

COVID-19 PANDEMIC AND VACCINE EQUITY IN SRI LANKA



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After the rollout of the COVID-19 vaccines, people expected to get a vaccine dose at the earliest possible in a free and fair manner irrespective of the national borders. However, vaccine hoarding, stockpiling, vaccine apartheid, vaccine nationalism, and blocking the sharing of vaccine manufacturing technology with the countries without such capacities remained major hurdles against achieving vaccine equity. The inability of states to rise above the use of life-saving vaccine as a political tool and the vaccine-manufacturing pharmaceutical companies' never-ending desire for profit have failed the humanity. A study by Imperial College London (2022) shows that 599,300 additional deaths could have been averted, mostly in low and lower-middle-income countries, if all countries had reached a 40% vaccination rate with two or more doses by the end of 2021. However, disregarding the lives that could have been saved, wealthy countries stockpiled vaccines. They did not provide their committed donation of vaccine doses to developing and low-income countries, while pharmaceutical companies were determined to protect their commercial interests through the use of the 'safeguarding intellectual property' argument, supported by the international trade regime serving the neoliberal interests.

In this context, SAAPE, as a member of the People's Vaccine campaign, took the initiative to organise some research in South Asian countries to bring into light the issues of vaccine equity by assessing the internal dynamics of the countries where vaccine inequity could have been the case, possibly because of disproportionate access to vaccine doses based on income, class, caste, religion, spatial locations, and other socio-economic factors. We thank Dr. Vinya Ariyaratne for agreeing to prepare this paper on COVID-19 and vaccine equity in Sri Lanka. His three decades of work as a public health and development practitioner has helped in the analysis of the situation in Sri Lanka during the COVID-19 pandemic and subsequent state responses and preparedness. The report has also provided useful recommendations to civil society to take forward some issues regarding strengthening the public health sector. We are also thankful to our SAAPE Core Committee members, Herman Kumara and Nalini Ratnarajah, for their support and coordination from the beginning of this work.

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We hope this publication helps further evidence to organise public campaigns to ensure people's vaccines for all.

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ABBREVIATION

AEFIs	Adverse Effects following Immunization
CBOs	Community based Organisations
CEPA	Centre for Poverty Analysis
CPA	Centre for Policy Alternatives
DGHS	Director General of Health Services
DIVE	Diversity Impact on Vaccine Equity
EPI	Expanded Programme on Immunization
FBOs	Faith-based Organisations
FTZ	Free Trade Zone
GoSL	Government of Sri Lanka
H1N5	Avian Influenza Virus
HEOs	Health Education Officers
HPB	Health Promotion Bureau
I/NGOs	National and international non-governmental organisations
IHP	Institute for Health Policy
ILO	International Labour Organization
LKR	Sri Lankan Rupee
LST	Law and Society Trust
MoH	Ministry of Health
MPHSS	Mental Health and Psychosocial Support
NACCD	National Advisory Committee on Communicable Diseases
NCC	National Coordination Committee
NDVP	National Deployment Vaccine Plan
NDVP	National Deployment and Vaccination Plan
NGOs	Non-governmental Organisations
NIID	National Institute of Infectious Diseases
NIP	National Immunization Programme
NITAG	National Immunization Technical Advisory Group
NOCPOC	National Operation Centre for Prevention of COVID 19 Outbreak
NSC	National Steering Committee
PTF	Presidential Task Force
RCCE	Risk Communication and Community Engagement
SRP	Strategic Preparedness and Response Plan
TISL	Transparency International Sri Lanka
UN	United Nations

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Introduction

As has been the case with most countries in the South Asian region and beyond, the COVID-19 pandemic has had a profound social and economic impact on Sri Lanka. As a country with universal access to a free healthcare delivery system, Sri Lanka has historically demonstrated better health outcomes compared to countries with similar per-capita incomes. However, this relatively “robust” healthcare system of Sri Lanka was also under severe strain with major challenges observed in dealing with the pandemic, which has now been further exacerbated by a devastating economic crisis in the country. This paper provides an overview of the issues surrounding the COVID-19 pandemic, including pandemic preparedness and the restrictions imposed in the country in the

name of the pandemic. It also analyses the manner in which the pandemic has affected disadvantaged groups and state response in Sri Lanka, with a particular focus on the country’s COVID-19 vaccination program and the status of vaccine equity in the country.

Background and context

The first case of COVID-19 in Sri Lanka was reported on 27 January 2020, when a foreign national quarantined at the National Institute of Infectious Disease (NIID) tested positive for the infection. The first Sri Lankan to be tested positive for COVID-19 was a 52-year-old male on 11 March 2020.

Sri Lanka had three waves of COVID-19 infections and as on 17 August 2022, 667,497 cases have been reported, with 16,635 deaths (Epidemiology Unit, 2022).

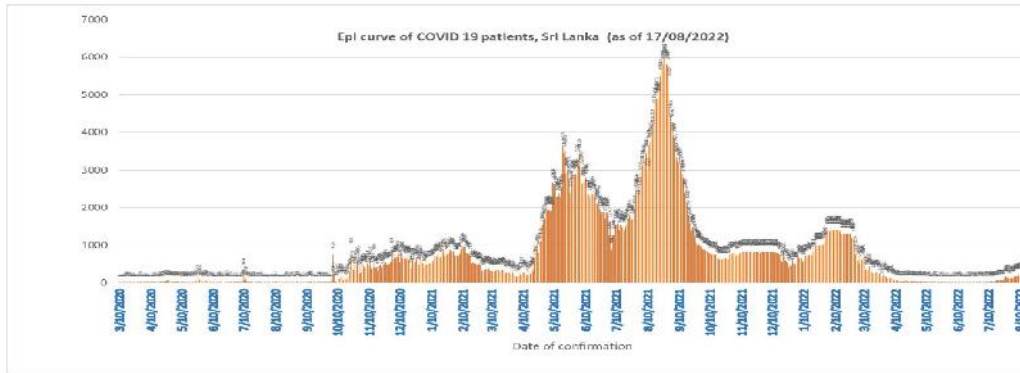
Table 1 – COVID-19 Cases and Deaths in Sri Lanka from 27.01.20 to 17.08.2022

Wave	Duration	No. of Cases	No. of Deaths	Case Fatality Rate
1 st	27.01.2020 - 03.10.2020	3,396	13	0.38
2 nd	04.10.2020 - 14.04.2021	92,341	591	0.64
3 rd	15.04.2021 – to-date (17.08.2022)	667,497	16,634	2.49

(Source: Epidemiology Unit, 2022)

It can be observed that Sri Lanka, despite having been able to control the pandemic well in the first wave, was unable to maintain the same control during the third wave of the pandemic, causing unacceptably high rates of infection and deaths due to COVID-19. It must

also be noted that Sri Lanka’s fatality rate due to coronavirus is one of the highest figures among South Asian countries, being second only to Afghanistan (The Johns Hopkins University, 2022).



