Report and Recommendation of the President to the Board of Directors

Project Number: 51107-002
October 2018

Proposed Loan and Grant
Democratic Socialist Republic of Sri Lanka: Health System Enhancement Project

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 1 October 2018)

Currency unit	–	Sri Lanka rupees (SLRe/SLRs)
SLRe1.00	=	$0.00591
$1.00	=	SLRs169.080

ABBREVIATIONS

ADB	–	Asian Development Bank
GDP	–	gross domestic product
GIS	–	geographic information system
IHR	–	International Health Regulations
MOHNIM	–	Ministry of Health, Nutrition and Indigenous Medicine
NCD	–	noncommunicable disease
PAM	–	project administration manual
PHC	–	primary health care
PIU	–	project implementation unit
PMU	–	project management unit
POE	–	port of entry
WHO	–	World Health Organization

NOTE

In this report, “$” refers to United States dollars.

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PROJECT AT A GLANCE

1. Basic Data — **Project Number:** 51107-002

Project Name	Health System Enhancement Project	**Department /Division**	SARD/SAHS
Country	Sri Lanka	**Executing Agency**	Ministry of Health, Nutrition and Indigenous Medicine
Borrower	Democratic Socialist Republic of Sri Lanka		

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ **Health**	Disease control of communicable disease	10.00
	Health sector development and reform	40.00
	Total	**50.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Medium
Environmentally sustainable growth (ESG)	Global and regional transboundary environmental concerns	**ADB Financing**	
Regional integration (RCI)	Pillar 4: Other regional public goods	Adaptation ($ million)	3.20
		Mitigation ($ million)	1.80

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Organizational development	Effective gender mainstreaming (EGM)	✓
Knowledge solutions (KNS)	Application and use of new knowledge solutions in key operational areas		
Partnerships (PAR)	Implementation United Nations organization		

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	Yes	Rural	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG3, SDG13		

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** B **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**50.00**
Sovereign Project grant: Asian Development Fund	12.50
Sovereign Project (Concessional Loan): Ordinary capital resources	37.50
Cofinancing	**0.00**
None	0.00
Counterpart	**10.00**
Government	10.00
Total	**60.00**

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed loan and (ii) a proposed grant, both to the Democratic Socialist Republic of Sri Lanka for the Health System Enhancement Project.

2. The project will contribute to the government's development objective to ensure a healthier nation by supporting the development of a more responsive and comprehensive primary health care (PHC) system in Sri Lanka. It will enhance planning and delivering of essential PHC to geographically and socioeconomically deprived populations of Central, North Central, Sabaragamuwa, and Uva provinces. The project will (i) help operationalize the government's PHC reform initiatives, (ii) improve underserved communities' access to primary health services, and (iii) address selected gaps in core public health capacities in line with the International Health Regulations (IHR).[1]

II. THE PROJECT

A. Rationale

3. Sri Lanka has made impressive gains in ensuring access and quality to health services for all. Life expectancy at birth increased to 75 years in 2015 from 70 in 1990.[2] Maternal mortality reduced from 75 to 30 per 100,000 live births and infant mortality from 17.9 to 8.0 per 1,000 live births during the same period.[3] Sri Lanka has achieved these efficiently with low overall health spending at 3% of gross domestic product (GDP).[4] Most vaccine preventable diseases are at near elimination stage with immunization coverage at more than 99%.[5] Sri Lanka has been polio-free since 1994, and malaria- and filariasis-free since 2016.

4. Although Sri Lanka made significant improvements in health outcomes during the Millennium Development Goals period (1990 to 2015), it is now facing new health challenges related to population aging, changing disease pattern, economic and social changes, and changing lifestyles. These dynamics have resulted in a dramatic increase in noncommunicable diseases (NCDs), which are causing a surge in demand for health services and an increase in health care costs while reemerging and emerging communicable diseases remain a threat. Disparities in health outcomes, health-seeking behavior, life expectancy, and disease burden remain in lagging geographic areas especially in rural and estate sector populations, e.g., malnutrition in mothers and children is a persistent health issue and more acutely seen in the

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[1] World Health Organization (WHO). 2005. *International Health Regulations*. Geneva.

[2] United Nations, Department of Economic and Social Affairs, Population Division. 2017. *World Population Prospects: The 2017 Revision*. New York (custom data acquired via website).

[3] United Nations Maternal Mortality Estimation Interagency Group. 2015. *Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva; and United Nations Interagency Group for Child Mortality Estimation. 2017. *Levels and Trends in Child Mortality: Report 2017*. New York.

[4] WHO. 2017. WHO Global Health Expenditure Database. Government health spending is also low at 1.9% of GDP, with most of the out-of-pocket spending borne by the higher wealth quintiles and partly because of strong preventive services available universally.

