Project Administration Manual

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Democratic Socialist Republic of Sri Lanka: Health System Enhancement Project—Additional Financing

ABBREVIATIONS

ADB	-	Asian Development Bank
AGD	-	Auditor General's Department
APFS	-	audited project financial statements
ATR	-	action taken report
BCCM	-	behavior change communication and community mobilization
CBSL	-	Central Bank of Sri Lanka
CIGAS	-	computerized integrated government accounting system
COVID-19	-	coronavirus disease 2019
DMF	-	design and monitoring framework
EARF	-	environment assessment and review framework
EGM	-	effective gender mainstreaming
EMP	-	environment management plan
EMR	-	electronic medical record
ERD	-	Department of External Resources
ERTU	-	education, training, and research unit
ESP	-	essential service package
FHB	-	Family Health Bureau
FHC	-	field health center
FMA	-	financial management assessment
GAP	-	gender action plan
GBV	-	gender-based violence
GOSL	-	Government of Sri Lanka
HCWM	-	healthcare waste management
HIT	-	health information technology
HPB	-	Health Promotion Bureau
HRH	-	human resources for health
IEC	-	information, education, and communication
IHR	-	International Health Regulations
MIS	-	management information system
MOF	-	Ministry of Finance
MOH	-	Ministry of Health
MOMCH	-	medical officer maternal and child health
NCD	-	non-communicable diseases
OCB	-	open competitive bidding
PBS	-	patient-based system
PCC	-	project coordination committee
PCR	-	project completion report
PDHS	-	provincial director health services
PFM	-	public financial management
PHC	-	primary health care
PHI	-	public health inspector
PHM	-	public health midwife
PHN	-	patient healthcare number
PIU	-	project implementation unit
PMCU	-	primary medical care unit
PMU	-	project management unit
POE	-	point of entry

PPER	-	project performance evaluation report
PPTA	-	project preparatory technical assistance
PSC	-	project steering committee
QCBS	-	quality- and cost-based selection
RDHS	-	regional director of health services
SOE	-	statement of expenditure
TOT	-	training of trainers

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Project Administration Manual Purpose and Process

The project administration manual (PAM) describes the essential administrative and management requirements to implement the additional financing of the project on time, within budget, and in accordance with the policies and procedures of the Government of Sri Lanka and the Asian Development Bank (ADB). The PAM should include references to all available templates and instructions either through linkages to relevant URLs or directly incorporated in the PAM.

The Ministry of Health (MOH) is the executing agency and four provincial councils of Central, North Central, Sabaragamuwa, and Uva provinces as implementing agencies for the output 1 activities are wholly responsible for the implementation of ADB-financed projects, as agreed jointly between the borrower and ADB, and in accordance with the policies and procedures of the Government and ADB. The provincial departments of health of all 9 provinces across the country will support MOH to coordinate the implementation of relevant activities under output 2 and 3 of the project. ADB staff is responsible for supporting implementation including compliance by MOH and Provincial Councils of the four provinces (Central, North Central, Sabaragamuwa, and Uva provinces) of their obligations and responsibilities under output 1 of the project implementation in accordance with ADB's policies and procedures.

At loan negotiations, the borrower and ADB shall agree to the PAM and ensure consistency with the loan agreement. Such agreement shall be reflected in the minutes of the loan negotiations. In the event of any discrepancy or contradiction between the PAM and the loan agreement, the provisions of the loan agreement shall prevail.

After ADB Board approval of the project's report and recommendations of the President (RRP), changes in implementation arrangements are subject to agreement and approval pursuant to relevant government and ADB administrative procedures (including the Project Administration Instructions) and upon such approval, they will be subsequently incorporated in the PAM.

I. PROJECT DESCRIPTION

1. The **Health System Enhancement Project (the original project),** for $60 million (comprising $37.5 million in concessionary loan and $12.5 million grant, and $10 million equivalent from the Government of Sri Lanka in counterpart funds), was approved in October 2018, effective since February 2019 and is due to close on 30 November 2023. The original project aims to improve efficiency, equity, and responsiveness of the primary health care (PHC) system based on the concept of providing universal access and continuum of care to provide high quality package of essential health services. The original project pursues an equity perspective by targeting underserved populations access to PHC. It expects to further inform and operationalize government PHC reform initiatives by making accessible more comprehensive package of services, developing a referral system by establishing shared care clusters by linking PHC hospitals as feeder hospitals to an apex secondary care hospital, by mapping the population served by the clusters to the nearest cluster hospital, by improving the quality of care, including continuity of care, via an interoperable information technology (IT) system and functionally integrating preventive and curative services for disease prevention, surveillance and notification. Furthermore, the project will strengthen e-learning facilities to improve capacity of the human resources in health sector and supports to address selected gaps in core public health surveillance areas in line with the international health regulations (IHR). The original project is well performing at the end of 2.5 years, as of 15 June 2021, and is on track to meeting its objective.

2. **Reallocation.** Due to the coronavirus disease (COVID-19) pandemic affecting Sri Lanka in March 2020, $15 million was reallocated from the original project ($10 million from the concessionary loan and $5 million from the grant) via memos dated 25 March and 10 April 2020 to meet the urgent financing requirements on curtailing the COVID-19 pandemic. The government made this reallocation request from the original project as COVID-19 related interventions are coming under the scope of the project which included interventions to improve communicable disease surveillance and strengthen IHR (output 2). The reallocated resources were requested for meeting the emergency activities related to scaling up of molecular biology laboratory capacity, increasing the accessibility to emergency medical equipment at hospitals, expanding high dependency and intensive care units, expanding oxygen accessibility, and increasing the availability of consumables like surgical masks, personal protection equipment and reagents and other consumables for polymerase chain reaction (PCR) testing and screening of COVID-19.

3. **Additional financing.** The additional financing is the most appropriate and efficient modality to finance the scale up of the outputs of a well performing ongoing project, addressing the government's urgent financing requirements to support and manage the third wave of COVID-19 pandemic, and the replenishment of reallocated funds approved in 2020 to complete the originally planned activities mainly related to PHC development.

4. The additional financing is classified as low risk given that: (i) the loan amount is not exceeding $200 million; (ii) the Asian Development Bank (ADB)'s experience in the health sector in the country has a positive record of; (iii) considerable executing agency capacity in terms of externally financed project administration exists; (iv) there are no known integrity concerns in the project; and (v) the proposed safeguards categorizations continue as B for environment, C for involuntary resettlement, and C for indigenous peoples.

5. The total additional financing to the original project will be for $123 million which includes $110 million from ADB country allocation, $3 million grant resources via the ADB-managed Japan

Fund for Poverty Reduction (JFPR);[1] and $10 million as Government of Sri Lanka counterpart funds.

6. The objectives of the additional financing are to:

(i) meet the funding shortfall due to above reallocation to implement the original scope of the original project;
(ii) meet further increasing demands due to the ongoing third wave of COVID-19 pandemic management;
(iii) support developing of at least one secondary care facility (including for COVID-19 case management) in each of the original nine project districts that will be developed as the cluster apex hospitals;
(iv) expand the facilities available for distance and e-learning, given the rising COVID-19 situation in the country;
(v) extend the project closing date by 24 months, or up to November 2025 to successfully implement and achieve the outcomes of the scaled up project ; and
(vi) access the JFPR for a grant of $3 million to meet the COVID-19 related financing gaps.

7. **Policy alignment.** The additional financing aligns closely with the government's priorities identified in its development strategy, the National Policy Framework Vistas of Prosperity and Splendor 2019[2] and the National Health Policy of 2016-2025.[3] It intends to (i) ensure that existing free health care system will be further developed to reduce waiting times, with special focus at the district level; (ii) expand the services available to patients; (iii) ensure that all hospitals are developed; and (iv) ultimately achieve universal health coverage as aligned with the United Nations Sustainable Development Goal 3. The project is in line with ADB's country partnership strategy (2018–2022)[4] for Sri Lanka supporting the inclusive growth pillar which further strengthens the relationship with the Government of Sri Lanka for a long term programmatic approach consistent with ADB's health operations plan. The additional financing is also consistent with ADB's Strategy 2030 operational priority (OP) 1: addressing remaining poverty and reducing inequalities; OP 2: accelerating progress in gender equality and social inclusion; OP 3: tackling climate change, building climate and disaster resilience, and enhancing environmental sustainability; OP 5: promoting rural development and food security; OP 6: strengthening governance and institutional capacity; and OP 7: regional cooperation and integration.

8. **Impact and outcome:** The aggregate impact of the original and the additionally financed projects continue to be aligned with the original project impact: a healthier nation is ensured with a more comprehensive PHC system. Similarly, the project outcomes continue to ensure that efficiency, equity, and responsiveness of the PHC system is improved. The combined design and monitoring framework for original and additional financing projects is in Annex 1.

