INITIAL POVERTY AND SOCIAL ANALYSIS

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

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

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

The proposed assistance is aligned with government's post-war Development Policy Framework which aims to improve social indicators, eradicate hard-core poverty, and strive for a socially inclusive economic growth.[a] It also supports implementation of the government Public Investment Program (2017–2020), which included strengthening primary health care for more efficient utilization of resources in the public health system, addressing regional disparities and health needs of estate communities, and reducing communicable diseases as among government key strategies and policy directions.[b] It is also included in Asian Development Bank (ADB)'s Sri Lanka country operations business plan, 2017–2019 and reinforces ADB's increasing investments in health systems and health security, acknowledged as critical for inclusive growth in the Midterm Review of Strategy 2020.[c]

B. Poverty Targeting

☐ General Intervention ☐ Individual or Household (TI-H) ☐ Geographic (TI-G) ☒ Non-Income MDGs (TI-M1, M2, etc.)

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries. Sri Lanka's health indicators are generally well-performing, and the sector is known for achieving good health at relatively low cost. Despite its achievements, Sri Lanka's health system today is facing challenges to sustain its performance, due to rapidly changing demographics and epidemiological transitions. In particular, the cost of health care has been increasing due to the sharp rise in noncommunicable diseases linked to lifestyles and rapidly aging population. The national health system also needs to further improve to expand services to vulnerable populations with lagging health indicators. In addition, there is increased threat of emerging and resurging infectious diseases linked to environmental factors and increased cross-border migration. The status quo of the health system is inadequately prepared to deal with these evolving challenges without significant reorientation and further improvements. Investments towards overall health system strengthening and health security measures will directly or indirectly benefit the entire Sri Lankan population (officially about 20 million). For primary health care (PHC) strengthening, most of the estate population living in plantations (895,815 total in Sri Lanka) will directly benefit from expanded health services. The project will have a geographic focus on indicatively four provinces (Uva, Sabaragamuwa, Central, and North Central), which comprise nine districts, with a total population of about 7,003,338. These areas have high presence of vulnerable communities, especially estate communities and farming communities affected by chronic disease of unknown etiology who are underserved in health services (781,208 from estate communities [about 87% of total estate populations] are covered in Central, Uva, and Sabaragamuwa provinces; 96% of population in North Central province is rural).

2. Impact channels and expected systemic changes. The proposed assistance will further enhance the health system through support for strengthened PHC, especially in lagging areas, and improved health and disease surveillance capacity for improved compliance with the International Health Regulations. It will enhance the Sri Lanka health system to adapt to emerging challenges and deal with shifting disease burdens. It also supports the achievement of Sustainable Development Goal 3: *Ensure healthy lives and promote well-being for all at all ages.*

3. Focus of (and resources allocated in) the PPTA or due diligence. Project preparatory technical assistance (PPTA) of $500,000 is proposed for due diligence, which will include: (i) review of disease surveillance system and enhancement requirements at MOH and facility levels; (ii) review of key health security gaps and measures to strengthen them; (iii) review of primary health human resources requirements; (iv) review of primary health service delivery gaps and referral linkages; and (v) review of information, education, communication requirements.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector/subsector that are likely to be relevant to this project or program?

Despite Sri Lanka's high achievements in reducing maternal mortality ratio (34.2 per 100,000 population in 2013), the health system requires further improvements to address regional disparities within the country. For example, the maternal mortality ratio per 100,000 live births is comparably high in Monaragala district of Uva province (66.5) and Ratnapura district of Sabaragumuwa province (50.2), compared to 27.7 in Colombo.[d] Male children may also be more slightly favored in health care-seeking behaviors. For example, care seeking for pneumonia among male children is 60%, compared to 56% for girls and diarrheal treatment (children receiving oral rehydration therapy and continued feeding) is 69 % for boys compared to 64% for girls.[e] As part of PHC strengthening, the project will support the national health system to further improve to expand services to vulnerable populations that are lagging in health indicators, especially in the estates. For example, according to the Demographic Health Survey, 2006–2007, the infant mortality rate per 1,000 live births in estates is reported as 29, compared to 9.7 at the national level. The proportion of stunting among children under 5 years in estates is also 40% compared to 18% nationally. The number of economically active females is also higher in estates (44.3%) than in other sectors (national economically active population consist of mainly males [69.9%] while 30.1% are females).[f] As such, the project will also review occupational health issues, and related long hours and tedious work affecting these estate women as part of improving health services.