[5] Government of Sri Lanka; Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM); Medical Statistics Unit. 2015. *Annual Health Bulletin 2015*. Colombo.

estate sector.[6] The country is now more exposed to communicable diseases because of increased labor mobility and connectivity. Sustaining control of vaccine preventable diseases, malaria elimination efforts, and containment of global diseases will require continuous investments in the prevention and control of communicable diseases and disease surveillance in Sri Lanka.

5. **Primary health care delivery system.** The public PHC system in Sri Lanka has been instrumental in providing universal comprehensive care at no cost to the population at the point of service delivery. One of the most characteristic features of the system is preventive health care services focusing on communicable diseases control and maternal and child care. The preventive health system covers 341 geographic areas, each with a population of about 60,000. Each area is managed by a medical officer of health and served by 5–10 field health centers with midwives, public health inspectors, and preventive health care staff. In parallel, there is an extensive network of curative services in three tiers of care (955 PHC hospitals and dispensaries, and 149 secondary and tertiary health care hospitals). The government health sector provides as much as 90% of inpatient care, nearly 100% of preventive care, and 50% of outpatient care (footnote 5). At present, the health system planning, policy, and stewardship functions are centrally managed while management of primary and most secondary health care services is decentralized to provincial governments.[7]

6. **Constraints.** Since 1990, changing health challenges and population aging have led to prioritized investments for secondary and tertiary health care services at the expense of investments for primary curative and preventive care services. Deterioration of PHC facilities led to bypassing of primary curative care services for secondary and tertiary care for most health problems faced by the population. For example, secondary and tertiary health care today manage as much as 93% of childbirths, 75% of NCD patients, and 50% of outpatient services (footnote 5). On the preventive side, the medical officers of health continue to provide antenatal care, nutrition, and immunization services. However, the quality of services decreased because of lower investments (about 4.5% of public health spending), inadequate staffing, and other resource constraints. Expanded outreach and interventions for populations living in vulnerable and lagging areas are also hampered. Preventive health care services are limited to mothers and children and village environments. There is a need to expand the target group to include the total population (children, youth, adult men and women, and elderly) and expand coverage of NCDs.[8]

7. **Government initiatives.** The Government of Sri Lanka is reprioritizing PHC in line with its national health policy and strategic master plan.[9] Sector reforms aim to establish a more responsive, patient-centered, and person-focused health care system. The system will enable health seekers to access a comprehensive package of essential health services including financial risk protection. The government's most recent policy on health care delivery for universal health coverage provides the guiding framework to reform the existing PHC system.[10]

8. The government is committed to develop a more comprehensive, accessible, and higher-quality PHC package to strengthen PHC services, reduce bypassing, and reach vulnerable

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[6] The estate sector consists of all plantations, such as for tea, rubber, and coconut, which are 20 acres or more and with 10 or more resident laborers under a single administration.

[7] The line ministry directly manages selected base hospitals, teaching hospitals, and specialized tertiary care hospitals.

[8] NCDs and their risk factors (diet, high blood pressure, smoking, physical inactivity) are reaching 76% of the total disease burden.

[9] Government of Sri Lanka, MOHNIM. 2016. *Sri Lanka National Health Policy 2016–2025.* Colombo; and Government of Sri Lanka, MOHNIM. 2016. *National Health Strategic Master Plan, 2016–2025, Volume IV*. Colombo.

[10] Government of Sri Lanka, MOHNIM. 2018. *Policy on Healthcare Delivery for Universal Health Coverage.* Colombo.

groups. It is also committed to implement e-health to strengthen evidence-based health services.[11] This includes scaling up the introduction of a patient e-health card, connecting health services for referral and better patient care, and improving information on diseases and health-seeking behavior using a geographic information system (GIS). The system will be linked to disease surveillance for national health security. To comply with international standards (footnote 1), the government aims to strengthen the health assessment of migrants and quarantine services at ports of entry (POEs). In support of efforts to strengthen PHC and the digital health information system, policy developments are in preparation for the essential services package, health human resources, family medicine, facility norms, and testing innovative approaches to strengthen PHC. Capacity building will also be implemented in management, e-health, quarantine and health security, procurement, accounting, gender, nutrition, and health care waste management.

9. **Value added by ADB assistance.**[12] Asian Development Bank (ADB) assistance brings value by (i) supporting equity-focused health care delivery reform especially in rural areas and the estate sector which are lagging in socioeconomic and health indicators; (ii) adopting evidence-based planning based on GIS mapping[13] and vulnerability index[14] to identify and target underserved districts and populations; (iii) enhancing infrastructure design to address climate change and disaster risk resilience; (iv) scaling up e-health card and its integration with the government's web-based health information system to improve continuity of care and disease surveillance; (v) supporting GIS units in central and district planning departments to improve disease surveillance and monitor health-seeking behavior; (vi) institutionalizing distance learning for training PHC staff; and (vii) helping districts develop and implement innovative solutions to integrate and improve PHC services.