9. **Key indicators for monitoring project outcomes.** The project outcomes of the additional financing will continue to be measured via the original project outcome indicators; (i) outpatient utilization at PHC facilities (primary medical care units [PMCU] and divisional hospitals) (disaggregated by age, sex, place of residence, district, and province) increased by at least 20% from the baseline; (ii) patients reporting knowledge of and satisfaction with PHC services

[1] JFPR is a possible funding source subject to the approval of the Government of Japan.
[2] Government of Sri Lanka. 2019. *Vistas of Prosperity and Splendour*. Colombo.
[3] Government of Sri Lanka, MOH. 2016. *Sri Lanka National Health Policy 2016–2025*. Colombo.
[4] ADB. *Sri Lanka: Country Partnership Strategy (2018–2022)*. Manila.

(disaggregated by age, sex, district) increased by at least 20% from the baseline; (iii) notifiable diseases notified by cluster linked hospitals to the medical officers of health offices, within the stipulated time, in the target provinces increased to at least 90%; (iv) cluster system reform implemented and evaluated in all nine clusters; and (v) the average response time of 1990 Suwa Seriya ambulance system in all districts reduced by 25%".

10. **Project beneficiaries.** The beneficiary population of the original project and the additional financing will include the entire population of 21.9 million people while approximately 7 million (which is 33% of the Sri Lanka population) will receive additional benefits via the clusters and PHC development identified using an equity perspective within each of the 4 original project supported provinces.

11. The project outputs of the additional financing are:

(i) Primary and secondary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces;
(ii) Health information system, disease surveillance capacity, and COVID-19 response strengthened; and
(iii) Policy development, capacity building, and project management supported.

12. **Output 1: Primary and secondary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces ($36.29 million).** This output intends to strengthen PHC services in the targeted four provinces of Central, North Central, Sabaragamuwa, and Uva with a special focus on the socially, economically, and geographically disadvantaged populations. The PHC services are defined as primary health care services that are provided via primary medical care units (and the divisional hospitals (curative facilities), and via the preventive health network led by the medical officers of health. It also supports the development of nine secondary care hospitals, which are identified as apex hospitals in each of the shared care clusters.

13. The additional financing under output 1, supports two sets of activities. The first set are planned activities in the four provinces of Central, North Central, Sabaragamuwa, and Uva under output 1 of the original project which were intended to be implemented from 2021 but were placed on hold because of the COVID-19 pandemic. The second set of activities are additional activities newly included under the additional financing.

14. There are four activities under the first set of activities (planned activities from the original project) under output 1:

15. **(i) Developing 42 PHC facilities ($6.12 million).** The original project intended to support the development of 135 curative PHC facilities (this includes PMCUs and DHs). Due to the reallocation of funds for COVID-19, this activity will support the development of 42 of the originally planned 135 PHC facilities (the balance of 90 PHC facilities will be developed under the original project) (the list of PHC hospitals is available in Annex 2). The infrastructure designs will continue to be based on a MOH-approved physical space norm for PHCs.[5]

16. **(ii) Expanding the package of nutrition services ($0.46 million).** The activity to expand the targeted nutrition related services available to the mothers and children in the four provinces with a special focus of more vulnerable populations in the estate and rural areas, which was in the

[5] The MOH published a Physical space norm that should be followed when developing PHC facilities in Sri Lanka. Government of Sri Lanka, MOH. 2018. *General Circular No 1-29/2018 of June 29, 2018*. Colombo.

original project scope and given the reallocation, will be financed via the additional financing.

17. **(iii) Renovating 127 field health centers ($3.69 million).** This activity will support to renovate and refurbish 127 field health centers selected from each of the medical officer of health areas in the nine districts in the four provinces which was in the scope of the original project but was not able to be carried out due to the reallocation.

18. **(iv) Public awareness and behavior change communication for increasing PHC utilization ($0.71 million).** The objective of this activity is to create demand and support a behavior change of health seekers who regularly bypass PHC services. This activity, which was in the original project scope, will be supported via the additional financing. The public awareness and behavior change communication campaign, will be implemented via an agency, will encourage utilization of primary health care utilization and wellness and healthy living promotion in the community. Moreover, the campaign will also promote the nine selected clusters and the related-medical officer of health areas (Annex 3) for (i) wellness and healthy lifestyle; (ii) integrated services such as nutrition, non-communicable diseases (NCDs), and elderly care; and (iii) for convergence with other vertical programs (for increasing case detection and early management of tuberculosis, prevention and control of sexually transmitted diseases including HIV prevention and surveillance for malaria etc.).

19. There are two new activities under the second set of activities (new activities via additional financing) under output 1:

20. **(i) Upgrading nine base hospitals (one in each of the nine districts in the four provinces) ($20.19 million).** The activity will support to develop the already identified nine secondary care hospitals (36%) (9 out of 25)[6] that will function as apex hospitals in each of the nine clusters. The infrastructure development at the apex hospitals will ensure better facilities for COVID-19 care, elderly care and services for mental health, eye care, and non-communicable diseases and risk factor prevention related care, rehabilitation and disability care services, and will provide on call rooms, additional laboratory services to ensure that the demarcated population belonging to a shared care cluster will receive a package of care that is of higher quality (civil works support to cluster apex hospitals and the list of cluster facilities are in Annex 3). This activity will also support a consultancy firm to carry out design and supervision of civil works and an individual consultant to support cluster implementation. This activity will also support to purchase the medical equipment needs which will be identified based on the areas of development in each of the nine apex hospitals.

21. **(ii) Expanding the existing PHC innovation fund to improve continuity of care, quality of care ($1.4 million).** This activity will allocate additional funding to the existing PHC innovation fund which was functional under the original project. These additional PHC innovation funds will be authorized to be used only for cluster linked hospitals or the cluster linked medical officer of health unit development (for repairs, refurbishment, and minor civil works), improving cluster services and for supporting cluster operational expenses (the updated PHC innovation fund utilization guidelines for the additional financing is in Annex 4).

22. **Output 2: Health information system, disease surveillance capacity and COVID-19 response strengthened ($70.24 million).** Like output 1, there are two sets of activities under this

[6] There are 25 secondary care level hospitals in the four provinces while the country has 90 secondary level hospitals. In addition, there are 23 tertiary level hospitals across the country with five of them located in the four provinces that ORIGINAL PROJECT is supporting. Government of Sri Lanka, MOH. Hospitals.

output. The first set includes the planned activities under the output 2 of the original project which were kept on hold due to the reallocation and will be replenished and expanded under the additional financing. The second set of activities are activities that are newly included under the additional financing for addressing the ongoing COVID-19 pandemic.

23. There are two activities under the first set of activities (planned activities under the original project) under output 2:

24. **(i) Adopt health information technology for better continuity of care and disease surveillance ($1.77 million).** This activity under the original project intends to strengthen health and disease surveillance to provide real time sharing of health information vertically and horizontally across facility levels and across different episodes of care for an individual patient in the nine shared care clusters (Annex 4). This system will help enhance the referral system, patient quality of care, and disease surveillance capacity and will establish a mechanism for continuity of care for health seekers. This sub-output will further support disease surveillance with the establishment of geographic information system (GIS) enabled services in the four provincial directors' health offices and in the respective nine regional directors of health offices linked to the medical officer of health. The additional financing will support to procure the computers and peripherals while the system development is supported via the original project and will hire the services of a GIS specialist. The adoption of HIT in shared care clusters, including the procurement of computers and peripherals, will be implemented in a phased approach. The first phase will roll out the HIT in two selected shared care clusters and the second phase will be implemented in the remaining seven shared care clusters conditional to successful integration and implementation of the first phase following the clearance of initiating the second phase made by the project steering committee in consultation with ADB. The decision on whether second phase will be initiated or not should be made before the midterm review of the project.

25. **(ii) Implement IHR recommendations ($0.6 million).** This activity under the original project intends to support the equipment gaps to meet the core capacity levels at all eight ports of entry (POEs) in Sri Lanka. Via the additional financing under this output 2(ii), three more vehicles (two vehicles to the ports of Hambantota and Trincomalee and the Quarantine Unit of the Ministry of Health [MOH]) will be provided to improve the core capacity. In addition, via additional financing, to further strengthen the disease surveillance related tasks carried out by the Quarantine Unit, the ongoing web-based surveillance system for notifiable diseases will be upgraded via additional financing resources by hiring the services of a consultancy firm. Within this activity, the sub-activities carried out since the reallocation of April 2020 are also included (the details of activities carried out using the reallocated $15 million is in Annex 5.)