(Source:https://www.epid.gov.lk/web/images/pdf/Circulars/Corona_virus/epi-curve_17-08-2022_1.jpg accessed on 17th August 2022)

Figure 1 Epi Curve – COVID-19 cases in Sri Lanka as on 17th August 2022

The first wave (27 January 2020 to 3 October 2020) had two large clusters of infections – an outbreak in a Navy camp in Welisara in the Colombo District and an outbreak in a state-run rehabilitation centre for drug addicts in the Polonnaruwa District in the North Central Province in Sri Lanka.

The second wave (4 October 2020 to 14 April 2021), which peaked around late January/early February 2021, had several clusters of COVID-19 infections. The second wave started with an outbreak of COVID-19 infection in a garment factory in Minuwangoda in the Gampaha District in the Western Province. The second cluster of infection was triggered by an outbreak in the Central Fish Market in the outskirts of the capital Colombo, and a third cluster was in the Remand Prison of Colombo. The first and the second waves of

the pandemic in Sri Lanka were dominated by the *Alpha* variant.

The third wave, which started around mid-April 2021, was the most devastating in terms of both the number of infections and the death toll. The *Delta* variant became dominant during this third wave. Since April is the month of New Year celebrations for Sinhala and Tamil communities in Sri Lanka, traditionally, people, especially migrant workers living in the cities, leave their temporary dwellings to travel to their permanent homes, often in different rural districts of the country, to celebrate the New Year with their families. Most people who were unable to celebrate the New Year in 2020 gathered in their traditional homes with poor adherence to COVID-19 preventive measures. The gathering to observe the

festival further led to the spike in the number of infections. Consequently, the third wave affected all districts in the country with the peak observed in June 2021.

The Government response

In January 2020, when the possible spread of COVID-19 beyond Wuhan (China) was alerted, the President of Sri Lanka appointed a National Action Committee for COVID-19. Travel restrictions were imposed on travellers from China and a mandatory quarantine period of 14 days was imposed on travellers who were coming from or through specific countries which were reporting increasing numbers of COVID-19 cases.

The first formal health sector plan in response to the pandemic “The Sri Lanka Preparedness and Response Plan – COVID-19” was released in April 2020 (Ministry of Health and Indigenous Medical Services, 2020). Later, in March 2021, two separate bodies were appointed by the President of Sri Lanka:

1. The “National Operation Centre for Prevention of COVID 19 Outbreak” (NOCPOC) which would ‘coordinate preventive and management measures to ensure that healthcare and other services are well geared to serve the general public’
2. A “Presidential Task Force to direct, coordinate and monitor the delivery of continuous services for the sustenance of overall community life, including the

supply of food provisions produced in rural areas directly to consumers giving priority to the districts of Colombo, Kalutara, Gampaha, Puttlam, Jaffna, Mannar, Kilinochchi, Vavuniya and Mullaitivu which have greater vulnerability in the eradication of coronavirus in Sri Lanka.’ (Government of Sri Lanka, 2020).

A key feature of the COVID-19 management strategy employed in Sri Lanka was the heavy involvement of security forces with the NOCPOC itself being headed by the Army Commander, who was also serving as the Chief of Defense Staff. It is also important to note that the very first formal strategic document prepared by the government on combatting COVID-19 in Sri Lanka came from the State Intelligence Service (State Intelligence Service 2021). There have been mixed reactions to this mechanism of governance to curb COVID-19 in Sri Lanka. Even though the officials managing the NOCPC obtained technical advice from a variety of experts on an ad-hoc basis, the decision-making did not formally involve the established mechanisms such as the technical committees in the decision-making process (for instance, see Figure 2 for the decision-making process in the case of COVID-19 vaccines).

However, it was later evident that the role played by the security forces was largely confined to specific logistical support and was time-bound. The key strategic and technical decisions were still taken by public health experts. It must be acknowledged that

the logistical support provided by the Army for home vaccinations (for the elderly and the disabled) and 24-hour public vaccination sites in Colombo significantly contributed towards increasing the vaccination coverage in Sri Lanka.

Pandemic preparedness in Sri Lanka

Prior to the onset of the COVID-19 pandemic in January 2020, the Ministry of Health (MoH) had already taken several proactive measures to face the possible threat of the pandemics. Sri Lanka has been known to have a very effective disease surveillance system, which has evolved over a period of over six decades. The Epidemiology Unit of the Ministry of Health, which was established in 1959, is mandated to lead disease prevention and control measures at a national level, including surveillance and notification of infectious diseases. There are two important statutory committees that guide the Epidemiology Unit, the first being the National Advisory Committee on Communicable Diseases (NACCD) and the second being the National Immunization Technical Advisory Group (NITAG).

Soon after the advent of the Avian Influenza Virus (H1N5) that caused large poultry disease outbreaks in Asia in 2003, it prompted the authorities in Sri Lanka to prepare against possible future outbreaks of the virus in the country. In 2004, the Ministry of Health coordinated with the Ministry of

Livestock & Agriculture to establish a joint programme following the global guidelines (Epidemiology Unit, 2012). A National Steering Committee (NSC) on Pandemic/Avian Influenza Preparedness, chaired by the respective Ministers of Health and Livestock and Agriculture, and National Technical Committee on Pandemic/Avian Influenza Preparedness, chaired by the respective heads of health and animal health departments were created. The process led to the development of a “National Influenza Preparedness Plan” in 2005, which was revised in 2006 and with the global experience of managing the Influenza A (H1N1) outbreak in 2009/2010, a revised plan was launched in 2012.

The “Quarantine and Prevention of Disease Ordinance” which was introduced to the country during the time of the British Rule (1897) (with revisions made in 2005) was the main legal instrument that was used to guide the preventive and control measures against pandemic/epidemic (Ministry of Justice, 2016). The Director General of Health Services (DGHS) is the designated “proper authority” with wide powers to implement the provisions in the ordinance.

Restrictions imposed

At the initial stages of the pandemic in Sri Lanka, the country was able to effectively control the spread of infection with a multitude of coordinated actions by the Government of Sri Lanka and strict adherence to the preventive measures by the public

without reaching the stage of community transmission.

Since the first local case of COVID-19 was reported on the 11th of March 2020, the government took immediate preventive actions, including closure of all schools and government offices, followed by an island-wide curfew which lasted for over eight weeks (until mid-May 2020). Mechanisms for rigorous surveillance, contact tracing, isolation, quarantine and treatment were swiftly established building on the robust and strong pre-existing public health infrastructure.

The government took an early policy decision to hospitalise all COVID-19 positive individuals, even if they were asymptomatic, to facilitate monitoring and to prevent the spread of the disease to the wider community. All contacts were taken out of their homes and

were placed in government run quarantine centres. The National Institute of Infectious Diseases (NIID), the only specialised hospital in Sri Lanka for communicable diseases, was designated as the main hospital for the management of COVID-19 patients.

