SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Sri Lanka	Project Title:	Health System Enhancement Project – Additional Financing
Lending/Financing Modality:	Project Loan and Grant	Department/ Division:	South Asia Department / Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: Targeted intervention—Sustainable Development Goals (SDGs)

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy

The project aligns with the Government of Sri Lanka's development strategy, the National Policy Framework Vistas of Prosperity and Splendour 2019, which is founded on inclusive economic growth.[a] Under the Suwa Divimaga program of the strategy, the government intends to ensure that the existing free health care system is further developed to reduce waiting times (with special focus at the district level), expand the services available to patients, and ensure that all hospitals are developed to change from the current approach from treating a patient after the disease has developed to preventing diseases by promoting a healthy lifestyle (note a). Its target of vulnerable groups using a multidimensional poverty lens heightens this focus. The project supports the inclusive growth pillar of the Asian Development Bank (ADB) country partnership strategy of contributing to further reduction of poverty, narrowing inequality gaps, and balancing geographical development.[b]

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. **Key poverty and social issues.** Multidimensional poverty across sectors indicates that 12.4% of estate sector households are multidimensional poor.[c] Poverty because of multiple variables persists in the four provinces and nine districts targeted by the project. Inability to access a comprehensive package of health services and suboptimal utilization (because of limitations in existing physical facilities) have contributed to poor health outcomes. Vulnerability is heightened for some subgroups such as informal laborers and households, older females, and segments of the plantation sector. The need to improve disease surveillance and continuity of care at the national level, especially in the geographically and economically disadvantaged areas, has become a priority. The coronavirus disease (COVID-19) and the policy measures implemented to control its spread have made more people vulnerable to poverty. With the pandemic affecting Sri Lanka since January 2020, it is of utmost priority to improve and expand disease surveillance and notification mechanisms, improve COVID-19 treatment and management facilities including better access to oxygen and roll out COVID-19 vaccination within the health sector and across other sectors.

2. **Beneficiaries.** Beneficiaries of the proposed project are users of public health services in the selected provinces and the rest of the population living in Sri Lanka. With the increasing COVID-19 burden in Sri Lanka; the project beneficiaries have expanded to the wider total country population. Through a life cycle approach, the project will support human development at multiple levels (household, community, and district). The project will address development and long-term poverty reduction through a package of complementary services—infrastructure development, strengthening of health services at the primary and secondary level, provision of medical supplies, and capacity building to health workers. With the reallocation of funds for addressing COVID-19 in Sri Lanka, the project will also address COVID-19 prevention, diagnosis, and management and strengthen Sri Lanka's capacity to implement the International Health Regulations (IHR) at the ports of entry in Colombo, Galle, Hambantota, and Trincomalee. The overarching objective is to improve health services and thereby quality of life of the selected populace. The project will also improve the MOH's operational capacity and efficiency and contribute to the achievement of SDG 3 indicators.

3. **Impact channels.** The project will improve the health system by (i) strengthening primary and secondary care, especially in lagging areas and in other selected areas; (ii) strengthening health and disease surveillance capacity for improved compliance with the IHR and support the country's response to COVID-19; and (iii) support the strengthening of distance learning facilities for training and knowledge improvement. A responsive health care and disease prevention and control system will improve both the quality of life and productivity of the population.

4. **Other social and poverty issues.** In schooling, completion of secondary school is low and is combined with poor adult literacy, especially in the estate sector population. Vulnerability to external shocks such as droughts and floods is high. The major social protection program, Samurdhi, has also been updated to ensure better protection of the poor. In addition, with the COVID-19 economic stress faced mainly by the daily wage earners and the poor and more vulnerable populations, the government provides a welfare package (note a).

5. **Design features.** The project will enable the provision of a wider range of services and thereby attract a higher number of patients to seek preventive and curative care at primary and secondary care levels. A continuum of care and special provision to support vulnerable groups such as children and disabled and elderly people are key provisions. This will help prevent and control COVID-19-related issues and reverse the current trend of bypassing PHC and reduce high out-of-pocket expenditure for health by the poor. As ADB's interface in the health sector, the project is also closely coordinated with the national COVID-19 vaccination program and ADB's Asia Pacific Vaccine Access Facility which supports COVID-19 vaccination.