10. **Link to national development strategy and ADB sector priority.** The project aligns with the government's priorities identified in the Public Investment Programme, 2017–2020 and Vision 2025, and with the United Nations Sustainable Development Goal 3 on universal health coverage.[15] The project is in line with the objective of ADB's country partnership strategy for Sri Lanka to promote inclusiveness.[16]

11. **ADB experience and lessons learned.** The project is ADB's reentry to the health sector in Sri Lanka after a gap of about 20 years. ADB's previous projects in the health sector were in general successfully implemented.[17] These past experiences and the project preparation process indicate strong commitment by the government at the national and regional levels. The

[11] Government of Sri Lanka, MOHNIM. 2017. *National Policy on Health Information*. Colombo.

[12] ADB provided project preparatory support through ADB. 2017. *Technical Assistance to the Democratic Socialist Republic of Sri Lanka for Preparing the Health System Enhancement Project.* Manila.

[13] The ADB team developed a model in consultation with MOHNIM and the four provinces to identify the target population. The model used three variables to develop the list of *Grama Niladharis*: (i) the vulnerability index, (ii) the dependency ratio of the *Grama Niladhari* populations (population over 60 years and children below 15 years divided by the population of adults 15−59 years), and (iii) the distance to the nearest primary medical care facility (primary medical care unit or a divisional hospital).

[14] The vulnerability index of the Census Department identifies the most vulnerable *Grama Niladhari* divisions (the smallest administrative division in Sri Lanka) based on five variables from Census 2012: (i) percentage of households with basic facilities more than 5 km away from the *Grama Niladhari* division; (ii) percentage of households using kerosene and other sources of non-electricity for lighting; (iii) percentage of households made of low-quality material; (iv) percentage of households using unprotected water sources; and (v) percentage of households with low-quality sanitation facilities.

[15] Government of Sri Lanka, Ministry of National Policies and Economic Affairs. 2017. *Public Investment Programme, 2017−2020*. Colombo; and Government of Sri Lanka. 2017. *Vision 2025: A Country Enriched*. Colombo.

[16] ADB. 2017. *Country Partnership Strategy: Sri Lanka, 2018–2022*. Manila.

[17] ADB. 2000. *Project Completion Report: Second Health and Population Project in Sri Lanka*. Manila; and ADB. 1995. *Project Completion Report: Health and Population Sector in Sri Lanka*. Manila.

leadership provided by the Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM) and the four provincial administrations during the project preparation stage is expected to continue into project implementation.

12. **Development coordination.** MOHNIM convened the donor coordination committee to ensure collaboration with and among development partners. The World Health Organization (WHO) has a leading role in policy development and sector coordination. The project will collaborate with WHO in terms of technical assistance to support selected areas related to the essential services package, health system strengthening, human resource development, and health security. The project also intends to work with the United Nations Children's Fund (UNICEF) and the World Food Programme on nutrition, as well as the International Organization for Migration on migrant issues. ADB's support will be coordinated with the World Bank program support to strengthen PHC, and regular discussions are held to prevent duplication of efforts and to synergize on the results and outcomes.

B. Impact and Outcome

13. Sri Lanka's overarching development objective is a healthier nation that contributes to its economic, social, mental, and spiritual development.[18] The project is aligned with the following impact: a healthier nation is ensured with a more comprehensive PHC system. The project will have the following outcome: efficiency, equity, and responsiveness of the PHC system improved.[19]

C. Outputs

14. The project has three outputs: (i) PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces; (ii) health information system and disease surveillance capacity strengthened; and (iii) policy development, capacity building, and project management supported.

15. **Output 1: Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces.**[20] Output 1 covers four sets of activities: (i) upgraded curative services, (ii) improved preventive services, (iii) public awareness to use PHC, and (iv) tested models for improving PHC.[21]

16. First, the project will upgrade and rehabilitate 135 curative PHC facilities (primary medical care units and divisional hospitals) in the four provinces, supporting equipment for improving laboratory, emergency treatment, dental, and NCD-related clinical services. Second, the project will (i) renovate and refurbish one field health center for preventive health for each of the 127 medical officers of health in the four provinces, (ii) provide medical equipment for these centers, (iii) conduct staff training in nutrition counseling, and (iv) design community health and nutrition promotion. Third, the project will improve health-seeking behavior to use PHC by developing a communication strategy and implementing a communication campaign, which will include staff training, health promotion materials, and outreach activities. The campaign will inform and encourage the community, adult men, and other groups to seek preventive and curative care at

[18] Government of Sri Lanka, MOHNIM. *Sri Lanka National Health Policy 2016–2025.* Colombo.
[19] The design and monitoring framework is in Appendix 1.
[20] The four provinces have been selected based on high poverty levels, health disparities, as well as percentage of rural and estate sector populations.
[21] Activities on medical waste management; public health promotion and outreach on water, sanitation and hygiene; communicable disease; and vector source reduction will all contribute to health security.

the nearest PHC facility. Finally, the project will support testing models whereby provincial and regional health staff propose and implement strategies to improve PHC under a PHC innovation fund. In the final years of project implementation, successful initiatives will be incorporated as national reforms to improve PHC services in Sri Lanka.