Since late January 2020, all individuals who were suspected of COVID-19 were admitted to the NIID. As the patient numbers were rising, MoH designated several other hospitals to accommodate COVID-19-suspected individuals. At the time, there were 41 hospitals and treatment centres around the country caring for COVID-19 patients (Epidemiology Unit, 2012). The capacity of the government hospitals to provide care for COVID-19 patients was not exceeded at any point by the overflow of patients. There was a rapid mobilisation of external donor support to provide the government hospitals with the necessary equipment.

Impact on informal sector workers, tea plantation sector workers, garment sector workers, fisherfolks, peasants, women, and children

Informal sector workers

Daily wage earners and other informal sector workers were most severely affected by the spread of COVID-19 and the control measures enforced in response to the pandemic. These informal workers, many of whom are low-income earners, often do not benefit from the formal social protection systems that exist in the country. According to the International

Labour Organization (ILO) (2020), informal employment in Sri Lanka is particularly widespread in agriculture, where 90 per cent of workers are informal, and is also significant in industry (66 per cent) and services (52 per cent). There is evidence that informal workers suffered from loss of earnings during the pandemic. It is also important to note that, even within formal enterprises, there are informal workers that are not protected by

written contracts and may be bearing the brunt of the impact. Those who lose their jobs in formal sector also do not have access to job-linked social protection benefits like unemployment insurance. (ILO, 2020). In addition, women have disproportionately been impacted by COVID-19 in Sri Lanka (Saroor, 2020).

Tea plantation sector workers

The social well-being of plantation workers in Sri Lanka has been historically lagging. Most indicators in the sector, including child mortality and malnutrition figures, are higher than the national average. These pre-existing vulnerabilities have disproportionately impacted the working population in the tea estates due to the COVID-19 pandemic. Recent studies on food security also clearly indicate a deteriorating trend amongst households in the plantation districts such as Nuwara Eliya, Badulla, Kandy, Matale and Moneragala (Jayatissa, 2022).

Fisheries sector workers

A study on the impact of COVID-19 on fishers, sellers/traders and processors, carried out during the first wave in Sri Lanka and published in April 2021 (prior to the onset of the devastating third wave) reported that restrictions imposed in response to the pandemic adversely impacted their respective fisheries-related activities (Nadiya et al., 2021). The study revealed that the inability of fishers to go to sea disrupted the whole fisheries

value chain. 84% of the respondents reported a decrease in their income, which could be attributed to inaccessibility to fisheries-related activity, a decrease in consumer demand and steep decline in export. Overall, this study showed that inaccessibility to the ocean, and thereby fishing, negatively impacted small-scale fisheries communities due to limited coping strategies and lack of alternative modes of income. These compounding effects, along with pre-existing vulnerabilities related to structural, social and economic inequality, can in turn increase the effect that COVID-19 and similar shocks will have on health and socioeconomic factors in fisheries communities.

It must, however, be noted that even before the fisheries sector could recover from the impact of COVID-19, on 21 May 2021, the X-Press Pearl ship disaster further devastated the fisheries sector. The ship, which was carrying flammable cargo, erupted into flames about 18 kilometres northwest of Colombo while awaiting permission to enter the port.

Impact on the poor

There is strong evidence of the devastating impact of the pandemic on the poorer segments of society in Sri Lanka. According to the World Bank analysis in 2020, the COVID-19 crisis increased the international US \$3.20 poverty rate from 9.2 per cent in 2019 to 11.7 per cent in 2020 in Sri Lanka. This change translates into over 500,000 new poor

people. Livelihood support programmes and various relief measures implemented by the government (described below) over the course of the pandemic are expected to have mitigated the labour market shock. It alerts that the increase in inequalities in the short term, due to reduced social mobility, could extend further in the long term as a consequence of widening disparities in access to education. (World Bank, 2021). There has also been a significant impact on children as a result of the negative impact on nutritional status and disruption of schooling (Nanayakkara, 2021).

The situation calls for shifting towards a more adaptive social protection system, which would allow much-needed support to be scaled up quickly and effectively at times of crisis. There is much interest and ongoing debate amongst think tanks and civil society on the issue of social protection which is an encouraging trend.

Effectiveness of government support mechanisms during lockdowns

The sudden lockdown and curfew in March 2022 created mass panic, which resulted in panic buying and a shortage of essential consumable items. Although the government made arrangements with vendors to deliver essential items to households, many underprivileged communities could not access these services, facing a food crisis in their homes. These unprivileged

communities also faced financial difficulties as the breadwinners were mostly daily wage earners; therefore, they were unable to purchase adequate quantities of essential items to prepare for the long periods of curfew. However, the government came up with a cash grant scheme in April 2020 which did alleviate the suffering to some extent. This included a one-off payment of Sri Lankan Rupee (LKR) 5,000 to vulnerable groups, including a) samurdhi recipients – 1,798,655 existing recipients plus 600,339 new recipients; b) senior citizens (416,764 existing recipients, 142,345 new recipients); c) differently-abled (84,071 existing and 35,229 new recipients) (ILO, 2020). This one-off payment was repeated a month later in May 2022.

It must also be stated that the communities even in the economically poorer rural areas themselves contributed significantly through sharing food among neighbours during lockdowns. The civil society organisations, including national and international non-governmental organisations (I/NGOs) were also involved in the distribution of cash grants and provision of dry rations to the most vulnerable groups, which contributed in a significant way to mitigating the short-term effects of the lockdowns.

Vaccination and vaccine equity

In analysing Sri Lanka's approach to COVID-19 vaccination, it is important to understand the larger context in relation to the status of vaccination in Sri Lanka.

Sri Lanka's immunisation vaccination programs dates back to the 19th century. Vaccination was initiated with the outbreak of smallpox which occurred in 1800 during British colonial rule. The Vaccination Ordinance was introduced in 1886.

The Expanded Programme on Immunization (EPI), established in 1978, has continued to make excellent progress over the past two decades, most notably in terms of achieving high immunisation coverage and disease control. The Sri Lankan immunisation program for children is widely recognised as one of the strongest and most successful programmes in the region and is also considered as one of the best in the world. The revised National Immunization Programme (NIP), approved by the Cabinet in 2015, is the guiding framework for all vaccination in the country, including the introduction of new vaccine (Ministry of Health, 2015).

The National Immunization Technical Advisory Group (NITAG)/National Advisory Committee on Communicable Diseases (NACCD), chaired by the Director General of Health Services (DGHS), takes all policy and technical decisions related to vaccination in Sri Lanka and it includes experts and representative from all relevant health units.

The existing organisational structure for NIP is

provided for the most part, by the public health system through its preventive and curative health systems. The robust vaccination infrastructure in the country has supported and enabled successful implementation and supportive supervision systems across national, provincial, district and community levels. The existing system and network of national immunisation programmes provide a functional platform for successfully conducting vaccination campaigns, National Immunization Days (NID), subnational NIDs, mopping up campaigns for polio and outbreak control campaigns, such as H1N1 pandemic situation in 2009, and measles outbreak situation in 2015.