II. PARTICIPATION AND EMPOWERING THE POOR

1. Participatory approaches and project activities that will strengthen inclusiveness in project implementation. Pre-implementation preparatory activities will focus on awareness raising and information sharing with the user groups on upgrading and outfitting the facilities, and behavior change communication (BCC). Health facility selection is based on an inclusive approach of targeting those that service a high number of poor and vulnerable people.

2. Civil society organization participation. Local organizations will be involved in organizing awareness sessions targeting engagement of men in higher utilization of PHC services.

3. Approaches of civil society organization participation envisaged during project implementation:

NA Information gathering and sharing NA Consultation L Collaboration NA Partnership

4. Participation plan. ☐ Yes ☒ **No** ☐ Other plans/frameworks

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. Key gender issues identified include (i) child and maternal malnutrition (of children aged under 5 years, 21% are underweight and 4% severely underweight; 22% of women aged 15–49 in the estate sector are acutely undernourished),[d] (ii) low health-seeking behavior and low utilization of PHC among men, (iii) occupational health issues of women and men (e.g., work-related musculoskeletal pain, headaches, neck pains),[e] (iv) gender-based violence (GBV) (17% of women have experienced some form of GBV),[f] and (v) absence of gender-disaggregated data in the e-health surveillance system. Studies suggest that the highest intimate partner violence in Sri Lanka occurs in tea plantations, where more than 72% of married women reported being subjected to violence by an intimate partner.[g] According to the World Bank data 46% of men use tobacco in some form.[h] Alcohol dependence is 4.9% among men compared to a regional average of only 2.9%.[i] Women (34%) are more obese than men (25%). More women (38%) have raised total cholesterol than men (19%). Over 90% of adults were estimated to have at least one risk factor, with similar rates for women and men.[j]

B. Key actions. ☒ **Gender action plan** ☐ Other actions or measure ☐ No action or measure

To enhance utilization of PHC facilities and reproductive health services by men and youth, the project will undertake BCC and encourage partnerships with local organizations. Further, to address GBV, the project will support a review of BCC material on gender sensitivity. A national resource pool of gender experts will be formed to provide technical inputs in capacity building of PHC staff and in gender mainstreaming undertaken by the gender and women's health unit of the Family Health Bureau. A capacity development program will be undertaken to strengthen the capacities of heath staff to respond to GBV. A strategy will be piloted to involve men as active participants in reproductive health education, maternal and child health and nutrition, and positive and active fatherhood, all targeted to promote engagement of men to promote positive health outcomes for men and women. Gender-disaggregated data will be included in the e-health surveillance system to strengthen the capacity of the health and disease surveillance mechanisms. An organizational strategy to mainstream gender through a participatory procedure involving staff from identified selected units will be identified.

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement	**Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. The additional financing will not require any land acquisition. No involuntary resettlement impacts are identified in the proposed project activities. Civil works including construction of new buildings and renovation of existing buildings in the selected nine apex hospitals will be limited to the existing land areas of these hospitals. Ambulance stations selected for renovation are also located within government land and do not require acquisition of private land leading to any involuntary resettlement impacts.

2. Strategy to address the impacts. Not applicable.

3. Plan or other Actions.

☐ Resettlement plan	☐ Combined resettlement and indigenous people's plan
☐ Resettlement framework	☐ Combined resettlement framework and indigenous peoples planning framework
☐ Environmental and social management system arrangement	☐ Social impact matrix
☒ No action	

B. Indigenous Peoples	**Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. Is broad community support triggered? ☐ Yes ☒ No

The additional financing will not have impacts on indigenous peoples and their communities since the proposed civil works are confined within the existing government health facilities on government-owned land. The interventions do not directly target indigenous peoples as a group but may benefit individual indigenous peoples who seek medical assistance from these hospitals.

