Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 21-Sep-2021 | Report No: PIDA32680

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Sri Lanka	P177714	Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project	P173867
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Sri Lanka COVID-19 Emergency Response and Health Systems Preparedness Project	SOUTH ASIA	20-Sep-2021	28-Sep-2021
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Democratic Socialist Republic of Sri Lanka	Ministry of Health, State Ministry of Samurdhi, Household Economy, Micro Finance, Self-Employment, Business Development,, Ministry of Finance

Proposed Development Objective(s) Parent

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

Components

Component 1: Emergency COVID-19 Response
Component 2: Strengthening National and Sub-national Institutions for Prevention and Preparedness
Component 3: Strengthening Multi-sectoral, National institutions and Platforms for One Health
Component 4: Implementation Management and Monitoring and Evaluation
Component 5: Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	100.00

Total Financing	100.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	100.00

Environmental and Social Risk Classification

Substantial

Other Decision (as needed)

B. Introduction and Context

Country Context

1. Sri Lanka has shown steady growth over the last decade although key macroeconomic challenges persist. Sri Lanka is an upper-middle-income country with a gross domestic product (GDP) per capita of US$3,852 (2019) and a total population of 21.8 million. Following 30 years of civil war that ended in 2009, Sri Lanka's economy grew at an average of 5.3 percent during 2010–2019, reflecting a peace dividend and a determined policy thrust toward reconstruction and growth. However, economic growth witnessed a slowdown in the last few years.

2. Social indicators rank among the highest in South Asia and compare favorably with those in middle-income countries. The country has been gradually transitioning from a predominantly rural-based production towards a more urbanized economy oriented around manufacturing and services. Economic growth has translated into shared prosperity with the national poverty headcount ratio declining from 15.3 percent in 2006/07 to 4.1 percent in 2016. Extreme poverty is rare and concentrated in some geographical pockets. However, a relatively large share of the population subsists on slightly more than the poverty line. Female labor force participation at 34.9 percent was less than half of men (73.4 percent) by 2019 and needs to increase to facilitate sustained economic growth and poverty reduction.

3. Macroeconomic vulnerabilities remain high due to weak fiscal buffers, high indebtedness, and large refinancing needs. Low fiscal revenues along with rigid expenditures have led to high fiscal deficits (14.0 percent of GDP, 2020) and an accumulation of public debt (112.4 percent of GDP, 2020). Around 44.3 percent of the central government debt is foreign currency-denominated and the repayment profile requires the country to access financial markets frequently. Official reserves (USD 7.6 billion, end-2019) provide a sufficient import cover in the short run amid decelerating imports; however, they remain low relative to short-term external liabilities.

Sectoral and Institutional Context

4. Sri Lanka's health system has been known globally as one of the best performing in the world, having achieved "good health at low cost". This reputation largely remains, and for good reason. It has already achieved maternal, under-five, and neonatal mortality rates that are less than half the 2030 SDG targets. These achievements have been made despite Sri Lanka allocating a lower share of its GDP to public health sector spending than countries at similar income levels (about 1.57 percent of GDP compared to an average of 2.91 percent in other countries, based on data from 2017). This is primarily due to the small size of the overall government budget (partly a result of low revenues) and not due to the low prioritization of the sector within the budget.

5. Reforms to address emerging issues in the health sector, however, have been slow in the making. The health sector has been showing signs of stress in responding to growing and changing health needs reflective of the ongoing demographic and epidemiological transition. Non-communicable diseases (NCDs) already account for 81 percent of total deaths and 77 percent of disability-adjusted life years (DALYs). Sri Lanka is also one of the fastest aging populations which are expected to accelerate the stress on the health system. This is particularly relevant in the context of infectious diseases such as COVID-19, with the elderly and those with chronic conditions (such as diabetes, heart conditions, kidney disease, etc.) being most at risk of morbidity and mortality.

6. Sri Lanka's health system was assessed as having limited capacity to deal with impacts from pandemics and other public health emergencies. In 2016, a Joint External Evaluation of the International Health Regulations conducted by Sri Lanka assessing core capacities to prevent, detect, and rapidly respond to public health threats, whether occurring naturally or due to deliberate or accidental events, found that while it scored highly (4 out of 5) on national legislation and policies for implementation of required responses, surveillance and workforce development, it scored poorly on emergency preparedness and response planning and operations (1 out of 5), biosafety and biosecurity (1 out of 5) and personnel deployment and management during a public health emergency (1 out of 5), suggesting a limited capacity to respond to public health emergencies.