26. There are three new activities under the second set of activities under output 2:

27. **(i) Support to COVID-19 care ($45.47 million).** This activity will support COVID-19 care which is essential with the rapid increase of cases since April 2021. This includes to support the procurement of emergency medical equipment and supplies for all hospitals (secondary and tertiary care level) to be used across the country to meet the increasing demands for expanding the number of functional beds for Intensive care, high dependency and emergency treatment units, and for inpatient hospital wards. This activity will also support the purchase of oxygen cylinders, establish wall oxygen facilities in hospitals, establish oxygen generators and liquid oxygen tanks in selected secondary and tertiary care hospitals. In addition, the activity will also support the medical officers of health to have better mobility to manage COVID-19 patients who are now managed as "home care" due to the increasing COVID-19 patient load in the hospitals by providing the necessary resources to hire vehicles for each of the 356 medical officers of health, and the

regional and provincial directors' offices to enable easy access to vehicles to carryout supervision and home care visits. The activity will also support transport of COVID-19 patients from home care to hospitals when needed via purchase of 50 ambulances managed by the 1990 Suwa Seriya Ambulance service (20) and Ministry of Health (30). The Ministry will provide basic life support equipment for the ambulances and will provide a set of basic equipment as a home care pack to COVID-19 patients which will include a pulse oximeter (finger type), a small oxygen concentrator, and a thermometer; and the respective medical officers of health in each of the areas will train the caregivers.

28. **(ii) Support to laboratory development ($14.58 million).** This activity will support the MOH in establishing laboratories, and procurement of point of care tests and other equipment and consumables for testing COVID-19 and related diseases. In addition, output 2(iv) supports the Sri Lanka Institute of Biotechnology (SLIBTEC), a government owned institute, to establish advanced PCR and virology testing facilities with the purchase of required laboratory equipment and also support MOH to conduct a feasibility study of increasing the access to testing in rural and hard-to-reach areas through deploying mobile laboratories.

29. **(iii) Support to improve the efficiency of prehospital care system (1990 Suwa Seriya ambulance system) for COVID-19 prehospital care ($2.79 million).** This activity aims to support the government to enhance the efficiency of Sri Lanka's only island-wide accessible, free-of-charge, prehospital ambulance system (1990 Suwa Seriya ambulance system) to efficiently link the exponentially increasing third wave of the COVID-19 patients to the defined hospitals across the country. The activity intends to reduce the (a) average response time of the 1990 Suwa Seriya ambulance service for patients with COVID-19 and other emergencies; (b) turnaround time of the 1990 Suwa Seriya ambulance service by reducing the time taken at the receiving hospitals; and (c) strengthen capacity of the human resources of the prehospital services. This activity will support to expand the ambulance fleet by 8% to improve the service capacity of 1990 Suwa Seriya to provide timely prehospital services in identified underserved areas through the procurement of 25 25 ambulances (Annex 6); provide trainings on infection prevention and control (IPC) to ambulance teams who are involved in transporting patients seeking COVID-19 treatment and other emergency care to maintain safety measures, and provide needed trainings to new emergency medical technicians (approximately 250 personnel) who will be recruited to operate the new fleet of ambulances.

30. This activity will also improve the efficiency of the 1990 Suwa Seriya ambulance system and the receiving end at the secondary and tertiary care hospitals to reduce the time lag from patient arrival to initiation of treatment at the Emergency Treatment Units (ETU) through the support and technical collaboration with Japanese Emergency Medical Services or via consultants with the ambulance and the receiving ETU of the hospital in selected secondary and tertiary care hospitals to provide the best benefit of the 'golden hour' to the COVID-19 and other emergency care patients, and to improve the staff and center facilities by renovating 20 ambulance stations for 1990 Suwa Seriya staff who are located at local police stations (Annex 6).

31. In addition, this activity will also support a refresher training (via a combination of virtual and face to face training in country) to all paramedical staff of the Suwa Seriya team (approximately a 10-day training for 2000 staff), a training of a team of six personnel from each of the receiving hospital ETUs from approximately100 secondary and tertiary care hospitals in the country, improvement of training facilities of the 1990 Suwa Seriya trainers by purchasing required emergency care related training equipment, and a workshop for concerned MOH and 1990 Suwa Seriya officials to learn on the emergency medical service systems in Japan, including but not limited to its operational mechanism, service delivery model, technology innovations and private

sector engagement, and discuss further technical cooperation in other areas such as prehospital elderly care services in the future.

32. **Output 3: Policy development, capacity building, and project management supported ($5.09 million).** Additional financing to output 3 will continue to support the activities: (i) policy development, activity (ii) capacity building, and activity (iii) project management and results monitoring.

33. **(i) Policy development ($0.45 million).** This activity under the original project intends to support policy and strategy development for comprehensive PHC and continuum of care, especially for vulnerable groups living in plantations with priority given to nutrition and reproductive health. The additional financing continues to provide selective support in the form of consulting services and workshops for various policy initiatives of the MOH. These supports will include (i) establishment of clusters to explore strategies for strengthening PHC; (ii) personnel workforce planning with a special focus on PHC workforce; (iii) development of policies and guidelines related to the implementation of the essential service package; and (iv) review and development of the reproductive health and gender related guidelines. Under the additionally financing, the additional required technical consultants for monitoring, procurement, and finance, and providing technical assistance on gender, healthcare waste management (HCWM), environment, social safeguards, communications, and expertise in molecular biology will be engaged to support the government to address the relevant technical areas in the project (details of consultant positions are given in the implementation arrangements section below).

34. **(ii) Capacity building ($2.43 million).** This activity under the original project intends to support the MOH with capacity building and training resources for (i) workshops for nutrition and health promotion, emergency management, cluster planning and management, infection prevention and control, distance learning for GIS; (ii) training for relevant staff in the target provinces to expand knowledge on family health, PHC, gender, infection prevention and control, HCWM, monitoring and evaluation (M&E) methodologies, hospital design and infrastructure, counselling; (iii) support the implementing of the gender action plan and environmental and social safeguards; (iv) support training in procurement and financial management; and (v) hiring the services of a firm or individual consultants for developing course content and other technology-related enhancements. The output 3(ii) under the original project also supports the development of a distance learning center at the National Institute of Health Sciences (NIHS), Kalutara (for 40 trainees) and for about 10–20 trainees at the regional level.

35. This activity under the additional financing, will scale up the development at the NIHS for it to be re-positioned as a state-of-the-art national center of excellence in primary health and preventive health care training with linkages to all nine (one in each province) regional centers. It will support the e-health infrastructure at the nine regional training centers and will support the procurement of training equipment and furniture requirements to carryout pre-service and in-service training of PHC staff. Under this output, a gender responsive module, a hospital design module, and PHC training modules will also be developed.

36. **(iii) Project management and results monitoring ($1.74 million).** This activity under the original project intends to support the operating costs (both fixed and variable) related to central and provincial project management and coordination and operating project management unit (PMU) and the four project implementation units (PIUs). In addition, this activity intends to support the conduct of a baseline and an endline survey including case studies and impact evaluations. It will also support the PMU staff and administrative costs for 24 months, related to extension of the project from November 2023 to November 2025.

II. IMPLEMENTATION PLANS

A. Project Readiness Activities

37. The project readiness activities, responsibilities, and estimated time frames for the additional financing are as follows:

Table 1: Project Readiness Activities for Additional Financing

Indicative Activities*	Month (2021)								Responsibility
	May	June	July	Aug	Sep	Oct	Nov	Dec	
Retroactive financing actions	X	X	X	X	X				MOH
Review stakeholders of and reconvene project steering and implementation committees of the proposed additional financing	X	X							MOH
Prepare RRP and loan agreements		X	X	X					ADB
Loan and grant negotiations				X					GOSL, ADB
Advance contracting actions		X	X	X	X				PMU
ADB Board approval					X				ADB
Loan and grant signing						X			GOSL, ADB
Loan and grant effectiveness						X			ADB, GOSL

ADB = Asian Development Bank; GOSL = Government of Sri Lanka; MOH = Ministry of Health; PMU = project management unit; RRP = report and recommendation of the President.
Note: The PMU and the project implementation units of the ongoing project will continue to manage the additional financing.
Source: Asian Development Bank.

B. Overall Project Implementation Plan

Table 2: Overall Project Implementation Plan

	Activities	Completed Activities	Year 1 2021				Year 2 2022				Year 3 2023				Year 4 2024				Year 5 2025			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Output 1. Primary and secondary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces																					
1.1	Complete civil works for developing physical infrastructure in selected 43 (Round 1 under the original project), 50 (Round 2 under the original project), and 42 (the additional financing) PMCUs and divisional hospitals																					
1.2	Complete physical infrastructure designs for all PMCUs, divisional hospitals, field health centers and nine base hospitals																					
1.3	Complete civil works of the nine base hospitals																					
1.4	Complete the provision of medical equipment to PMCUs, divisional hospitals, and nine base hospitals																					
1.5	Provide (replace) vehicles for PHC services																					
1.6	Finalize the communications strategy and terms of reference for the behavior change communication marketing firm and the nutrition firm																					
1.7	Award at least one innovative project by cluster via the PHC innovation fund																					
1.8	Award at least one innovative project by cluster via the PHC innovation fund financed under the additional financing																					
1.9	Select the construction supervision consultancy firm for nine base hospital construction repairs and renovations																					