COVID-19 vaccination

The Government of Sri Lanka (GoSL) initiated planning for vaccination towards the end of the year 2020 and on the 31st of December 2020, the President of Sri Lanka appointed a "Presidential Task Force for the Development of the National Deployment and Vaccination Plan (NDVP) for Sri Lanka" (Presidential Secretariat, 2020). The NDVP was released on 18 January 2021 and was considered the main policy document, which was supposed to govern and direct the COVID-19 vaccine roll out in Sri Lanka. The decision-making process for COVID-19 vaccination is given in Figure 2.

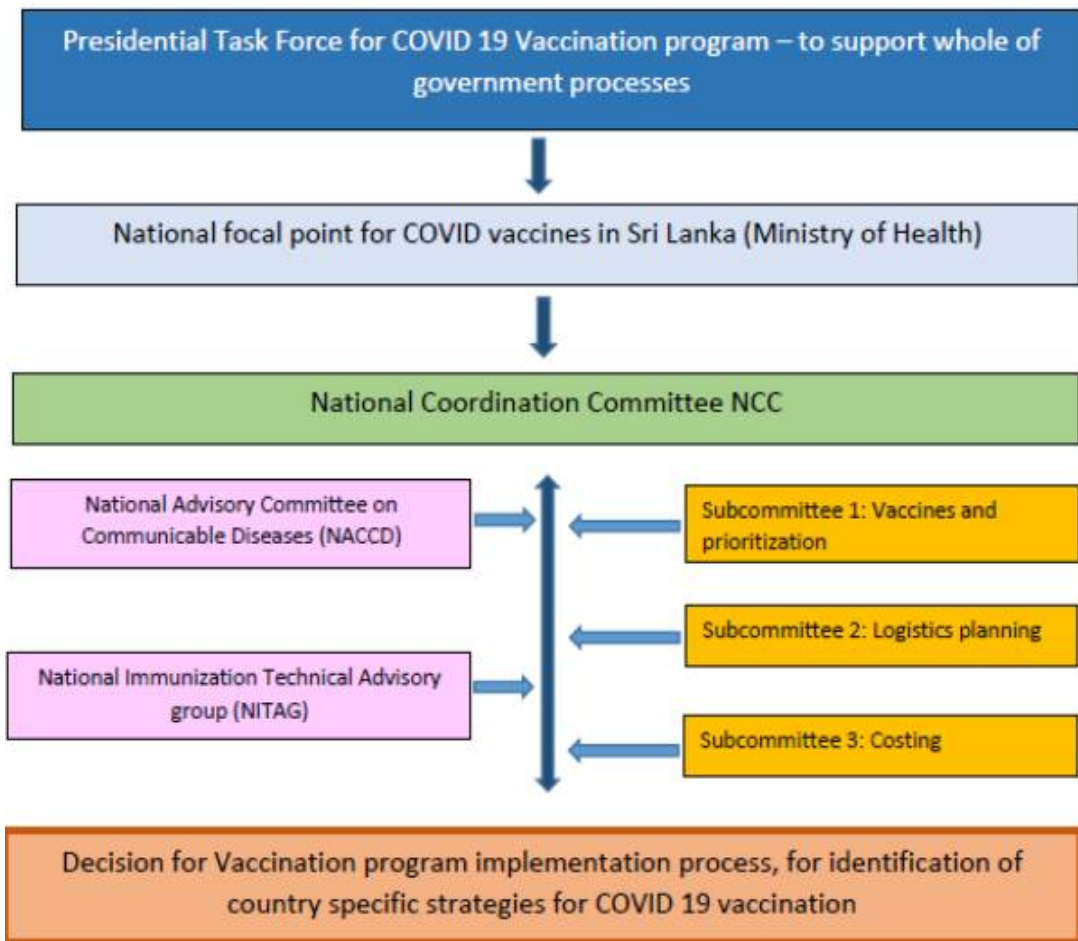


Figure 2 - Decision-making process for COVID-19 vaccines

(Source: NDVP, Ministry of Health, 2021)

The MOH convened the National Coordination Committee (NCC) for COVID-19 vaccine in November 2020, that included various stakeholders with different expertise from health and non-health sector, partner organisations and other experts. The NCC is supported by three technical subcommittees to work on a) COVID-19 vaccines, prioritisation and targeting; b) logistics for COVID-19 vaccination; and iii) costing for COVID-19 vaccination. NACCD/NITAG has

convened on multiple occasions to review the evidence and identify the best suited vaccines and vaccination strategies for the country. A technical expert working group was appointed in September 2020 to support the work of NACCD/NITAG.

COVID-19 vaccination – mode of delivery

The GoSL has adopted the time-limited

“campaign mode” vaccination strategy compared to “routine vaccination” strategy for achieving high coverage through the targeted vaccination rapidly (NDVP, 2021). Accordingly, the vaccines were to be administered in 2000 identified vaccine delivery points around the country. These include government health clinics, hospitals and public places such as temples and schools where mobile teams conduct the vaccination clinics. The coverage and the number of doses were to be determined by the availability of vaccine supplies. Later, the Sri Lanka Army was also entrusted with administering the vaccine in a walk-in facility in Colombo.

The actual vaccine rollout in Sri Lanka didn't strictly follow the roadmap laid out in the NDVP. The vaccination drive started with healthcare workers on the 29th of January 2021. What followed was a chaotic period with problems associated with change of priority groups initially selected for vaccination, shortage of stocks, approval process, irregularities in the procurement process, public concerns on vaccine safety *et cetera*. The NDVP priority list for vaccination was based on the quantity of vaccine available - with health workers, front line security forces personnel, persons with comorbidities, and the elderly in the order of priority (page 13, NDVP). However, around February/March 2020, a decision was made to vaccinate working population (age above 20 years) in the Western Province, deviating from the original priority framework. Even though this group was important from an economic perspective, this decision temporarily denied

providing vaccines to the elderly and persons with comorbidities. However, with vaccine supply being significantly increased in the following months, the vaccination program was put back on track and followed the original priority framework.

Several civil society groups took the issue of vaccine equity at an early stage of the vaccine rollout. On 2 February 2021, Transparency International Sri Lanka (TISL) highlighted two key issues regarding the COVID-19 vaccine rollout (TISL, 2021). The two key issues identified were:

- 1) The public needs assurance that proper screening is conducted of the vaccines obtained.
- 2) The procurement and distribution process must be transparent and accountable.

