COVID-19 cases have been identified among pregnant women with 35 deaths.

7. Given significant delays and uncertainties with vaccines to be received from the COVAX facility, Sri Lanka has embarked on direct procurement of vaccines to cover its population. Due to unforeseen circumstances, the vaccination drive from COVAX has not materialized as planned and support was limited to 0.264 million doses (0.6 percent population) of AZ through the COVAX grant. The country awaits to receive the subsequent batches of vaccine supplies from COVAX, Serum Institute of India, Sinopharm, and Pfizer to scale up the vaccination drive. The ERHSP-AF2 under subcomponent 1.3 is supporting the initial consignment of Pfizer vaccines. The GoSL has also entered into an agreement with COVAX to cost-sharing framework facility on July 30, 2021. However, no new procurement under the cost sharing framework has been done to date.

**Status of Vaccine supply as of August 31, 2021**

| Procurement modality | Source of financing | Doses (million) | Manufacturer |
|---|---|---|---|
| **Vaccines delivered** | | | |
| Gift | India | 0.5 | AZ |
| Grant | COVAX | 0.27 | AZ |
| Direct purchase | India (Serum Institute) | 0.5 | AZ |
| Direct purchase | GoSL | 15 | SP |
| Gift | China | 3.0 | SP |
| Direct purchase | Sputnik V | 0.21 | SV |
| Gift | Government of Japan (COVAX Dose-share) | 1.46 | AZ |
| Gift | United State of America (COVAX Dose-share) | 1.5 | MD |
| Purchase | IDA/IBRD | N/A* | PZ |
| Gift | United States of America (COVAX Dose-share) | 0.10 | PZ |
| **Vaccines expected to be delivered** | | | |
| Direct Purchase | TBD | TBD | AZ |
| COVAX Cost Share | COVAX/ADB | TBC | SP |
| Direct Purchase | TBD | TBD | SV |
| Purchase | IDA/IBRD | N/A* | PZ |
| Purchase | IBRD | N/A* | PZ |

**Information has been provided to the Bank in confidence and remains restricted from public access unless and until there is prior written consent to disclose.*
*Abbreviations: AZ, AstraZeneca/Covishield; J&J, Johnson & Johnson; MD, Moderna; PZ, Pfizer; SP, Sinopharm; SV, Sputnik V; TBD, to be determined*

## ANNEX 3: SUMMARY OF THE PARENT PROJECT COMPONENTS

***The project development objective (PDO) of the parent project is*** "to prevent, detect and respond to the threat posed by COVID-19 and strengthen national health systems for preparedness in Sri Lanka". The project comprises of five components, supporting the Sri Lanka Preparedness and Response plan (SPRP). The first AF has increased the scope of Sub-component 1.2 Social and Financial Support to Vulnerable Households. This subcomponent was originally designed to finance the scale-up of social cash transfers for the elderly, persons with disabilities, persons with chronic diseases, such as chronic kidney disease (CKD), and persons from low-income households in response to the current COVID-19 crisis. It also included temporary vertical expansion, that is, increase in the benefit amount for the senior citizens' assistance scheme.

***Component 1: Emergency COVID-19 Response (US$168.96 million—US$20 million from FTF, US$60 million from original IDA, US$87.24 million from ERHSP-AF1 and US$1.72 million from PEF)***

***Subcomponent 1.1: Strengthening the health system response (Total US$81.72 million—US$20 million from FTF, US$60 million from original IDA and US$1.72 from PEF):*** This subcomponent supports: (a) strengthening surveillance and response systems, (b) strengthening capacity of health care facilities for emergency response, (c) establishment of isolation wards and intensive care units (ICUs) in select tertiary and secondary hospitals, and (d) support for information and communication activities to raise awareness, knowledge and understanding among general population about the risk and potential impact of the pandemic.

***Subcomponent 1.2: Social and financial support to households (Total US$87.24 from ERHSP-AF1):*** This subcomponent, introduced through the first AF, is financing the scale-up of social cash transfers through existing well-established delivery mechanisms, and it supports: (a) provision of Cash Transfers to the elderly, persons with disabilities, chronic disease patients and persons who lost livelihoods; and (b) provision of In-Kind Support in the form of food packs to households under quarantine due to COVID-19.

***Subcomponent 1.3: COVID-19 Vaccination (Total US$80.52 from ERHSP-AF2)***

This subcomponent includes an indicative amount of US$41.41 million (51 percent) for eligible vaccine procurement, and procurable medical supplies and incremental staff costs as part of recurrent costs of an indicative amount of US$39.10 million. These resources will be used for: (a) purchase, delivery and distribution of COVID-19 vaccines, related cold chain commodities, PPEs and consumables, other goods, services and operating costs necessary for safe immunization service delivery, and incremental service delivery costs required for the deployment of vaccines to the target populations including incremental service delivery costs that supports the benefits of clinical and non-clinical staff implementing subcomponent 1.3 of the project consisting of provision of overtime and additional/special allowance, and (b) risk communication and advocacy, related analytical work, training of health personnel, supervisory activities, transport, medical waste management, registration systems, and supporting of existing management information systems. This subcomponent will be enhanced by the proposed ERHSP-AF3 of US$100 million.