17. **Output 2: Health information system and disease surveillance capacity strengthened.** Output 2 covers two sets of activities: (i) health information technology for better continuity of care and disease surveillance, and (ii) implementation of IHR recommendations for POEs and inbound health assessment services.

18. First, the project will strengthen the medical information system to provide real-time sharing of health information vertically and horizontally across health facilities and across different episodes of patient care. This will help enhance the referral system and quality of patient care, and establish a system of continuity of care for health seekers. The enhanced information system will include disease surveillance and GIS mapping functionalities for timely reporting of the 28 notifiable diseases of Sri Lanka to enhance health security. To improve PHC, overall sector efficiency, and reduce duplications in service delivery, the medical information system will link primary-level curative facilities to higher-level hospitals to track and refer patients. Second, the project will implement IHR recommendations to strengthen core capacities for POEs and inbound health assessment by (i) providing equipment required to meet core capacity levels at all eight POEs, (ii) enhancing the mobility of the quarantine unit at two designated ports in Sri Lanka, (iii) strengthening the web-based surveillance system for notifiable diseases managed by the quarantine unit, (iv) providing support for training health personnel on using the quarantine manual, surveillance, and vector control; and (v) supporting the review and development of inbound assessment guidelines for the new inbound migrant screening facility.

19. **Output 3: Policy development, capacity building, and project management supported.** Output 3 will support policy and strategy development for comprehensive PHC and continuum of care, especially for vulnerable groups living in plantations, and with priority to nutrition. The project will provide strategic support in the form of consulting services and workshops for policy initiatives of MOHNIM, including (i) the development of essential health services package for NCDs and emergency services, (ii) the development of clusters to explore strategies for strengthening PHC using funding under the PHC innovation fund, and (iii) personnel workforce planning. Output 3 will also support MOHNIM with capacity building for nutrition and health promotion, cluster planning and management, and training in procurement and financial management. The project will also support central and provincial project management and coordination, operating the project management unit (PMU) and project implementation units (PIUs), implementing the gender action plan, monitoring environmental and social safeguards, establishing a project planning and results monitoring system, and conducting baseline and endline surveys.

D. Summary Cost Estimates and Financing Plan

20. The project is estimated to cost $60 million (Table 1).

21. Detailed cost estimates by expenditure category and by financier are included in the project administration manual (PAM).[22]

[22] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

Table 1: Summary of Cost Estimates
($ million)

Item	Project Cost[a]
A. Base Cost[b]	
1. Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces	39.00
2. Health information system and disease surveillance capacity strengthened	3.70
3. Policy development, capacity building, and project management supported	9.87
B. Contingencies[c]	5.44
C. Financing Charges During Implementation[d]	1.99
Total (A+B+C)	**60.00**

[a] Includes taxes and duties of $4.98 million to be financed by the Government of Sri Lanka.
[b] In April 2018 prices, exchange rate of $1 = SLRs155.
[c] Physical contingencies computed at 5% of base costs on civil works, equipment, furniture, and administrative costs; and 3% on training and consulting services costs.
[d] Interest during construction for the ordinary capital resources loan has been computed at a concessional rate of 2%.
Source: Asian Development Bank estimates.

22. The Government of Sri Lanka has requested (i) a concessional loan of $37.5 million from ADB's ordinary capital resources, and (ii) a grant of $12.5 million from ADB's Special Funds resources (Asian Development Fund) to help finance the project (Table 2).[23] The ADB loan will have a 25-year term including a grace period of 5 years, an interest rate of 2% per annum throughout the grace period and thereafter; and such other terms and conditions as set forth in the draft loan agreement. ADB will finance the expenditures in relation to civil works, vehicles, consulting services, training, equipment, interest charges, and the PHC innovation fund.

Table 2: Summary Financing Plan

Source	Amount ($ million)	Share of Total (%)
Asian Development Bank		
Ordinary capital resources (concessional loan)	37.50	62.50
Special Funds resources (Asian Development Fund grant)	12.50	20.83
Government of Sri Lanka	10.00	16.67
Total	**60.00**	**100.00**

Source: Asian Development Bank estimates.