	Output 2. Health information system, disease surveillance capacity, and COVID-19 response strengthened
2.1	Finalize the rollout plan to introduce the health information system to nine cluster hospitals
2.2	Establish GIS units in provinces and districts
2.3	Design and layout local area internet connection and purchase computers and peripherals for 2 clusters in the phase 1 and 7 clusters in phase 2
2.4	Provide the equipment and vehicles for POEs under the original project (Round 1) and for 2 additional POEs under the additional financing (Round 2)
2.5	Complete first round of training for quarantine teams
2.6	Conduct second round of training for quarantine teams
2.7	Engage an individual consultant to carry out an IHR-related legal review
2.8	Procurement of essential medical equipment and consumables to combat COVID-19 pandemic under the original project reallocation
2.9	Establishment of PCR lab at Mulleriyawa Base Hospital, Colombo east
2.10	Establishment of molecular biology lab at national infectious disease hospital (IDH), Colombo
2.11	Renovation and refurbishment of isolation facilities at ports of entries at Colombo and Trincomalee
2.12	Hire transportation services for home care, quarantine and intermediate care
2.13	Complete the first round of procurement of emergency medical equipment and furniture under the additional financing
2.14	Complete the second round of procurement of emergency medical equipment and furniture

	under the additional financing																								
2.15	Establish oxygen concentration plant, wall oxygen outlets and liquid oxygen tanks in selected secondary and tertiary hospitals in all nine provinces																								
2.16	Supporting PCR laboratory testing and other equipment																								
2.17	Complete the procurement of ambulances for emergency medical services (50) and prehospital service (25)																								
2.18	Complete the renovation of 20 ambulance stations																								
2.19	Complete the procurement of training equipment for the trainings to prehospital staffs																								
	Output 3. Policy development, capacity building, and project management supported																								
3.1	Hire consultant (local) to support policy development for essential service package implementation																								
3.2	Hire consultant (local) to support policy development for cluster hospital reforms																								
3.3	Hire consultants (local) to review and monitor environmental and social safeguards																								
3.4	Develop the physical infrastructure and equip a distance learning center at the National Institute of Health Sciences in Kalutara and selected DLCs in nine provinces																								
3.5	Complete regular training annually in relevant PHC areas																								
3.6	Conduct baseline and endline surveys																								
3.7	Recruit the consulting firm to develop and support e-learning modules																								
3.8	Hire consultant (local) to support the implementation of gender action plan																								
	Project Management Activities																								

a	Conduct procurement advance actions																									
b	Prepare and submit quarterly and annual progress reports																									
c	Submit annual audited project financial statement																									
d	Submit environmental safeguards monitoring reports (with a section on social safeguards)																									
e	Prepare project completion report																									

COVID-19 = coronavirus disease 2019, DLC = distance learning center, GIS = geographic information system, IDH = infectious disease hospital, IHR = international health regulations, PCR = polymerase chain reaction, PHC = primary health care, PMCU = primary medical care unit, POE = port of entry, Q = quarter.
Source: Asian Development Bank.

III. PROJECT MANAGEMENT ARRANGEMENTS

A. Project Implementation Organizations: Roles and Responsibilities

Table 3: Project Implementation: Roles and Responsibilities

Organizations	Management Roles and Responsibilities
MOH Secretary/National Project Steering Committee	• Provide overall guidance on strategies and measures envisaged under the project • Coordination for effective project execution. • Liaise with other ministries and departments to resolve any project management issues brought to the notice • Undertake periodic review of project performance.
Project Coordination Committees (one per province)	• Preside on all project management, coordination, progress related aspects of the project at the provincial level • Provide guidance to the PIU based on the decisions taken by the committee
MOF	• Recipient of funds from ADB • Release of funds to MOH/PMU/PIU
DPMM	• Overall monitoring of project progress
ADB	• Reviews, approves, and disburses funds • Supervises overall project implementation • Implementation support including training on ADB procedures to project staff • Reviews and issues no-objection to procurement and disbursement documents • Ensures compliance to ADB procurement rules and procedures
PMU	• Overseeing day-to-day project operations including procurement, disbursement, accounting, logistics management, reporting, monitoring and supervision • Liaise among MOH and the other relevant participating agencies • Coordinate and manage with the PIUs for overall project procurement activities including procurement for civil works and equipment • Submission of quarterly project progress report to PSC and ADB • Responsible for preparation of annual budget requirements in consultation with provinces and its submission to National Budget Department for approval. • Provide sufficient funds for the PIUs to implement the project at the provincial level • Prepare annual disbursement schedules • Preparation of annual project financial statements • Ensure conducting of regular audits, presentation of audit reports to PSC, and submission to ADB and the Auditor General • Ensure compliance with national environmental regulations and ADB's requirements provided for in ADB's Safeguard Policy Statement 2009 during project implementation
PIU	• Implement and supervise the project at the provincial level • Regulate the disbursement of the loan funds and other government funds allocated to the project and ensure its effective utilization • Management of the finance, expenditure records for project disbursements, audit • Submission of the project performance reports to PCC and PSC for monitoring and evaluation of project progress • Submission of the Statement of Expenditure and accounting details to PMU

ADB = Asian Development Bank; DPMM = Department of Project Management and Monitoring, MOF = Ministry of Finance; MOH = Ministry of Health; PCC = project coordination committee; PMU = project management unit; PIU = project implementation unit; PSC = project steering committee; SPS = Safeguard Policy Statement.
Source: Asian Development Bank.

B. Key Persons Involved in Implementation

Executing Agency	Dr. Sanjeewa Munasinghe Secretary Ministry of Health secretary@health.gov.lk Tel: +94 112695811 Office Address: Suwasiripaya, No 385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka
Project Management Unit	Dr. Anil Dissanayake Project Director Tel +94 777591613 anilrd21@gmail.com
Project Implementation Units	**Central Province** Mr. Gamini Rajaratne Chief Secretary +94 812223418 csccp@yahoo.com **North Central Province** L.J.M.G. Chandrasiri Bandara Chief Secretary +94 252235790 csncpc@gmail.com **Sabaragamuwa Province** Mrs. Ranjanee Jayakody Chief Secretary +94 452224504 chiefsecretary@sg.gov.lk **Uva Province** Mr. P.B. Wijayarathna Chief Secretary +94 777812055 chiefsecuva@gmail.com
Asian Development Bank Division Director	Mr. Sungsup Ra Director, Human and Social Development Division Tel +63 2 632 4629 sungsupra@adb.org
Mission Leaders	Mr. Dai-Ling Chen Young Professional Tel +63 2 683 1166 dchen@adb.org Mr. Herathbanda Jayasundara Senior Social Development Officer Tel +94 11-2674499, ext: 427 hjayasundara@adb.org

C. Project Organization Structure

38. MOH as the executing agency will continue to maintain the PMU for the original project and for the additional financing. MOH together with the four PIUs under their provincial councils of Central, North Central, Sabaragamuwa, and Uva will implement both the original project and the additional financing. The national Project Steering Committee (PSC) chaired by Secretary, MOH via the PMU will provide strategic guidance, review the performance, and take timely strategic measures required to achieve the project outputs. PMU will provide all other necessary support required to functioning of PIUs in the four provinces under output 1 and ensure their effective support.

39. PMU will work under the direction of PSC and manage the overall project. MOH will provide the overall guidance to the PMU and the Deputy Director General (DDG) (Planning) of the Management Development and Planning Unit will work as a coordinator to link the PMU to the MOH. In addition, the DDG (Planning) will be the convenor of the PSC.