The Law and Society Trust, another leading non-governmental legal research, advocacy and legal documentation organisation, closely followed the process of vaccination rollout, held extensive public consultations, and came up with recommendations as early as April 2020 to make it more transparent and accountable (Law and Society Trust, 2021). The recommendations were:

- Creating a platform for official messaging on the COVID-19 response with clear leadership and lines of responsibility on all decisions related to COVID-19 measures
- Clear messaging to the public on the

strategy being followed and how it comes together

- Openness about who have received vaccinations so far and clarifying allegations of abuse
- Rational priority list of how vaccines will be rolled out as and when stocks arrive
- Clarity on the questions requiring expertise, such as how many vaccines are needed and for how long it is effective
- Contingency planning in the event when a fresh wave of infections occurs

Following a turbulent period of uncertainty, Sri Lanka approved the use of five brands

of COVID-19 vaccination (Covishield, Moderna, Sinopharm, Sputnik-V, and Pfizer) and arranged for adequate quantities through procurement or donations (mainly through COVAX). With this, the vaccination administration became better streamlined and higher percentage of the population was covered by the end of the year with two doses. Table 2 provides the details of vaccines received and procured by Sri Lanka.

Sri Lanka received a total of 39,890,332 vaccine doses, out of which 8,130,910 (20.4%) were received as donations and the balance (79.6%) were procured by the GoSL (Ginige, 2022).

Table 2 – Number of doses of each type of vaccine imported/received as donation (as on 25 August 2022)

Type of vaccine	Number of doses donated	Number of doses purchased	Total number of doses	Total number of doses administered	Utilisation rate
AstraZeneca	2,219,840 (COVAX & India)	500,000	2,719,840	2,898,224	107%
Sinopharm	2,500,000 (China)	23,500,000	26,000,000	23,234,187	89%
Sputnik V		333,000	330,000	314,922	95%
Moderna	1,500,100 (COVAX)	-	1,500,100	1,592,162	106%
Pfizer	1,910,970	19,000,064	20,911,034	11,850,837	56%
Total	8,130,910	43,327,380	51,458,290	39,890,332	77.5%

(Source: Epidemiology Unit, 2022)

Vaccine equity

Vaccine equity is to ensure that everyone who needs vaccine has access to one. Notwithstanding the initial hiccups, Sri Lanka has been able to reach a satisfactory level of national vaccination coverage.

As on 14 August 2022, of the total eligible population in Sri Lanka (12 years and above), 78 per cent received the 1st dose and 66.4 per cent received the 2nd dose. However, the 1st booster dose was received only by 36.75% and 2nd booster dose by a fraction of the population (0.28%). By 14 August 2022, a total of 39,735,513 doses have been administered. Table 3 gives the breakdown of doses administered. Out of this total, 90% of the vaccinations were carried out by the health staff, while 10% was administered by the tri-forces and the police (Ginige, 2022)

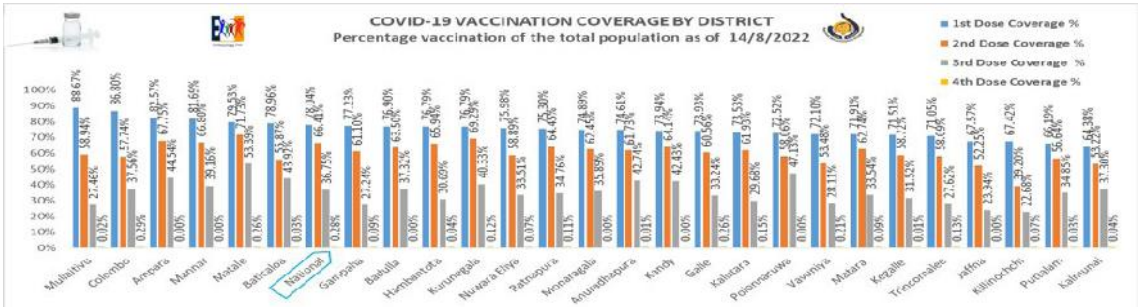
Table 3 - COVID-19 Vaccination in Sri-Lanka as of 14.08.2022

Dose	No. of persons vaccinated
1st Dose	17,108,834
2 nd Dose	14,565,905
1 st Booster	8,074,735
2 nd Booster	129,462

(Source: Epidemiology Unit, 2022)

Currently, disaggregated data on vaccination by ethnic and religious groups is not available. However, when one analyses the available data closely, considerable disparities can be seen between districts (geographic disparities) and for different categories of age groups.

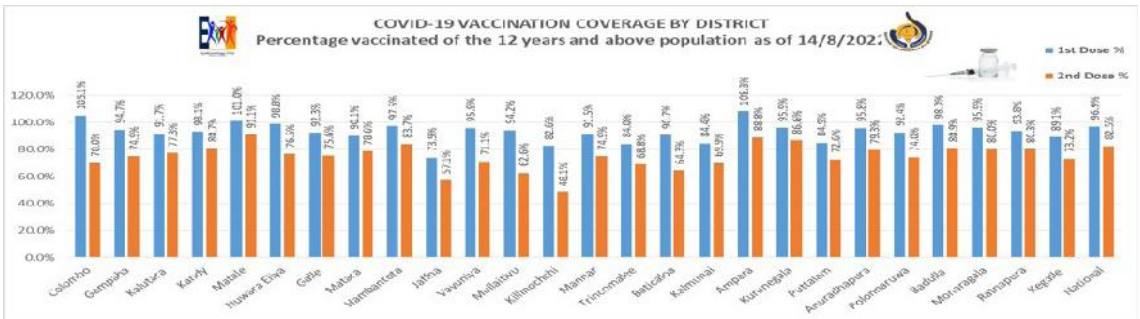
When one considers the percentage of vaccination of the total population, as it can be observed in Figure 2, there is some variation among districts, particularly for the 2nd dose and the 1st booster dose. However, it is difficult to say if these differences are statistically significant or the reasons for these differences are due to the non-availability of disaggregated data.

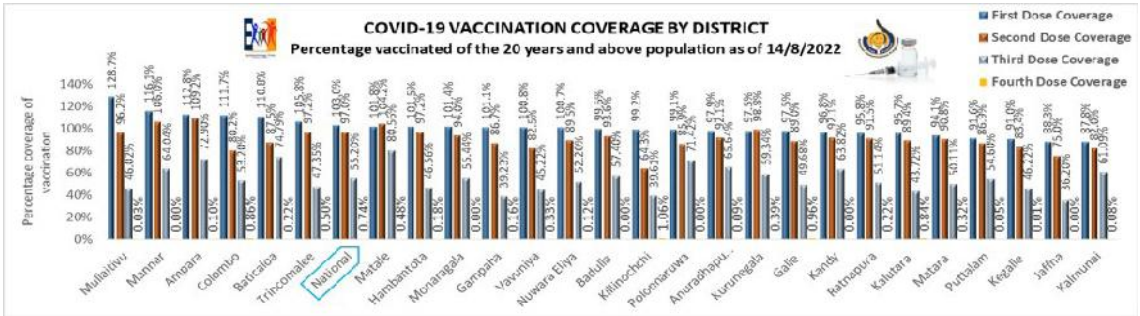


(Source: Epidemiology Unit, 2022; accessed 19.08.2022) <https://www.epid.gov.lk/web/index.php?lang=en>

Figure 3 COVID-19 Vaccination Coverage by District – Percentage vaccination of the total population as of 14/08/2022

Similar variation among districts can also be observed when the vaccination of 12 years and above is considered (Figure 3). It is observed that two Northern districts, namely, Jaffna and Mullativu lagged behind other districts in the coverage for 2nd dose.