23. Climate change mitigation is estimated to cost $1.80 million and climate change adaptation is estimated to cost $3.56 million. ADB will finance 100% of mitigation costs and 90% of adaptation costs ($3.20 million), excluding taxes and duties. Changes in rainfall may result in wetter or drier conditions that could contribute to landslides, flooding, or droughts. Details are described in the climate change assessment and the PAM (footnote 22).[24]

E. Implementation Arrangements

24. The project will be implemented over 5 years. The executing agency will be MOHNIM, which has established a PMU headed by a full-time project director. The PIUs under the four provincial councils will be the implementing agencies in their respective project areas and will be supervised by the respective project coordination committee headed by the chief secretary of the

[23] Although classified as an ordinary capital resources-blend country, Sri Lanka is eligible to receive a regional health security grant under special arrangements for the Asian Development Fund 12 period (2017−2020). Under this arrangement, one-fourth of the total financing amount can be from the grant while the remaining three-fourths is drawn from Sri Lanka's performance-based allocation. ADB. 2016. *Concessional Assistance Policy.* Manila.
[24] Climate Change Assessment (accessible from the list of linked documents in Appendix 2).

respective province. A national project steering committee chaired by the MOHNIM secretary will provide strategic guidance, review performance, and take timely strategic measures to achieve the project outputs through the PMU. The implementation arrangements are summarized in Table 3 and described in detail in the PAM (footnote 22). Procurement (including consulting services) to be financed by ADB will follow the *ADB Procurement Policy* (2017, as amended from time to time) and the *Procurement Regulations for ADB Borrowers* (2017, as amended from time to time).

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	1 December 2018–30 November 2023		
Estimated completion date	30 November 2023		
Estimated loan closing date	31 May 2024		
Management			
(i) Oversight body	National project steering committee chaired by the MOHNIM secretary		
(ii) Executing agency	MOHNIM		
(iii) Key implementing agencies	Provincial councils of Central, North Central, Sabaragamuwa, and Uva provinces		
(iii) Implementation units	PMU under MOHNIM and PIUs under the four provincial councils		
Procurement	OCB (civil works)	19 contracts	$16.95 million
	RFQ (civil works)	2 contracts	$4.77 million
	OCB (medical equipment, computers, furniture, vehicles)	14 contracts	$12.28 million
	RFQ (office equipment, medical equipment, computers, furniture)	9 contracts	$0.59 million
Consulting services	OCB (QCBS/CQS)	5 contracts	$3.07 million
	ICS (14 persons)	349 person-months	$0.42 million
Retroactive financing and advance contracting	MOHNIM has requested advance contracting to (i) recruit PMU and PIU staff; (ii) recruit a procurement expert; (iii) procure equipment; and (iv) procure vehicles, office equipment, and furniture. Retroactive financing of not more than 20% of loan and grant amounts is requested to establish the PMU and PIUs, including staff, and mobilize the procurement expert.		
Disbursement	The loan and grant proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.		

ADB = Asian Development Bank, CQS = consultants qualifications selection, ICS = individual consultants selection, MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine, OCB = open competitive bidding, PIU = project implementation unit, PMU = project management unit, QCBS = quality- and cost-based selection, RFQ = request for quotations.
Source: ADB.

III. DUE DILIGENCE

A. Economic and Financial

25. **Economic analysis.** Overall, the project is economically viable with an estimated internal rate of return of 14% and a net present value of $42.9 million. The economic benefits include (i) the direct benefit for project beneficiaries in health care cost savings, and (ii) productivity gains in terms of disability-adjusted life years averted. The main economic costs include (i) investment costs, such as construction and upgrading of health facilities and purchase of equipment; (ii) indirect project-related costs, such as maintaining and replacing capital investments; and (iii) operational costs, such as wages and utilities required to run health facilities. Additionally, economic benefits of health interventions accrue overtime; improved population health can lead to increased productivity and GDP growth in the long run.

26. **Financial sustainability.** Financial sustainability of the project depends on the ability of MOHNIM to allocate sufficient budget overtime and efficiency gains in the health sector. While the government is undergoing macroeconomic reforms because of its sizeable public debt, it is expected to continue its commitment to the health sector as indicated under Vision 2025 (footnote 15) and to prioritize the health sector through adequate budget support. The project annual commitment over 5 years is only 0.8% of the total health sector budget (MOHNIM and provinces) for 2018 and to extend the project 1 year beyond the project period would require only 0.3% of total health sector budget for 2018. As provided in the draft loan agreement, the government will ensure adequate funds towards operations and maintenance of project facilities will be provided to MOHNIM during and after project implementation. MOHNIM's budget has also been increasing in absolute terms since 2014 and is expected to continue its upward trend; the health budget increased by 26.5% from 2014 to 2015 and by 34.2% from 2015 to 2016. MOHNIM's recurrent budget (69.6%) is also higher than the capital budget (30.4%) in 2016, indicating government financial commitment to maintain capital investments. Efficiency gains are expected across the sector because of PHC reform initiatives, which will shift management of expensive NCDs from secondary to primary levels and encourage long-term cost containment. This will increase the fiscal space for health in the long run and encourage more efficient and optimal use of existing resources in the health sector.