2. Strategy to address the impacts. Not applicable.

3. Plan or other actions.

☐ Indigenous peoples plan ☐ Indigenous peoples planning framework ☐ Environmental and social management system arrangements ☐ Social impact matrix ☒ No action	☐ Combined resettlement plan and indigenous people's plan ☐ Combined resettlement framework and indigenous peoples planning framework ☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market ☐ Unemployment ☐ Underemployment ☐ Retrenchment ☒ Core labor standards

2. Labor market impact. Bid and contract documents will include clauses to ensure compliance with national labor standards and laws. The project will adhere to national labor laws, zero tolerance of child labor, ADB's core labor standards, and a fair wage for both men and women. The project has the potential for temporary employment and skill building for the local populace.

B. Affordability. Not applicable. Health services in Sri Lanka are provided free at the point of delivery. The project supports improvements in service provision and helps to minimize out-of-pocket expenses for health seekers.

C. Communicable Diseases and Other Social Risks. The impact of the following risks are rated as high (H), medium (M), low (L), or not applicable (NA) ☒ **(H) Communicable diseases** ☐ (NA) Human trafficking ☐ (NA) Others (please specify)

The project supports health care, especially for the poor and vulnerable. It enhances testing, prehospital management, transport, treatment, and appropriate referral for patients with communicable diseases including COVID-19, malaria, dengue, tuberculosis, and human immunodeficiency virus disease (HIV/AIDS).

Risks to people in project area. The risk related to the spread of COVID-19 and other communicable diseases persists in the project areas. These issues are addressed in the environmental management plan and in the initial environmental examination report.

VI. MONITORING AND EVALUATION

1. **Targets and indicators.** Targets and indicators defined in the design and monitoring framework comply with the project's priority to protect poor and vulnerable people. More than half of the outcome indicators included in the framework monitor the utilization of PHC facilities by vulnerable populations identified in the vulnerability mapping. More than 75% of the output indicators related to strengthening PHC provide disaggregated data for sex and vulnerability levels. Moreover, the project monitors the effective implementation of the gender action plan.
2. **Required human resources.** The project management unit, project implementation units, family health bureau of the MOH, and consultants will monitor project implementation for poverty and social impact. The project will fund human resource capacity building on gender and poverty and hire gender experts to carry out required reviews related to gender.
3. **Information in the project administration manual.** The project administration manual includes details of the monitoring mechanism. It covers poverty, social, and gender issues. Gender mainstreaming is highlighted in the gender action plan.
4. **Monitoring tools.** The project administration manual and loan agreement specify reporting through quarterly project reports, which will be disclosed on the ADB website. Quarterly progress reports, consolidated annual reports, and review missions will monitor the implementation progress. Baseline and endline surveys will generate most of the data necessary for monitoring gender, poverty, and social impact.

[a] Government of Sri Lanka, Ministry of Finance. 2019. *National Policy Framework Vistas of Prosperity and Splendour*. Colombo.
[b] ADB. 2017. *Country Partnership Strategy: Sri Lanka, 2018–2022—Transition to Upper Middle-Income Country Status*. Manila.
[c] ADB. 2020. *Basic Statistics 2020*. Manila.
[d] Department of Census and Statistics. 2017. *Sri Lanka Demographic and Health Survey – 2016*. Colombo.
[e] K. Suraweera et al. 2016. Occupational health issues in small-scale industries in Sri Lanka: An underreported burden. *Work*. 55(2): pp. 263–269
[f] Department of Census and Statistics. 2020. *Women's Wellbeing Survey – 2019*. Sri Lanka.
[g] S. Guruge et al. 2015. Intimate partner violence in Sri Lanka: a scoping review. *Ceylon Medical Journal* 60: pp. 133–138.
[h] World Bank data. Prevalence of current tobacco use, males (% of male adults) - Sri Lanka (accessed on 17 August 2021).
[i] World Health Organization. 2018. *Global status report on alcohol and health 2018*. Geneva.
[j] World Health Organization and Government of Sri Lanka, Ministry of Health. 2015. *Noncommunicable disease risk factor survey in Sri Lanka*. Colombo.

Source: Asian Development Bank