7. Thus, when the incidence of COVID-19 started increasing in Sri Lanka, in partnership with the World Bank, the Sri Lanka COVID-19 Emergency Response and Health Systems Preparedness Project was prepared. The project which became effective on April 3, 2020, focused on strengthening health systems and infrastructure to contain the outbreak and enhance preparedness for the current and future emergency response. Strategies to strengthen social measures to support vulnerable communities, particularly, the elderly who are most at risk from the disease, were also proposed to be put in place. 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 emergency COVID-19 response, including expanding the scope of cash assistance to those who lost livelihoods during the lockdown and in-kind transfer of food packs to those under home quarantine and to provide support for the national COVID-19 vaccination drive.

8. Sri Lanka is currently at the peak of the third wave of the COVID-19 pandemic with the increased prevalence of the Delta variant. Despite the significantly wider spread associated with the second wave which began in October 2020, the country did not experience an exponential increase in the number of cases at the time. The third wave came with a massive surge in case numbers from April to July 2021 attributable to the Alpha variant that led to a 30-day lockdown in May/June. 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 29, 2021, the country has reported a total of 426,169 cases and 8,775 deaths from COVID-19. 59,796 are currently active cases while 357,598 patients have recovered. Sri Lanka's recovery rate is around 84.71 percent, and the fatality rate is 4.7 percent (7-day average). Approximately 15,000-20,000 PCR tests per day are

being conducted with a positivity rate of 20 percent.

9. There has been a significant increase in the number of COVID-19 related deaths in August, especially among the unvaccinated population. An average of 200 deaths are being recorded per day, and deaths per million population are at 9.20. 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. 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

10. The purpose of the proposed third AF is to provide financing to help the government of Sri Lanka (GoSL) purchase and deploy additional COVID-19 vaccines that meet Bank's vaccine approval criteria (VAC). It will help vaccinate 26.5 percent of the country's population following Bank's VAC in addition to the current vaccine AF.

C. Proposed Development Objective(s)

Original PDO

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

Current PDO

The PDO remains unchanged.

Key Results

11. The Results Framework will be modified to reflect the new activities proposed under the AF to measure overall progress in the coverage and deployment of the COVID-19 vaccine and the gender dimension of the project. To that effect, the target for PDO indicator "Percentage of the population to be vaccinated" will be revised from 20 percent to 55 percent.

D. Project Description

12. The changes proposed for this AF *entail scaling-up of activities in the second AF.* It 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 under subcomponent 1.3 of the project.

13. *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 55 percent for both males and females.

14*. The GoSL is expanding the population to be vaccinated to go beyond the initially set target of 60 percent*. 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 AF. The priority order of different groups has been determined based on the WHO Fair Allocation Framework. It is anticipated that 80 percent of the population become eligible based on the current scientific evidence.

Project Components

15. Component 1: Emergency COVID-19 Response (US$347.76 million).

Subcomponent 1.1: Strengthening the health system response (US$81.72 million): 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 (US$87.24): 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 vaccine and deployment (US$180.52)
This subcomponent, introduced through the second AF, supports: (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; 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 AF of US$100 million.

16. *Component 2: Strengthening National and Sub-National Institutions for Prevention and Preparedness (US$35 million).* This component supports: (a) strengthening the national and local capacities for treating infectious disease, through expansion of isolation units as well as 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.

17. ***Component 3: Strengthening Multi-sectoral, national institutions and platforms for One Health (US$ 8.6 million).*** 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.

18. ***Component 4: Implementation Management and Monitoring and Evaluation (US$5 million).*** 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.

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

Legal Operational Policies

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

Summary of Assessment of Environmental and Social Risks and Impacts

20. The project will have net positive environmental and social impacts, insofar as it should improve COVID-19 surveillance, monitoring, and containment in the country as well as the health system's preparedness for future outbreaks. The environmental risks are considered Substantial because of the current uncertainty around specific interventions to be supported at specific project locations and the associated occupational health and safety as well as health care waste management issues. The main environmental risks are: (i) the occupational health and safety issues to health workers, arising from patient care, laboratory testing, handling of supplies, etc. during treatment to a large extent as well as due to civil works construction inside functional health care facilities to a lesser extent; (ii) health care waste management and community health and safety issues related to the handling, transportation and disposal of health care waste, and (iii) emissions and waste generation due to construction works.