B. Governance

27. **Financial management.** A financial management assessment conducted for the executing agency and implementing agencies concluded that the overall pre-mitigation financial management risk is *substantial*. The key risks identified are (i) delay in release of fund from different fund sources, (ii) MOHNIM not familiar with ADB procedures, and (iii) limited resource in internal audit. To mitigate these risks: (i) cost-sharing arrangements will be avoided, (ii) capacity building support will be provided to PMU and PIU accounting staff, and (iii) internal auditor will be recruited. The borrower, executing agency, and implementing agencies have agreed to implement the risk mitigating measures identified in the financial management action plan of the PAM so that the overall financial management risk of the project will become moderate (footnote 22).

28. **Procurement.** Procurement capacity and management risks at the central and provincial levels are assessed as moderate. The common finding was that while the executing and implementing agencies are well-versed with the national procurement guidelines and have experience in implementing development partner-funded projects, they have limited experience with ADB procurement practices. To mitigate this risk, the project will implement systematic procurement training to augment staff capacity in procurement and compliance monitoring. The project will also improve procurement transparency by setting up a project-specific webpage on the MOHNIM website wherein contract information as well as information relating to procurement processes will be uploaded.

29. **Anticorruption.** ADB's *Anticorruption Policy* (1998, as amended to date) was explained to and discussed with the government and MOHNIM. The specific policy requirements and supplementary measures are described in the PAM (footnote 22).

C. Poverty, Social, and Gender

30. Poverty in Sri Lanka is more relative than absolute; 4.1% of the country's population are deemed to be below the national poverty line while the selected four provinces show higher poverty rates: Central (5.4%), Sabaragamuwa (6.7%), and Uva (6.5%)—with North Central

(3.3%) being an exception.[25] Despite following a path of inclusive development, regional disparities remain, and are particularly evident in access, utilization, and service provision related to PHC. The country's changing epidemiological profile has presented a unique challenge to the existing system of non-fee-based universal health care. Capitalizing on the country's extensive PHC network, the project will support poverty reduction and strengthen human capital through improvements in both curative and preventive health care.

31. The project has been classified *effective gender mainstreaming* because the project outputs are designed to advance both women's and men's access to health services and infrastructure, which in turn will help promote gender equality. Some interventions include gender-responsive construction features (separate toilets, private examination and changing rooms); gender-responsive and inclusive essential service package; sex-disaggregated data in health information systems; and training for medical officers and PHC staff on gender sensitivity, gender-related policies, and interventions.

D. Safeguards

32. In compliance with ADB's *Safeguard Policy Statement* (2009), the project's safeguard categories are as follows. [26]

33. **Environment (category B).** The project will support minor renovations and expansion of PHC facilities as well as small repairs to field health centers. It is not expected to have any significant or irreversible adverse environmental impacts during either construction or operation. Any environmental risks can be effectively mitigated through the adoption of appropriate mitigation measures specified in the environmental assessment and review framework. An initial environmental examination and an environment assessment and review framework have been prepared covering 45 primary medical care units and both documents were disclosed on the ADB website on 31 July 2018. The executing agency has adequate institutional capacity to carry out environmental safeguards and compliance measures, along with capacity development activities to manage related risks.

34. **Involuntary resettlement (category C).** Civil works are limited to reconstruction and refurbishment of existing government health facilities, which does not necessitate land acquisition and resettlement. No temporary involuntary resettlement impacts are anticipated.

35. **Indigenous peoples (category C).** Physical parameters of the project are confined to existing health care facilities and do not include habitats and territories with indigenous peoples. Project activities will not affect traditional and sociocultural beliefs of indigenous peoples.

E. Summary of Risk Assessment and Risk Management Plan

36. Significant risks and mitigating measures are summarized in Table 4 and described in detail in the risk assessment and risk mitigation plan.[27]

[25] Government of Sri Lanka, Department of Census and Statistics. 2017. *Poverty Indicators, Household Income and Expenditure Survey 2016*. Colombo.
[26] ADB. Safeguard Categories. https://www.adb.org/site/safeguards/safeguard-categories
[27] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

Table 4: Summary of Risks and Mitigation Measures

Project risks	Mitigation Measures
MOHNIM and selected implementing agencies unfamiliar with ADB procedures.	PMU and PIU staff will be trained on ADB's disbursement procedures and procurement guidelines, regulations, and policy by attending training organized by ADB.
Delay in fund flow to the provinces and payments to the contractors may impede timely project implementation.	The government will ensure that sufficient counterpart funds are allocated to the project and will ensure timely release and transfer of funds to be completed within 2 weeks of receipt of request.
Changes in health-seeking behavior that lead to increased health utilization take time to effect beyond the project implementation period.	A behavior change communication campaign targeting increased primary health care utilization will be implemented early in the project.
Delay in approval and implementation of national policy and management reforms.	The project will provide technical support to MOHNIM to (i) develop the relevant circulars, guidelines, and standard operating procedures; (ii) conduct orientation sessions among key officials; and (iii) support implementation of policy reforms.