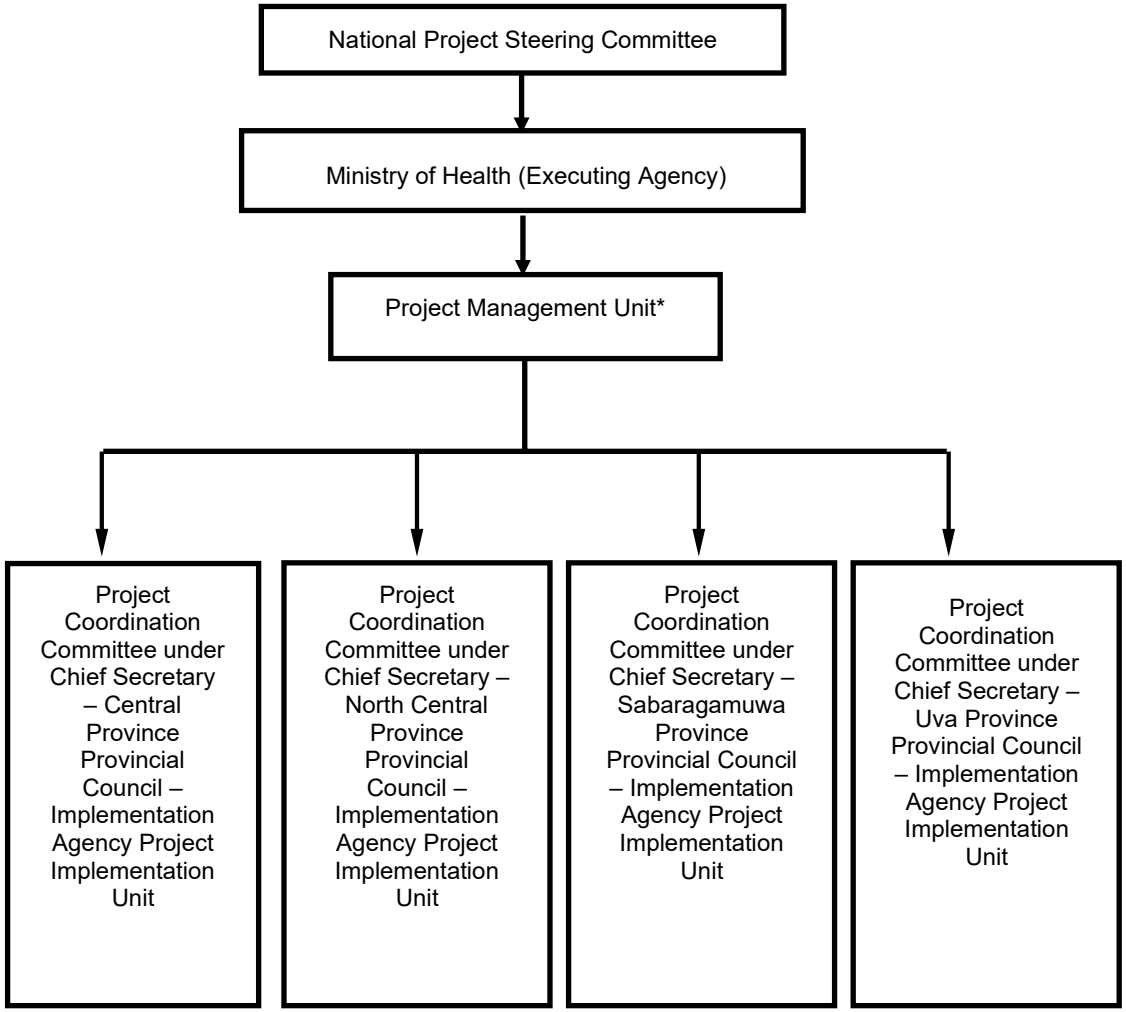
40. MOH, under the guidance of the Director General of Health Services, will formulate all necessary guidelines and provide policy and implementation support to the (i) PHC reforms related to the introduction of clusters, (ii) IT system to be developed and implemented across the clusters, (ii) behavior change communication campaign for encouraging PHC utilization, (iv) local level nutrition intervention activities, and (v) M&E activities planned for the project including a comparative analysis to measure the impact of the project interventions.

41. PIUs established at provincial level will continue to be supervised by the Project Coordination Committee (PCC) in each of the four provinces and which will be headed by the chief secretary of the respective province. PIUs will be responsible for implementation of the project at provincial level.

42. The PMU will be led by a project director supported by a deputy project director, project coordinator, procurement and finance specialists, M&E officer, IT officer and a few other technical and secretarial support staff. Each of the PIUs will be managed by a deputy project director who would be the provincial director of health services in each of the target four provinces and will be supported by a full time procurement specialist, finance manager, project engineer, and other staff. The terms of reference for PMU and PIUs are provided in Annex 2 of the project administration manual (PAM) of the original project.

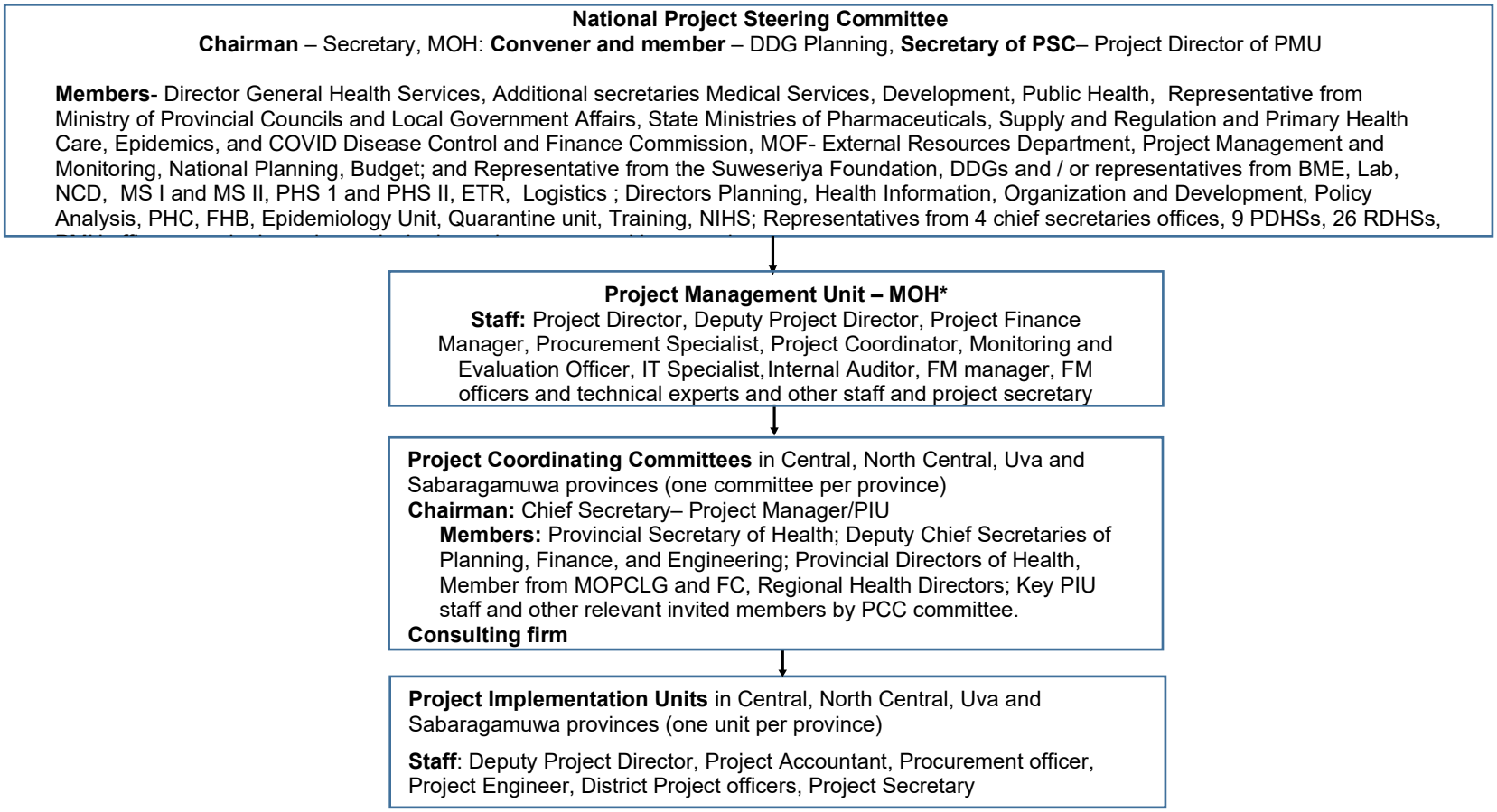
42. The additional financing project will be managed by the same PMU staff for all outputs and will be supported by the four PIU staff for activities implemented under output 1 of the additional financing. Additional staff positions will not be created for the project, but a few junior and senior level consultants will be hired on part time or full time basis for 3 years as required by the PMU. These positions will support project implementation and include the following: (i) cluster implementation support consultant (part time basis), (ii) molecular biologist for the PCR sequencing laboratory at Apeksha Hospital (on part time basis), (iii) environment officer (junior consultant), (iv) HCWM officer (junior consultant), (v) health communications officer (junior consultant), (vi) GIS specialist (part time basis), (vii) gender officer (junior consultant), (vii) two procurement officers (junior consultants), (viii) finance officer (junior consultant), and (ix) M&E officer (junior consultant).

Figure 1: Project Management Structure



* Activities under output 2 and output 3 will be centrally managed by the Project Management Unit
Source: Asian Development Bank.

Figure 2: Project Management Committees and their Composition



*Activities under output 2 and 3 will be centrally managed by the Project Management Unit
BME = Biomedical Engineering Services; DDG = deputy director general; ERD = Department of External Resources; ETR = Education, Training and Research; FHB = Family Health Bureau; FM = financial management; IT = information technology; MOF: Ministry of Finance, MOH = Ministry of Health; MS I and II = Medical Services I and II; NIHS = National Institute of Health Sciences; NCD = Non-Communicable Diseases; PDHS = Provincial Directors of Health Services (target 4 provinces); PHC = Primary Health Care; PHS I and II = Public Health Services I and II; PIU = project implementation unit; PMU = project management unit; RDHS = Regional Directors of Health Services (target 9 districts).
Source: Asian Development Bank.

IV. COSTS AND FINANCING

43. The additional financing investment cost is estimated at $123 million including taxes and duties of $10 million. The total cost includes physical and price contingencies as well as interest and commitment charges during implementation.