21. Health care waste and chemical wastes (including water, reagents, infected materials, etc.) generated from the labs, quarantine, and screening posts to be supported (drugs, supplies, and medical equipment) can have a significant impact on the environment and human health. Wastes that may be generated from health facilities/ labs could include liquid

contaminated waste, chemicals and other hazardous materials, and other waste from labs/quarantine/isolation centers including sharps used in diagnosis and treatment. All of this requires special handling and awareness as it may pose a huge risk to health care workers from occupational infections and the communities if not disposed of properly.

22. Sri Lanka has experience in managing infectious waste. Infection prevention and control procedures in health institutions, especially higher-level facilities, are fairly standardized. Waste separation at the source is almost 100% and many of the secondary and tertiary health institutions have already installed treatment capacities such as sterilizers and incinerators. However, the system is not without gaps and shortcomings. As COVID-19 is highly infectious, the project will need to exercise the highest level of due diligence in planning and implementing precautionary measures. To mitigate the above-mentioned risks, the Ministry of Health will prepare an Environmental and Social Management Framework (ESMF) which will be in line with WHO standards on COVID-19 response. The ESMF will include a generic Health Care Waste Management Plan (HCWMP) which will include specific guidance & protocols on developing site-specific HCWMPs.

23. Social risks under the project are also considered “Substantial” Given gender norms and the role of women and girls as caregivers within families and the front-line healthcare workers, the risk of infection among them is of paramount concern that the project would have to attend to. Similarly, other vulnerable groups such as the elderly, poor, and people with disabilities also risk not benefiting equally from public awareness campaigns, quality services in hospitals, quarantine facilities, etc., even whilst some of them are more at risk of contracting the virus. There are also increased risks for GBV and child abuse when women and children are under quarantine and self-isolation. The project will have to ensure that the quarantining interventions and health facilities are handled in a manner that would ensure dignified treatment of patients; pay attention to specific, culturally determined concerns of vulnerable groups; ensure the prevention of sexual exploitation and abuse (PSEA), and sexual harassment (SH), etc. Further, since most of the front-line health workers are females, the project would also need to attend to the specific needs of female health care workers beyond personal protective equipment (e.g., menstrual hygiene, transport when changing shifts and returning home). Finally, prevention of social tensions, especially in the vicinity of quarantine facilities and isolation units over the spread of disease and waste management, and conflicts resulting from false information/rumors, will be important factors that would need to be managed through the comprehensive and effective stakeholder engagement plan.

24. Procurement of goods (purchase of testing kits, medical equipment such as oxygen suppliers, etc.) and consultancy activities for public communications and outreach around COVID-19 can be initiated as soon as the project is approved as these activities have very limited potential to lead to major environmental and social risks and will be screened independently. However, the ESMF should be finalized before establishing the isolation units, quarantine facilities, and/or undertaking construction activities at any scale. In addition, any activities with potential environmental and social risks, as outlined above, will not be carried out without the project ESMF being completed and disclosed.

25. Component 5 of the project will be a Contingent Emergency Response Component (CERC). The project ESMF will be updated as soon as the scope of the contingency component becomes better defined during project implementation. In addition, a CERC Operations Manual will be prepared during project implementation to govern the operation of the component, this document will be aligned with the ESMF at the time of preparation and include provisions to ensure environmental and social due diligence in line with the requirements of the ESF.

E. Implementation

26. **Project implementation is satisfactory.** The project management unit (PMU) has made significant progress in filling the designated staffing positions for the Project. The recruitment process has been completed for all key positions. 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. 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. Project Steering Committee (PSC) and Project Review Committee (PRC) meet regularly.

27. As of September 5, 2021, overall project disbursement stands at 78.8 percent within sixteen months of implementation. A total of US$80.3 million out of US$80.5 million has been disbursed under AF2 for vaccine procurement and related 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.

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CONTACT POINT

World Bank

Deepika Eranjanie Attygalle
Senior Health Specialist

Srinivas Varadan
Senior Social Protection Specialist

Borrower/Client/Recipient

Democratic Socialist Republic of Sri Lanka
Mr. Ajith Abeysekera
Director General, Department of External Resources, Ministry
dg@erd.gov.lk

Implementing Agencies

Ministry of Health
Dr. S.H Munasinghe
Secretary, Ministry of Health
secretary@health.gov.lk

State Ministry of Samurdhi, Household Economy, Micro Finance, Self-Employment, Business Development,
Mr. N. Happuhinne
Secretary, State Ministry of Samurdhi
msesecretary@sltnet.lk

Ministry of Finance
Ajith Abeysekera
Mr.
ajith@erd.gov.lk

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Deepika Eranjanie Attygalle Srinivas Varadan

Approved By

Practice Manager/Manager:		
Country Director:	Chiyo Kanda	21-Sep-2021