ADB = Asian Development Bank; MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine; PIU = project implementation unit; PMU = project management unit.
Source: ADB.

IV. ASSURANCES

37. The government and MOHNIM have assured ADB that implementation of the project shall conform to all applicable ADB policies, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and loan documents. The government and MOHNIM have agreed with ADB on certain covenants for the project, which are set forth in the draft loan and grant agreement.

V. RECOMMENDATION

38. I am satisfied that the proposed loan and grant would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the loan of $37,500,000 to the Democratic Socialist Republic of Sri Lanka for the Health System Enhancement Project, from ADB's ordinary capital resources, in concessional terms, with an interest charge at the rate of 2% per year during the grace period and thereafter; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board; and

(ii) the grant not exceeding $12,500,000 to the Democratic Socialist Republic of Sri Lanka from ADB's Special Funds resources (Asian Development Fund) for the Health System Enhancement Project, on terms and conditions that are substantially in accordance with those set forth in the draft grant agreement presented to the Board.

Takehiko Nakao
President

1 October 2018

DESIGN AND MONITORING FRAMEWORK

Impact the Project is aligned with A healthier nation is ensured with a more comprehensive PHC system (National Health Policy, 2016–2025)[a]			
Results chain	**Performance Indicators with Targets and Baselines**	**Data and Reporting**	**Risks**
Outcome Efficiency, equity, and responsiveness of the PHC system improved	**By 2024 for all indicators:** a. Outpatient utilization (for each female and male) at PHC facilities (PMCUs and district hospitals) (disaggregated by age, sex, place of residence, district, and province) increased by at least 20% (2015 baseline: 62% for both sexes [sex-disaggregated data to be collected in baseline survey])	a. Annual health bulletins published by MOHNIM (data for the target provinces and districts) and baseline and endline surveys (disaggregated data)	Changes in health-seeking behavior that lead to increased health utilization take time to effect beyond the project implementation period
	b. Patients reporting knowledge of and satisfaction with PHC services (disaggregated by age, sex, district) increased to at least 20% (disaggregated by age, sex, district) (2018 baseline: NA)	b. Baseline and endline surveys	
	c. Notifiable diseases[b] notified to the medical officers of health offices, within the stipulated time, in the target provinces increased to at least 90% (2018 baseline: NA)	c. Routine data from a 25% sample of medical officers of health in provinces	
	d. Cluster system reform implemented and evaluated in all nine clusters[c] (2018 baseline: NA)	d. Evaluation report at end of project	
Outputs 1. PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces	1a. By 2023, PMCUs and district hospitals in target provinces upgraded and renovated with gender-responsive designs[d] reached at least 30% (2018 baseline: 0)	1a. PMU, PIU, and planning unit data	
	1b. By 2023, gender-responsive and inclusive essential service package for outpatient and clinic services provided by at least 75% of PHC facilities in target provinces (2018 baseline: 0)	1b. PMCU and district hospital data records and routine provincial administrative data	
	1c. By 2023, gender-responsive and inclusive nutrition services provided by at least 75% of medical officer of health's facilities (2018 baseline: 0)	1c. Medical officer of health's data records and routine provincial data	
	1d. By 1 July 2020, a gender-sensitive behavior change	1d. Health Promotion Bureau, PMU, and	