(Source: Epidemiology Unit, 2022; accessed 19.08.2022) <https://www.epid.gov.lk/web/index.php?lang=en>

Figure 6 COVID-19 Vaccination Coverage by District - Percentage vaccinated of the 20 years and above population as of 14/08/2022

The political economy of vaccines and its impact on the Sri Lankan situation

From the beginning of the vaccine rollout in Sri Lanka, civil society has expressed serious concerns about the lack of transparency in vaccine selection, procurement, deployment plans *et cetera*.

Notwithstanding a clear policy framework in Sri Lanka in the form of NDVP, there have been serious concerns regarding transparency and accountability of the entire process of identification, approval, procurement and equitable distribution of vaccines, and administration of vaccines in the country.

As early as 7 December 2020, in its Statement on International Anti-Corruption Day, Transparency International Sri Lanka (TISL) raised concerns about possible corruption in the vaccine procurement process. In its statement, the TISL said,

“Whilst recognising the daunting challenge facing the state in terms of the significant measures to address the health emergency and to avoid an economic collapse, TISL notes that urgent responses required during the pandemic create significant opportunities for corruption” (TISL, 2020). It further highlighted “the importance of the proactive disclosure of information on the procurement of COVID-19 vaccines, the quantities ordered and plans for prioritisation and distribution amongst those on the frontlines and vulnerable groups. The prompt and efficient communication of these messages will be key to building public trust in the recovery process”.

It is now evident from the various statements issued by professional bodies and the extensive newspaper coverage on the subject that the vaccine rollout in Sri Lanka faced serious problems.

The Minister of Health sacked a few key expert members of the NMRA in the wake of a controversy over approving the Sinopharm vaccine. When Sri Lanka received a donation of 600,000 doses of the Sinopharm vaccine, the Expert Panel of NMRA refused to give approval in the absence of required data from the manufacturer. Wide publicity was given to this controversial decision casting serious doubts in the public mind on the efficacy and safety of the Sinopharm vaccine eroding to a great extent the public trust that was there in the stringent approval process. Delays, mismanagement and other irregularities related to vaccine procurement has been a cause for concern as the country continued its vaccination campaign. Procurement guidelines provided extraordinary powers to the government to make emergency procurement through any means necessary. It was clear that there was no proper accountability or oversight mechanism in place to safeguard public interest in the vaccination process in Sri Lanka.

Vaccine hesitancy and misinformation

When the vaccine rollout started, there were some concerns on the part of the public due to doubts about the efficacy, side effects and other long-term complications that

could be caused by these vaccines, as they were developed within a short time. Sri Lankans have not shown much hesitancy towards the vaccine in comparison to other countries (Uduwaragedara, 2021). They have observed healthcare workers encouraging their colleagues, family and friends to receive the vaccine. Furthermore, the fear of being discriminated for being an infected individual and the trust people held about obtaining high protection and immunity against the virus from the vaccine were identified as two main reasons for an increase in motivation and competition to receive the vaccine in Sri Lanka.

Even though vaccine hesitancy has not been a serious concern for people in Sri Lanka for the 1st dose and to some extent in taking the 2nd dose, it has clearly been an issue for the 3rd and 4th doses (1st and 2nd booster doses) as evident from the low vaccination figures for the booster doses.

Even though hesitancy towards the vaccine was relatively low amongst people in Sri Lanka in comparison to other countries, numerous myths associated with the vaccine and other reasons have been identified within different communities, which have driven some individuals to reject the vaccine. This was evident in the reluctance that was observed amongst the youth in taking the 2nd dose.

Listed below are some of the myths and challenges associated with vaccines as reported in the media and as observed by the health staff.

- (i) Certain myths and beliefs about Adverse Effects following Immunization (AEFIs) and vaccine safety prevented people from accepting vaccine. Commonest beliefs were: vaccine causes body aches which lasts several weeks (preventing people from engaging in daily work), vaccine precipitates the risk of strokes and causes subfertility.
- (ii) Placing more trust in indigenous medicines - Media played a role in misleading the public with non-credible information with regard to indigenous medicine available in the country, which shifted people's attention from the vaccine leading to vaccine hesitancy.
- (iii) Doubts about the effectiveness of the vaccine - People tend to believe that the currently available vaccines will not be effective against the new variants that have been identified although there are plenty of credible sources confirming the efficacy of the vaccine, especially against the new variants identified in the UK and South Africa at that time (2021).
- (iv) Certain 'conspiracy theories' prevail in society. They are: people are used as 'lab rats'; Pfizer vaccine is rapidly given as there is a stock which is supposed to expire soon.
- (v) Many of the top-level government officers, including some health staff, have not been vaccinated. They refrained from actively engaging in vaccine promotion programme.
- (vi) Though improved communication has been noted, still the message about vaccination programmes and clinics did not adequately penetrate to the household level. Field level public health staff were disappointed due to the absence of an effective and properly coordinated national campaign to promote booster vaccine or to counteract myths.

A recent study by Verite Research (2022) titled "Diversity Impact on Vaccine Equity (DIVE)" sheds a lot of insights into ethnicity variations in vaccine confidence and uptake in Sri Lanka. This study also confirms that a vast majority of the respondents (95.6%) had received at least one dose of the COVID-19 vaccine; however, out of them, 38% had reservations prior to getting the vaccine. It also revealed that the Tamil and Muslim respondents were more likely to remain unvaccinated compared to the Sinhala respondents. As mentioned above, this study also confirmed that the youth were reluctant to get vaccinated. Those who wanted to get vaccinated but remained unvaccinated were due to external factors such as not finding time to go to the vaccination centre or due to their preference for a particular type of vaccine.

In September 2021, Sri Lanka's health authorities even claimed that they suspected an organised misinformation campaign behind an unusual increase in vaccine hesitancy among the country's youth (Economynext, 2021). Deputy Health Services Director Dr. Hemantha Herath told

reporters stated that a decline has been noted in vaccination of young people owing to misconceptions about side effects of COVID-19 vaccines and appealed the youth to go to the nearest vaccination centre and get the vaccine available there because the authorities might have to limit vaccination for certain age groups in future rollouts. According to the Deputy Health Services Director, as on September 2021, only 48 percent of Sri Lanka's 20-29 age group received at least one dose of a vaccine, while only 12.7 percent are fully vaccinated. Mainstream and social media reports indicate that vaccine centres dedicated to youth are not as full as they should be. Young people also showed a preference for vaccines such as Pfizer-BioNTech over the Chinese Sinopharm jab, which is Sri Lanka's most widely used COVID-19 vaccine at that particular point of time.