***Component 2: Strengthening National and Sub-National Institutions for Prevention and Preparedness (Total US$35 million—US$10 million from FTF and US$25 million from original IDA).*** This component supports: (a) strengthening the national and local capacities for treating infectious disease, through expansion of isolation units as well as a new construction of an isolation center within the National Institute of Infectious Diseases (NIID); (b) establishment and strengthening of sub-national emergency operation centers to enable effective pandemic response; (c) establishment of the Bio-Safety Level 3 laboratory facilities at the National Medical Research Institute (NMRI); and (d) Strengthening laboratory facilities and information systems.

***Component 3: Strengthening Multi-sectoral, national institutions and platforms for One Health (Total US$ 8.6 million—US$4 million from FTF and US$4.6 million from original IDA).*** This component supports: (i) conducting a needs assessment of national protocols for detection, surveillance, and response systems for animal and human health infections; (ii) establishing a mechanism for detection of priority existing and emerging zoonoses; (iii) conducting awareness on anti-microbial resistance among human health, agricultural, and veterinary and enforcement of related legislations; and (iv) establishing a mechanism to combat diseases which have a potential to reemerge.

***Component 4: Implementation Management and Monitoring and Evaluation (Total US$5 million—US$1 million from FTF and US$4 million from original IDA).*** This component supports the strengthening of public structures for the coordination and management of the project, including central and provincial arrangements for coordination of activities, financial management and procurement. This component also supports monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, and joint learning on pandemic preparedness across and within countries. In addition, it supports a mechanism for independent assessment or verification of progress and learning.

***Component 5: Contingent Emergency Response (US$0)*** supports the provision of immediate response to an Eligible Crisis or Health Emergency.

**Project Components and Disbursement as of September 23, 2021 (IDA and IBRD Financing)**

| Project Component /Subcomponent | Actual Allocated amount (US$ million) | Disbursement (US$ million) | Share of IBRD/IDA/PEF (US$ million) |
|---|---|---|---|
| **Parent project** | | | |
| 1. Emergency COVID-19 response | | | |
| 1.1 Strengthening the health system response | 81.73 | 74.87 | IBRD: 35.0<br>IDA: 93.6<br>PEF:1.7 |
| 2. Strengthening national and sub-national institutions for prevention and preparedness | 35.0 | 7.32 | |
| 3. Strengthening multi-sectoral, national institutions and platforms for one health | 8.6 | 0.0 | |
| 4. Implementation management and monitoring and evaluation | 5.0 | 4.00 | |
| 5. Contingent Emergency Response (CERC) | 0.0 | 0.0 | |
| **Additional financing (AF)** | | | |

| | | | |
|---|---|---|---|
| 1.2 Social and financial support to vulnerable households (ERHSP-AF1) | 87.24 | 71.2 | IDA: 87.2 |
| 1.3 COVID-19 Vaccination (ERHSP-AF2) | 80.52 | 80.2 | IBRD: 54.0<br>IDA: 26.5 |
| **Total** | **298.09** | **237.59** | |

***Key results achieved:***

- 1 million rapid antigen test kits, 390,000 PCR test kits, and 1.1 million set of PPEs procured for hospitals.
- 87 ICU/HDU beds supplied to increase the total national capacity of ICU/HDU beds to 650.
- 120 high-low nasal oxygen therapy units, 25 ICU ventilators, 7 neonatal ventilators 20 transport ventilators, 2,100 oxygen concentrators were procured through UNOPS.
- 26 cabs and 805 motorbikes procured for use by the Medical Officers of Health and Public Health Inspectors who are in charge of all grassroots-level health and COVID-19 management activities. The additional vehicles increased the capacity for contact tracing, testing, and follow up, and also support vaccine deployment activities.
- 60-70 intermediate care centers with isolation facilities refurbished or modified to handle COVID-19 patients.
- Work has initiated to strengthen four hospitals to function as mini-IDH at the provincial level (Kilinochchi, Hambanthota, Ampara, and NIID), and is expected to complete by mid-2022.
- The project supported improvement of laboratory capacity; automated PCR extraction units were established to accelerate COVID-19 testing capacity in selected laboratories. Furthermore, the project is supporting genomic sequencing by providing related consumables.
- Work has initiated to build/expand ICUs/facilities in six hospitals (Rathnapura, Anuradhapura, Eheliyagoda, Warakapola, Marawila, and Balangoda) and to build/expand high-dependency units/facilities (HDU) in two hospitals (Pimbura and National Institute of Mental Health) and is expected to complete by mid-2022.
- 629,303 elderly persons, 52,940 people with special needs, and 18,972 patients with chronic kidney disease were supported during the first wave of the pandemic.
- 1,338,422 beneficiaries who lost their livelihoods due to the lockdown received a one-time cash transfer of LKR 5,000, and 417,427 beneficiaries sent on home quarantine received an in-kind transfer of food packs worth LKR 5,000 for two weeks from October to December 2020.
- An additional US$80.5 million was provided to support vaccine procurement and deployment. World Bank financing is being used to procure the Pfizer vaccines, arriving in batches from early July and to be completed by late 2021. Further, WB financed costs related to the deployment of vaccines that meet WB VAC, which covers an estimated 14.6 percent of the population.