Table 4: Summary Cost Estimates
($ million)

Item	Current Amount[a]	Additional Financing[b]	Total
A. Base Cost[c]			
1. Primary and secondary health care enhanced in Central, Uva, North central, Sabaragamuwa provinces	39.00	36.29	75.29
2. Health information technology, disease surveillance capacity and COVID-19 response strengthened	3.70	70.24	73.94
3. Policy development support, capacity building, and project management supported	9.87	5.09	14.96
Subtotal (A)	**52.57**	**111.63**	**164.20**
B. Contingencies[d]			
Physical Contingencies	1.34	5.58	6.92
Price Contingencies	4.10	3.36	7.46
Subtotal (B)	**5.44**	**8.94**	**14.38**
C. Financial Charges During Implementation[e]			
Interest during Implementation	1.99	2.18	4.17
Commitment Charges	0.00	0.25	0.25
Subtotal (C)	**1.99**	**2.43**	**4.42**
Total (A+B+C)	**60.00**	**123.00**	**183.00**

Note: Numbers may not sum precisely due to rounding off.
[a] Refers to the original loan amount.
[b] Includes taxes and duties of $10 million to be financed by the Government of Sri Lanka by cash contribution.
[c] In mid-2021 prices as of 17 August 2021.
[d] Physical contingencies are computed at 5.0% for all categories. Price contingencies are computed at 1.6%–1.8% on foreign exchange costs and 4.0%–4.5% on local currency costs; includes provision for potential exchange rate fluctuation under the assumption of a purchasing power parity exchange rate.
[e] Includes interest and commitment charges. Interest during construction for the Asian Development Bank ordinary capital resources regular loan has been computed at the 6 months United States dollar London-interbank offered rate (LIBOR) rate plus a spread of 0.5%, funding cost margin of 0.01% (1 basis point for 1 July–31 December 2021) and a commitment charge of 0.15% of undisbursed amount.
Source: Asian Development Bank.

44. The Government of Sri Lanka has requested (i) a regular loan of $110 million from ADB's ordinary capital resources and (ii) a grant of $3 million from ADB-administered JFPR to help finance the project. The ADB loan will have a 29-year term including a grace period of 8 years; 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, project management, incremental administration and the PHC innovation fund. JFPR grant fund will finance expenditures in relation to civil works, equipment, vehicles, training, and consulting services.

Table 5: Summary Financing Plan

Source	Current[a] Amount ($ million)	Current[a] Share of Total (%)	Additional Financing Amount ($ million)	Additional Financing Share of Total (%)	Total Amount ($ million)	Total Share of Total (%)
Asian Development Bank						
OCR concessional loan	37.50	62.50	0.00	0.00	37.50	20.49
OCR regular loan	0.00	0.00	110.00	89.43	110.00	60.11
Special Funds resources (ADF grant)	12.50	20.83	0.00	0.00	12.50	6.83
JFPR grant	0.00	0.00	3.00	2.44	3.00	1.64
Government of Sri Lanka	10.00	16.67	10.00	8.13	20.00	10.93
Total	**60.00**	**100.00**	**123.00**	**100.0**	**183.00**	**100.00**

ADF = Asian Development Fund, JFPR = Japan Fund for Poverty Reduction, OCR = ordinary capital resources.
Note: Numbers may not sum precisely due to rounding off.
[a] Refers to the original amount
Source: Asian Development Bank.

A. Cost Estimates Preparation and Revisions

45. The cost estimates were prepared in United States dollars. The cost estimates were discussed and agreed with MOH and the four selected provinces during project processing.

B. Key Assumptions

46. The following key assumptions underpin the cost estimates and financing plan:

(i) Exchange rate: SLRs199.50 = $1.00 (as of 17 August 2021).
(ii) Physical contingencies are calculated at 5% of base costs on all categories of costs.
(iii) Price contingencies are calculated based on Table 6 below:

Table 6: Escalation Rates for Price Contingency

Item	2021	2022	2023	2024	2025
Domestic rate of price inflation	4.0%	4.5%	4.5%	4.5%	4.5%
Foreign rate of price inflation	1.6%	1.7%	1.7%	1.8%	1.8%

Source: Asian Development Bank.

C. Detailed Cost Estimates by Expenditure Category

Table 7: Detailed Cost Estimates by Expenditure Category

Item	Foreign Exchange ($ million)	Local Cost ($ million)	Total Cost ($ million)	% of Total Base Cost
A. Investment Costs[a]				
1. Civil works	14.32	14.32	28.65	25.7%
2. Medical equipment, supplies and furniture[b]	59.10	10.43	69.53	62.3%
3. Vehicles	4.16	-	4.16	3.7%
4. Training	0.04	0.74	0.78	0.7%
5. Consulting services	0.38	3.44	3.82	3.4%
6. Project management costs	-	1.93	1.93	1.7%
7. PHC innovation fund	0.38	1.14	1.53	1.4%
Subtotal (A)	**78.39**	**32.00**	**110.39**	**98.9%**
B. Recurrent Costs				
1. Incremental administrative costs	-	1.24	1.24	1.1%
Subtotal (B)	**-**	**1.24**	**1.24**	**1.1%**
Total Base Cost	**78.39**	**33.24**	**111.63**	**100.0%**
C. Contingencies				
1. Physical	3.92	1.66	5.58	5.0%
2. Price	2.36	1.00	3.36	3.0%
Subtotal (C)	**6.28**	**2.66**	**8.94**	**8.0%**
D. Financing Charges During Implementation				
1. Interest during construction	2.18	-	2.18	2.0%
2. Commitment charges	0.25	-	0.25	0.2%
Subtotal (D)	**2.43**	**-**	**2.43**	**2.2%**
Total Project Cost (A+B+C+D)	**87.09**	**35.90**	**123.00**	**110.2%**

PHC = primary health care.
Note: The updated guidelines on PHC Innovation Fund is in Annex 4. Numbers may not sum precisely due to rounding off.
[a] $65.42 million out of the total investment costs is considered for the emergency COVID-19 response.
[b] Medical equipment includes all medical related equipment, tools and furniture. Furniture pertains to office furniture.
Source: Asian Development Bank.

D. Allocation and Withdrawal of Loan Proceeds

Table 8: Allocation and Withdrawal of Loan Proceeds

No.	Item	Total Amount Allocated for ADB Loan Financing ($)	Basis for withdrawal from the loan account	
A.	**Investment Costs**			
1	Civil Works	25,715,707	100.0%	of expenditure claimed[a]
2	Medical Equipment, Supplies and Furniture	63,477,603	100.0%	of expenditure claimed[a]
3	Vehicles	2,656,642	100.0%	of expenditure claimed[b]
4	Consulting Services	3,459,774	100.0%	of expenditure claimed[a]
5	PHC Innovation Fund	1,400,000	100.0%	of expenditure claimed[a]
6	Project Management Costs	1,766,050	100.0%	of expenditure claimed[a]
7	Incremental Administration	1,135,723	100.0%	of expenditure claimed[a]
8	Interest Charge	2,430,346	100.0%	of amounts due
9	Unallocated (Contingency)	7,958,155		
	TOTAL	**110,000,000**		

ADB = Asian Development Bank, PHC = primary health care.
[a] Exclusive of taxes and duties imposed within the territory of the Borrower.
[b] ADB will finance cost of vehicles including applicable duties and excluding local indirect taxes (value-added tax and national building tax as applicable).
Source: Asian Development Bank.

Table 9: Allocation and Withdrawal of JFPR Grant Proceeds

No.	Item	Total Amount Allocated for JFPR Grant Financing ($)	Basis for withdrawal from the loan account	
A.	**Investment Costs**			
1	Civil Works	556,439	100.0%	of expenditure claimed[a]
2	Medical Equipment, Supplies and Furniture	280,654	100.0%	of expenditure claimed[a]
3	Vehicles	1,159,248	100.0%	of expenditure claimed[a]
4	Training	711,278	100.0%	of expenditure claimed[a]
5	Consulting Services	46,370	100.0%	of expenditure claimed[a]
6	Unallocated (Contingency)	246,011		
	TOTAL	**3,000,000**		

ADB = Asian Development Bank.
[a] Exclusive of taxes and duties imposed within the territory of the Recipient.
Source: Asian Development Bank.