2. Does the proposed project or program have the potential to make a contribution to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision making?
☒ Yes ☐ No

3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality?
☐ Yes ☒ No

4. Indicate the intended gender mainstreaming category:
☐ GEN (gender equity) ☒ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the project, including beneficiaries and negatively affected people? Identify how they will participate in the project design.

Primary stakeholders are Ministry of Health, Nutrition, and Indigenous Medicine; provincial health departments of Uva, Sabaragamuwa, Central, and North Central provinces; Ministry of Provincial Councils and Local Government and estate management of regional plantation companies, health workers, and project beneficiaries. During PPTA, stakeholder consultations will be held and their views and recommendations will be incorporated when and where possible. The team will organize consultations and workshops with communities, nongovernment organizations, and other relevant stakeholders when and as needed.

2. How can the project contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable and excluded groups? What issues in the project design require participation of the poor and excluded?

Access to health services that meet the local communities' needs and disease burdens need to be ensured. Mass education, and community engagement need to be ensured for preventive health and to deal with public health threats. Health workers need to be properly incentivized to serve remote underserved areas, and trained and sensitized on the needs and perspectives of poor and vulnerable groups, and in conducting health education and behavior change to empower and raise health awareness. During project preparation and implementation, participatory processes and community consultations will be incorporated. Consultation and participation will also be managed through behavior change, communication, and marketing activities involving communities and other stakeholders.

3. What are the key, active, and relevant civil society organizations in the project area? What is the level of civil society organization participation in the project design? ☐ Information generation and sharing
☐ Consultation ☐ Collaboration ☒ Partnership

The project plans to partner with established community structures for community mobilization and information, education, and communication to influence positive health and nutrition behaviors.

4. Are there issues during project design for which participation of the poor and excluded is important? What are they and how shall they be addressed? ☒ Yes ☐ No

PPTA due diligence will be conducted, and pro-poor and demand-side approaches will be examined.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No

There will be no new constructions, and no land acquisition. Infrastructure support will be limited to some renovation and "face-lifting" of existing primary health facilities. No involuntary resettlement impact is expected.

2. What action plan is required to address involuntary resettlement as part of the PPTA or due diligence process?

☐ Resettlement plan ☐ Resettlement framework ☐ Social impact matrix
☐ Environmental and social management system arrangement ☒ None

B. Indigenous Peoples Category ☐ A ☐ B ☒ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No

In the project area, there are no indigenous people who fall within the purview of ADB Safeguard Policy Statement.

2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No

4. What action plan is required to address risks to indigenous peoples as part of the PPTA or due diligence process?

☐ Indigenous peoples plan ☐ Indigenous peoples planning framework ☐ Social Impact matrix
☐ Environmental and social management system arrangement ☒ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?

☐ Creating decent jobs and employment ☐ Adhering to core labor standards ☐ Labor retrenchment
☒ Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking ☐ Affordability
☒ Increase in unplanned migration ☒ Increase in vulnerability to natural disasters ☐ Creating political instability
☐ Creating internal social conflicts ☐ Others, please specify _____

2. How are these additional social issues and risks going to be addressed in the project design?

The project will help mitigate spread of communicable diseases and vulnerability of natural hazards through health security interventions.

VI. PPTA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the PPTA (or other due diligence) contain key information needed to be gathered during PPTA or due diligence process to better analyze (i) poverty and social impact; (ii) gender impact, (iii) participation dimensions; (iv) social safeguards; and (v) other social risks. Are the relevant specialists identified?

☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social and/or gender analysis, and participation plan during the PPTA or due diligence?

A PPTA of $500,000 from ADB's Technical Assistance Special Funds for preparing the project is proposed.

[a] Government of Sri Lanka, Department of National Planning, Ministry of Finance and Planning. 2010. *Sri Lanka, The Emerging Wonder of Asia: Mahinda Chintana—Vision for the Future.* Colombo.

[b] Government of Sri Lanka, Ministry of National Policies and Economic Affairs. 2017. *Public Investment Program (2017–2020).* Colombo.

[c] It is mentioned that ADB will explore support for the health sector under the new country program strategy to be approved in 2017. ADB. 2016. *Country Operations Business Plan: Sri Lanka, 2017–2019.* Manila.

[d] Government of Sri Lanka, Ministry of Health, Nutrition, and Indigenous Medicine. 2014.*Annual Health Bulletin 2014*. Colombo.

[e] Government of Sri Lanka, Department of Census and Statistics. 2009. *Sri Lanka Demographic Health Survey, 2006–2007*. Colombo.

[f] Government of Sri Lanka, Department of Census and Statistics. 2012. *Census of Population and Housing Sri Lanka, 2012*. Colombo.

Source: Asian Development Bank.