This official statement came a day after Health Minister Keheliya Rambukwella revealed plans for a possible vaccine mandate for Sri Lanka (Economynext, 2021). Speaking to reporters in Kandy on 26 September 2021, Minister Rambukwella said *"if the need arises, the government may discuss a legal framework for such a mandate with the advice of health experts. Just as one has a right to one's own life, there is a problem if one opposes decisions that will prevent someone else being infected. So, we might have to take a decision, in the event of [a vaccine mandate] becoming essential,"*

Vaccines and the WTO framework

Sri Lanka has not used TRIPS flexibilities for vaccines or any other medicine to this date. As described earlier, the vaccines came as donations through COVAX, WHO, UNICEF and other bilateral arrangements with foreign governments, and through direct procurement in the open market.

Cost of vaccines

As a state policy, Sri Lanka provides universal free health care service to the public. Following this policy, GoSL is obliged to provide COVID-19 vaccines to the population free of charge. A costing and funding plan was included in the NDVP.

The NVDP has estimated the approximate cost for procurement of vaccines (outside COVAX and bilateral donations), operations and distribution cost. The cost per vaccine is calculated at US \$ 7 per vaccine dose and US \$ 2.45 per person for vaccine distribution/administration (NVDP, 2021).

Sri Lanka has received vaccines from a combination of sources – COVAX, direct donations, direct procurement using government funds or grants from the United Nations (UN) and bilateral agencies, and through loans from multilateral agencies such as the Asian Development Bank (Asian Development Bank, 2021).

Gaps in the government policy and implementation to contain the spread of the virus

There wasn't a genuine "whole of society"¹ or even for that matter, a "whole of government"² approach. As stated elsewhere, the approach to prevent and control COVID-19 was very centralised and extensively involved security forces. Formal or planned CSO involvement in government programmes was minimal. Had there been a formal recognition and involvement of the CSOs, the social and economic impact on the poor could have been mitigated more.

The government did not follow its own strategic documents, such as the Strategic Preparedness and Response Plan (SRP) or the National Deployment Vaccine Plan (NDVP).

Civil society movements, activism and demands from the grassroots

As mentioned, CSO space in Sri Lanka has been shrinking even before the onset of the COVID-19 pandemic. The present government came into power on a "nationalist platform" and non-governmental organisations were portrayed as "unpatriotic" and "Western-funded" organisations seeking regime

change. Hence, right after the new President was elected in November 2019, the NGO Secretariat was brought under the Ministry of Defence and state intelligence agencies, the Police and the military were used to visit NGO offices, gather information, and make the process of NGO registration and opening bank accounts extremely difficult. Prior approval was required for NGOs particularly in the North and the East of Sri Lanka to do any kind of development or humanitarian activity.

Overall, curfews, lockdowns, restrictions on mass gatherings *et cetera* prevented CSOs from organising events, protests *et cetera*. Additionally, the government used the COVID-19 control measures to suppress political dissent, civil society voice or action. These exacerbated the pre-COVID restrictions and control measures that the government had adopted. The quarantine regulations were used to curtail public dissent and protests, particularly by teachers' unions. Protest leaders were arrested and even after they were released on bail through legal interventions, they were forcibly taken to quarantine centres (Law and Society Trust, 2021).

1 Whole-of-society approach means government engaging all stakeholders including the civil society, communities, academia, media, private sector, NGOs, other voluntary associations, families, and individuals to strengthen the resilience of communities and society as a whole. See <https://www.apc.org/en/news/voice-whole-society-approach-covid-19-pandemic>

2 Whole-of-government approach is defined as "an approach in which public service agencies work across portfolio boundaries to develop integrated policies and programmes towards the achievement of shared or complementary, inter-dependent goals." See <https://gh.bmj.com/content/7/7/e009972#ref-10>

Role of civil society

Responding to COVID-19 in Sri Lanka was also a challenging experience for the civil society. CSOs, including Non-governmental Organisations (NGOs), Faith-based Organisations (FBOs), Community based Organisations (CBOs) who were amongst the “first responders” to any previous man-made or natural disasters found it nearly impossible to find their role or niche in the national response to COVID-19.

The complexity of reasons, which included the animosity and distrust (both perceived and real) that existed between CSOs and the newly elected government, prevented any formal engagement of the CSOs and this remains largely unchanged until now when the country is facing a devastating socioeconomic and political crisis. None of the national-level bodies created to manage COVID-19 in Sri Lanka included any representation from civil society.

However, it is extremely encouraging to note the dynamic and significant role played by civil society in combatting the impact of COVID-19 on several fronts. The CSO interventions included:

- 1) Emergency relief for vulnerable groups
- 2) Livelihood support
- 3) Risk Communication and Community Engagement (RCCE)
- 4) Psycho-social support
- 5) Policy advocacy

Emergency relief for vulnerable groups

The immediate lockdowns caused enormous hardships to low-income families and vulnerable communities, such as daily wage earners and informal sector workers.

National, district and local level CSOs, though constrained by the possible risk of COVID-19 infection to their own workers and volunteers, mobilised themselves and provided dry food items to vulnerable groups from the very beginning of the epidemic in Sri Lanka. The religious institutions and clergy also played a major role in supporting vulnerable families in their own localities.

Residents in institutional care

Amongst the most vulnerable groups during the time of the lockdown were those in institutional care – the elderly, children, differently-abled, women in shelters, and residents of probation homes. On a formal request made by the Presidential Task Force (PTF), a group of leading Civil Society Organisations (CSO) formed a collective and initiated a comprehensive plan to look after the needs of residents of care institutions. These institutions included a) government and private children’s homes; b) government and private elderly homes; c) care and rehabilitation centres for people living with disabilities; d) safe houses for women; e) rehabilitation centres; and 6) probation centres.

The civil society actors involved in the response voluntarily organised themselves by district and established contact with the relevant centres and corresponding government officials. A management arrangement was set up at the national level to coordinate the response, and a core group was formed to support the two national-level representatives. The district representatives began contacting the centres, quickly assessing urgent needs, and responding to them. First, they utilised local resources available in the district from various actors and, when needed, reached out for support from national-level organisations. As on 31 August 2021, 544 requests (including 523 institutions) comprising a total of 7,595 children and 9,378 adults (including staff), were supported under this initiative. A total of LKR 35,406,419 worth of dry rations and NFRIs (safety and hygiene products including masks, sanitisers, PPE, cleaning items, sanitary products *et cetera*) was distributed across 24 districts.

Livelihood support

Many CSOs came forward to assist the affected groups beyond relief to help them to restart their lives and livelihoods badly affected by the lockdowns and the COVID-19 infection itself. The vulnerable communities included the urban poor, estate worker families, garment factory workers, low-income groups in rural villages and the fishing community. Cash grants as well as materials to restart small businesses, were provided along with

technical assistance and even establishing market linkages for their products and services.

Risk communication and community engagement (RCCE)

Notwithstanding the absence of CSO involvement in the main COVID-19 decision-making mechanisms, the Ministry of Health, particularly the Health Promotion Bureau which had the official mandate for RCCE, made an attempt to link with CSOs from the beginning of the COVID-19 epidemic in Sri Lanka.