E. Detailed Cost Estimates by Financier

Table 10: Detailed Cost Estimates by Financier

Item		ADB Loan $ million	ADB Loan % of cost category	JFPR Grant $ million	JFPR Grant % of cost category	GOSL $ million	GOSL % of cost category	Total Cost ($ million)	Taxes and Duties
A.	**Investment Costs[a]**								
	1. Civil works	25.72	91.7%			2.33	8.3%	28.04	2.33
				0.56	91.7%	0.05	8.3%	0.61	0.05
	2. Medical equipment, supplies and furniture[b]	63.48	91.7%			5.74	8.3%	69.22	5.74
				0.28	91.7%	0.03	8.3%	0.31	0.03
	3. Vehicles	2.66	91.7%			0.24	8.3%	2.90	0.24
				1.16	91.7%	0.10	8.3%	1.26	0.10
	4. Training			0.71	91.7%	0.06	8.3%	0.78	0.06
	5. Consulting services	3.46	91.7%			0.31	8.3%	3.77	0.31
				0.05	91.7%	0.00	8.3%	0.05	0.00
	6. Project management costs	1.77	91.7%	-	0.0%	0.16	8.3%	1.93	0.16
	7. PHC innovation fund	1.40	91.7%	-	0.0%	0.13	8.3%	1.53	0.13
	Subtotal (A)	**98.48**	**89.2%**	**2.75**	**2.5%**	**9.16**	**8.3%**	**110.39**	**9.16**
B.	**Recurrent Costs**								
	1. Incremental administrative costs	1.14	91.7%	-	0.0%	0.10	8.3%	1.24	0.10
	Subtotal (B)	**1.14**	**91.7%**	**-**	**0.0%**	**0.10**	**8.3%**	**1.24**	**0.10**
	Total Base Cost	**99.61**	**89.2%**	**2.75**	**2.5%**	**9.26**	**8.3%**	**111.63**	**9.26**
C.	**Contingencies**								
	1. Physical	4.97	89.1%	0.14	2.6%	0.46	8.3%	5.58	0.46
	2. Price	2.98	88.8%	0.10	3.0%	0.28	8.3%	3.36	0.28
	Subtotal (C)	**7.96**	**89.0%**	**0.25**	**2.7%**	**0.74**	**8.3%**	**8.95**	**0.74**
	Financing Charges								
D.	**During Implementation**								
	1. Interest during construction	2.18	100.0%	-	0%	-	0.0%	2.18	
	2. Commitment charges	0.25	100.0%	-	0%	-	0.0%	0.25	
	Subtotal (D)	**2.43**	**100.0%**	**-**	**0%**	**-**	**0.0%**	**2.43**	**-**
	Total Project Cost (A+B+C+D)	**110.00**	**89.4%**	**3.00**	**2.4%**	**10.00**	**8.1%**	**123.00**	**10.00**

ADB = Asian Development Bank, GOSL = Government of Sri Lanka. JFPR = Japan Fund for Poverty Reduction, PHC = primary health care.
Note: ADB will finance cost of vehicles including applicable duties and excluding local indirect taxes (value-added tax and nation building tax as applicable). Numbers may not sum precisely due to rounding off.
[a] $65.42 million out of the total investment costs is considered for the emergency COVID-19 response.
[b] Medical equipment includes all medical related equipment, tools and furniture. Furniture pertains to office furniture.

Source: Asian Development Bank.

F. Detailed Cost Estimates by Outputs and/or Components

Table 11: Detailed Cost Estimates by Output ($ million)

Item	Total Cost ($ million)	Output 1 Amount	Output 1 % of cost category	Output 2 Amount	Output 2 % of cost category	Output 3 Amount	Output 3 % of cost category
A. Investment Costs[a]							
1. Civil works	28.65	26.16	91.3%	0.61	2.1%	1.88	6.6%
2. Medical equipment, supplies and furniture	69.53	4.91	7.1%	63.57	91.4%	1.05	1.5%
3. Vehicles	4.16	-	0.0%	4.16	100.0%	-	0.0%
4. Training	0.78	0.78	100.0%	-	0.0%	-	0.0%
5. Consulting services	3.82	2.92	76.3%	0.54	14.1%	0.37	9.6%
6. Project management costs	1.93	-	0.0%	1.37	71.0%	0.56	29.0%
7. PHC innovation fund	1.53	1.53	100.0%	-	0.0%	-	0.0%
Subtotal (A)	**110.39**	**36.29**	**32.9%**	**70.24**	**63.6%**	**3.85**	**3.5%**
B. Recurrent Costs							
1. Incremental administrative costs	1.24	-	0.0%	-	0.0%	1.24	100.0%
Subtotal (B)	**1.24**	**-**	**0.0%**	**-**	**0.0%**	**1.24**	**100.0%**
Total Base Cost	**111.63**	**36.29**	**32.5%**	**70.24**	**62.9%**	**5.09**	**4.6%**
C. Contingencies							
1. Physical contingencies	5.58	1.81	32.5%	3.51	62.9%	0.25	4.6%
2. Price contingencies	3.36	1.09	32.5%	2.11	62.9%	0.15	4.6%
Subtotal (D)	**8.94**	**2.91**	**32.5%**	**5.63**	**62.9%**	**0.41**	**4.6%**
D. Financing Charges During Implementation							
1. Interest during construction	2.18	0.71	32.5%	1.37	62.9%	0.10	4.6%
2. Commitment charges	0.25	0.08	32.5%	0.16	62.9%	0.01	4.6%
Subtotal (D)	**2.43**	**0.79**	**32.5%**	**1.53**	**62.9%**	**0.11**	**4.6%**
Total Project Cost (A+B+C+D)	**123.00**	**39.99**	**32.5%**	**77.40**	**62.9%**	**5.61**	**4.6%**

PHC = primary health care.
Note: Numbers may not sum precisely due to rounding off.
[a] $65.42 million out of the total investment costs is considered for the emergency COVID-19 response.
Source: Asian Development Bank.

G. Detailed Cost Estimates by Year

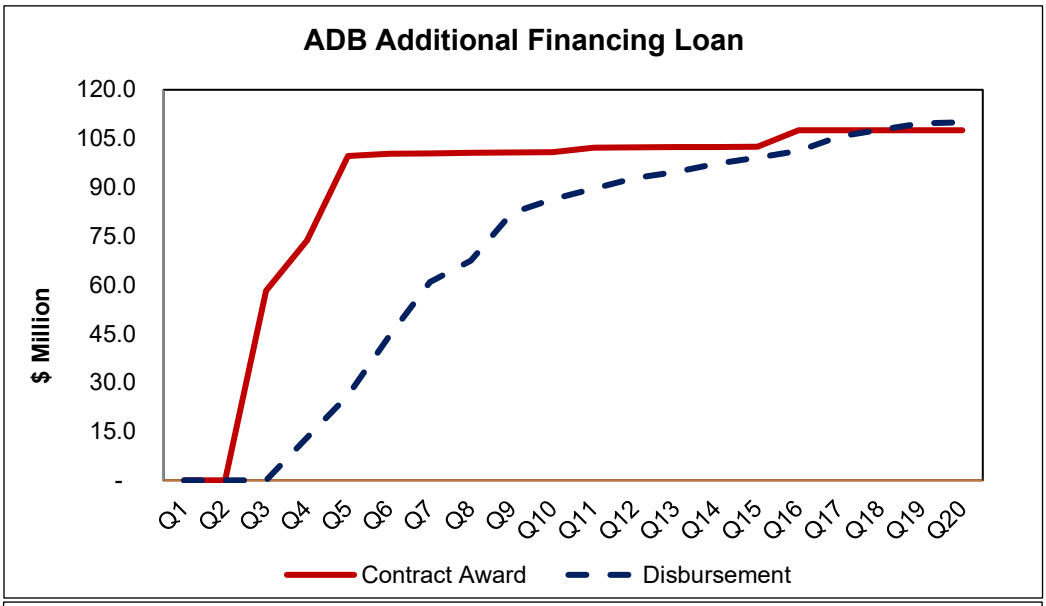
Table 12: Detailed Cost Estimates by Year ($ million)