Results chain	Performance Indicators with Targets and Baselines	Data and Reporting	Risks
	communication plan is initiated by all target provinces (2018 baseline: NA)	provinces to monitor agreed interventions; baseline and endline surveys	
2. Health information system and disease surveillance capacity strengthened	2a. By 2023, electronic patient information sharing system across cluster facilities used by at least 25% of PMCUs and district hospitals and medical officers of health areas in all target provinces (2018 baseline: 0) 2b. By 2023, notifiable disease surveillance information via an electronic system sent to medical officers of health areas by at least 25% of PMCUs and district hospitals in target provinces (2018 baseline: 0) 2c. Core capacities to carry out quarantine services with a score of at least 4 in joint external evaluation report 2021 increased in the eight ports of entry in Sri Lanka (2017 baseline score in joint external evaluation report 2017: 3)	2a–b. Provincial administrative data Data to be reported by the PMCUs and district hospitals using the new data format developed for target provinces and districts 2c. MOHNIM quarantine unit administrative data; joint external evaluation report 2021	
3. Policy development, capacity building, and project management supported	3a. By 2023, operational policies and guidelines with gender dimensions are developed for (i) delivering a comprehensive package of PHC (incorporating the essential service package); (ii) management and functioning of cluster hospitals; and (iii) GIS-based planning and monitoring in health sector (2018 baseline: NA) 3b. By 2020, 11 units of FHB have integrated gender dimensions into all of their policies and strategic plans (2018 baseline: 0) 3c. By 2023, at least 25% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in target provinces are trained in PHC (family medicine) (2018 baseline: 0) 3d. By 2023, at least 25% of PHC staff from PMCUs, divisional	3a–b. MOHNIM Planning Unit and FHB administrative data 3c. MOHNIM Education, Training and Research Unit administrative data 3d. Provincial level administrative data	Delay in approval and implementation of national policy and management reforms

Results chain	Performance Indicators with Targets and Baselines	Data and Reporting	Risks
	hospitals, and medical officer of health areas (of whom 35% are women) in the target provinces are trained in gender sensitivity, and gender related policies and interventions (2018 baseline: 0)		

Key activities with milestones

1. **PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces**

1.1 Develop physical infrastructure in selected PMCUs and district hospitals (first round completed by Q4 2021)
1.2 Complete physical infrastructure designs for all facilities (Q4 2019)
1.3 Provide medical equipment to PMCUs and district hospitals and apex hospitals (first round completed by Q4 2019)
1.4 Develop physical infrastructure in selected field health centers (Q4 2021)
1.5 Provide (replace) vehicles for PHC services (completed by Q2 2019)
1.6 Finalize the communications strategy and terms of reference for the behavior change communication marketing firm (Q2 2019)
1.7 Award at least one innovative project by cluster via the PHC innovation fund (Q4 2019)

2. **Health information system and disease surveillance capacity strengthened**

2.1 Finalize the rollout plan to introduce the health information system to nine cluster hospitals (Q1 2020)
2.2 Establish GIS units in provinces and districts (Q4 2019)
2.3 Purchase computers and peripherals for clusters (Q2 2020)
2.4 Provide the equipment and vehicles for POEs (Q2 2019)
2.5 Complete first round of training for quarantine teams (Q4 2019)
2.6 Engage an individual consultant to carry out an IHR-related legal review (Q2 2019)

3. **Policy development, capacity building, and project management supported**

3.1 Hire consultant (local) to support policy development for essential service package implementation (Q1 2019)
3.2 Hire consultant (local) to support policy development for cluster hospital reforms (Q1 2019)
3.3 Hire consultants (local) to review and monitor environmental and social safeguards (Q1 2019)
3.4 Develop the physical infrastructure and equip a distance learning center at the National Institute of Health Sciences in Kalutara (Q3 2020)
3.5 Complete regular training annually in relevant PHC areas (Q4 each year)
3.6 Conduct baseline (Q1 2019) and endline (Q1 2023) surveys

Inputs

ADB: $12.5 million (Asian Development Fund grant), $37.5 million (concessional ordinary capital resources lending)
Government: $10 million

ADB = Asian Development Bank; FHB = family health bureau; GIS = geographic information system; IHR = International Health Regulations; MOHNIM = Ministry of Health, Nutrition, and Indigenous Medicine; NA = not available; PHC = primary health care; PIU = project implementation unit; PMCU = primary medical care unit; PMU = project management unit; POE = port of entry.

[a] Government of Sri Lanka, MOHNIM. *Sri Lanka National Health Policy 2016–2025.* Colombo.
[b] Government of Sri Lanka, Ministry of Health, Epidemiology Unit. 2005. *Surveillance Case Definitions for Notifiable Diseases in Sri Lanka.* Colombo.
[c] In each of the nine project districts, a cluster of PHC level facilities will be functionally linked to one apex secondary care level facility wherein provincial and regional health staff propose and implement strategies to strengthen PHC management for continuity of care.
[d] Separate toilets for male and female patients; separate examination and changing areas for improved privacy.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=51107-002-3

1. Loan Agreement
2. Grant Agreement
3. Sector Assessment (Summary): Health
4. Project Administration Manual
5. Contribution to the ADB Results Framework
6. Development Coordination
7. Financial Analysis
8. Economic Analysis
9. Country Economic Indicators
10. Summary Poverty Reduction and Social Strategy
11. Risk Assessment and Risk Management Plan
12. Climate Change Assessment
13. Gender Action Plan
14. Initial Environmental Examination
15. Environmental Assessment and Review Framework

Supplementary Documents

16. Financial Management Assessment
17. Procurement Capacity Assessment