The Health Promotion Bureau (HPB) took proactive measures to engage with CSO and religious leaders. HPB has developed a separate strategy, the “Community Engagement Plan for COVID-19 vaccination” and has identified key activities to be undertaken in partnership with the CSOs (Health Promotion Bureau, 2021). The Plan highlights the risk communication and community engagement strategies that could be used especially by CSOs and religious organisations.

The plan is operationalised through direct programme implementation by the HPB through their technical staff at the national level and through the Health Education Officers (HEOs) at the district level. The selected national-level NGOs and CSOs have been invited to serve in a committee on RCCE convened by the HPB and specific activities have been assigned to each agency. The HPB

has sent a circular to the RDHSs on the plan indicating the contact details of partnering CSOs/NGOs and activities are implemented jointly by the respective organisations in close coordination with the HEOs and local health staff.

Many CSO leaders and religious leaders were trained and working in their own communities to raise awareness amongst people at grassroots levels on COVID-19 prevention and control in general and vaccination in particular.

The HEOs have engaged CSOs in pre-vaccination awareness programs to address misconceptions and to provide support at vaccination sites. In addition, organisations such as Sarvodaya have been supporting mobile public address systems to educate the people and, when required, with other support such as mobilising volunteers for crowd control at vaccination sites.

Psycho-social support

CSOs who were specialising in Mental Health and Psychosocial Support (MPHSS) work formed a collective during the COVID-19 lockdown period and provided counselling and other services through telephone hotlines.

Policy advocacy

The CSOs, particularly the human rights and research Organisations played a crucial role in keeping alive critical issues related to human

rights, access to vaccinations, provision of essential services to vulnerable groups and other issues related to social protection. There was clearly a “watch-dog” role played by these CSOs/Think Tanks, such as Centre for Policy Alternatives (CPA), Law and Society Trust (LST), Centre for Poverty Analysis (CEPA) and Institute for Health Policy (IHP).

Recommendations and CSOs’ key asks to the government and the international community

1) Overall, the COVID-19 vaccination programme in Sri Lanka has been a success with satisfactory coverage for the 1st and 2nd doses and, to a great extent, for the 1st booster dose. However, district disparities have been observed and cannot be fully explained within further systematic study and analysis.

Recommendation: Have in-depth quantitative and qualitative studies to verify whether these differences are statistically significant and identify underlying reasons for such differences.

2) The uptake by the public of the 2nd booster dose has been poor, despite wide publicity by the health authorities indicating a degree of vaccine hesitancy. Even though the risk of COVID-19 is now waning, addressing misinformation and disinformation related to vaccines are of paramount importance to managing future pandemics.

Recommendation: Set up an independent mechanism to monitor public perceptions and make appropriate recommendations to the government and other stakeholders to initiate timely action.

- 3) The socioeconomic impact of COVID-19 has been devastating, particularly on the poor and marginalised. This has been further aggravated by the socioeconomic and political crisis which followed in early 2022.

Recommendation: Review the existing social protection systems in Sri Lanka with the objective of revamping and/or establishing a new and modern social protection mechanism which is more targeted and inclusive of vulnerable groups in the country. Civil society organisations can play a significant role in such a mechanism by helping to identify such communities and empowering them to graduate from such benefit schemes within a specified period of time.

- 4) COVID-19 is not the last pandemic that

humanity will face. Therefore, pandemic preparedness is an important area of public health intervention. The Sri Lankan experience has clearly proven the important role played by communities and the CSOs in both the prevention and control of COVID-19.

Recommendation: Set an integrated coordination mechanism (building on the UN HCT Cluster Mechanism) where the government, CSOs, private sector and development partners can work together towards pandemic preparedness and response. Such efforts should centre around *resilience building* at the community level.

- 5) Significant deficiencies and even malpractices were reported in Sri Lanka vaccine procurement, highlighting the importance of health governance.

Recommendation: The public and the donors should demand full transparency in the procurement and distribution process of medicines, vaccines and devices.

CASE STUDY ONE

I am Kumari Sandamali and I am 26 years old. I came to work at Katunayaka Free Trade Zone in 2018 and I have worked at two different places so far. On the last week of March 2020, we were suddenly told that because of the Corona outbreak, transportation service would be provided for us to go back to our villages. Therefore, on the given day, we came to a place near the Free Trade Zone (FTZ) at 7.00 in the morning. We stayed there till 2.00 pm in the afternoon and we did not have anything to eat since morning. Around 3.00 pm, a charity organisation gave us a lunch packet and we went back to the boarding place hopelessly. Again, we were informed to come back the next day, and we went back. We waited there from 7.00 am to 12.00 noon, and again we were asked to come back the next day. On the third day, we were provided a bus to go back to our homes. But till the third day, none of the government officers or our employers bothered to check whether we were having a meal or our basic necessities were fulfilled. We were all dropped at the police stations closest to our homes and we were asked to find our own transport home. This was a traumatic experience. We were in our homes for many months with either full or half salary or with no compensation at all. It was a traumatic experience. Some of us got back to our jobs after the 2nd wave, while others decided not to return to their original jobs as factory workers were considered "high-risk" for COVID-19. For those who returned to work including myself, vaccines were given as factory workers in FTZs were given priority.

CASE STUDY TWO

I am K. A. Ajantha Siriwardhana. I am 32 years old. I am a married woman. I live in a rented house (a part of a house, a shared space) with my son and my husband. My son is three and a half years old. My husband is a mason. I married him one year after my arrival in Katunayaka Free Trade Zone. Now it has been five years. When the second Corona outbreak happened, we were in Katunayaka. My husband did not have a job for the last three months because of the COVID-19 pandemic. On the 24th of October 2020, we were asked to come to get the test done for the coronavirus. By that time, I had not been to work for 17 days. We had to stop because we were afraid that our children would get the virus. It was so difficult for us to reach the 'testing place' but we somehow went there. We were asked to stay there for three hours and asked to leave without the test being done since we did not have any symptoms. We couldn't even have a proper meal on that day. After two days, I went back to work. My employer had deducted 20 days' worth of salary from my total salary. I still have not received the salary for the month of October. Now we are in a helpless situation. There is no one to even check up on us. We do not have any recognition from the health sector and the government sector has also completely ignored us.

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About SAAPE

South Asia Alliance for Poverty Eradication (SAAPE) is a regional platform of civil society organisations, social movements and people's networks fighting unitedly against the structural causes of poverty and social injustices in the region and beyond. It was conceived in 2001 against the backdrop of increasing anti-people globalisation marked by privatisation, deregulation, extractivism and capital accumulation. SAAPE's mission is to facilitate the process for establishing mechanisms to ensure people's genuine participation in the decision-making processes at all levels to contribute towards poverty eradication and sustainable development. SAAPE facilitates linkages among and between groups in the region, throughout the global South and with like-minded groups in the North.



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