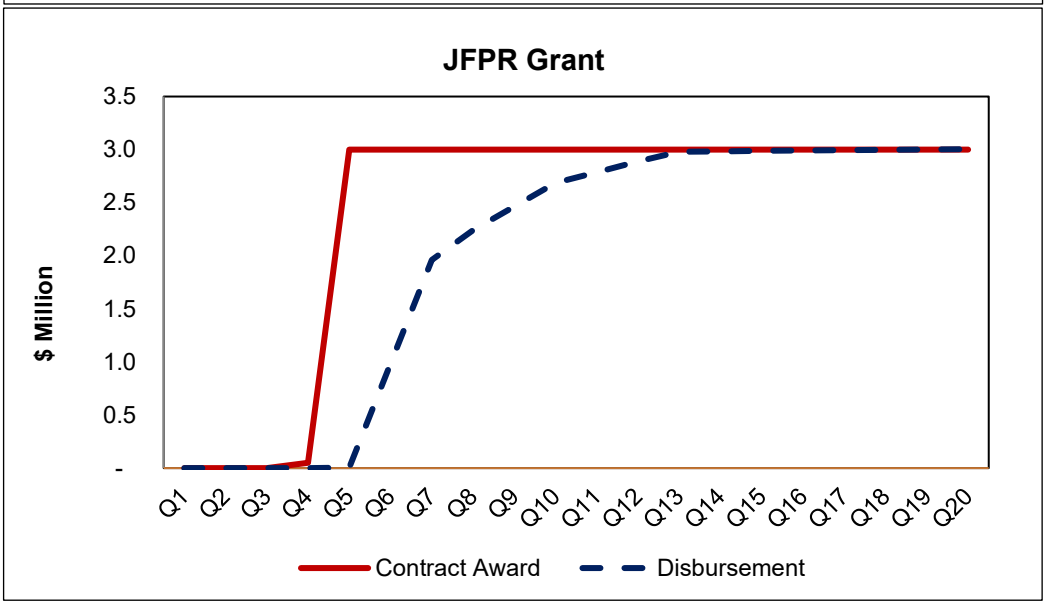
	Item	Total Cost	2021	2022	2023	2024	2025
A.	**Investment Costs[a]**						
	1. Civil works	28.65	-	9.33	10.96	6.11	2.26
	2. Medical equipment, supplies and furniture	69.53	12.89	39.63	12.10	-	4.91
	3. Vehicles	4.16	-	4.16	-	-	-
	4. Training	0.78	-	0.29	0.39	0.09	-
	5. Consulting services	3.82	0.05	1.72	1.43	0.48	0.14
	6. Project management cost	1.93	-	0.35	0.35	0.65	0.57
	7. PHC innovation fund	1.53	-	0.44	0.41	0.39	0.28
	Subtotal (A)	**110.39**	**12.94**	**55.92**	**25.64**	**7.73**	**8.17**
B.	**Recurrent Costs**						
	1. Incremental administrative costs	1.24	-	-	-	0.64	0.60
	Subtotal (B)	**1.24**	**-**	**-**	**-**	**0.64**	**0.60**
	Total Base Cost	**111.63**	**12.94**	**55.92**	**25.64**	**8.37**	**8.76**
C.	**Contingencies**						
	1. Physical contingencies	5.58	0.65	2.80	1.28	0.42	0.44
	2. Price contingencies	3.36	0.19	1.55	1.18	0.25	0.19
	Subtotal (C)	**8.94**	**0.84**	**4.35**	**2.46**	**0.67**	**0.63**
D.	**Financial Charges During Implementation**						
	1. Interest during construction	2.18	0.02	0.27	0.54	0.65	0.70
	2. Commitment charges	0.25	0.08	0.10	0.04	0.02	0.01
	Subtotal (D)	**2.43**	**0.10**	**0.37**	**0.58**	**0.67**	**0.71**
	Total Project Cost (A+B+C+D)	**123.00**	**13.88**	**60.64**	**28.68**	**9.70**	**10.10**
% Total Project Cost (A+B+C+D)		**100.0%**	**11.3%**	**49.3%**	**23.3%**	**7.9%**	**8.2%**

PHC = primary health care.
Note: Numbers may not sum precisely due to rounding off.
[a] $65.42 million out of the total investment costs is considered for the emergency COVID-19 response.
Source: Asian Development Bank.

H. Contract and Disbursement S-Curve

Figure 3: Contract Award and Disbursement S-Curve





ADB = Asian Development Bank, JFPR = Japan Fund for Poverty Reduction, Q = quarter.
Source: Asian Development Bank.

Table 13: Contract Awards and Disbursements

ADB Additional Financing Loan ($ million)

Year	Contract Awards[a]						Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.	Q1	Q2	Q3	Q4	Total	Cum.
2021	-	-	58.3	15.4	**73.7**	**73.7**	-	-	-	13.1	**13.1**	**13.1**
2022	26.0	0.7	0.1	0.2	**27.0**	**100.7**	13.0	18.1	16.7	6.6	**54.4**	**67.5**
2023	0.1	0.1	1.4	0.1	**1.6**	**102.3**	14.7	4.2	3.3	3.2	**25.3**	**92.9**
2024	0.1	0.1	0.1	5.0	**5.3**	**107.6**	1.9	2.5	1.9	2.0	**8.3**	**101.2**
2025	-	-	-	-	**-**	**107.6**	4.4	2.1	2.0	0.3	**8.8**	**110.0**
Total	**26.1**	**0.9**	**59.8**	**20.8**	**107.6**		**33.9**	**27.0**	**23.9**	**25.2**	**110.0**	

Q = quarter.
Note: Numbers may not sum precisely due to rounding off.
[a] Contract awards exclude financing charges which the loan is also funding.
Source: Asian Development Bank.

JFPR Grant ($ million)

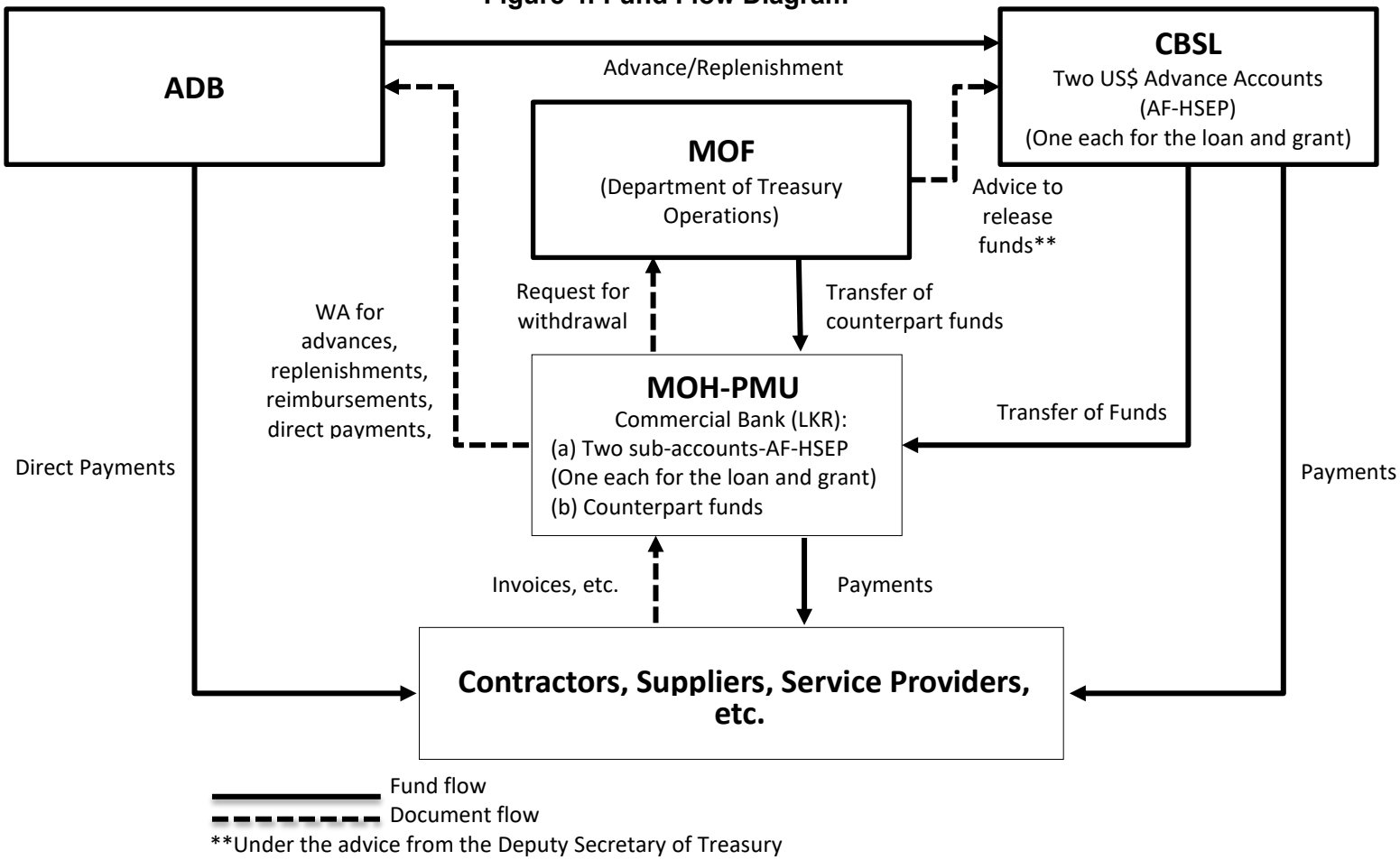
Year	Contract Awards						Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.	Q1	Q2	Q3	Q4	Total	Cum.
2021	-	-	-	0.1	**0.1**	**0.1**	-	-	-	-	**-**	**-**
2022	2.9	-	-	-	**2.9**	**3.0**	0.0	1.0	1.0	0.3	**2.2**	**2.2**
2023	-	-	-	-	**-**	**3.0**	0.2	0.2	0.1	0.1	**0.6**	**2.9**
2024	-	-	-	-	**-**	**3.0**	0.1	0.0	0.0	0.0	**0.1**	**3.0**
2025	-	-	-	-	**-**	**3.0**	0.0	0.0	0.0	0.0	**0.0**	**3.0**
Total	**2.9**	**-**	**-**	**0.1**	**3.0**		**0.3**	**1.2**	**1.1**	**0.4**	**3.0**	

Q = quarter.
Note: Numbers may not sum precisely due to rounding off.
Source: Asian Development Bank.

I. Fund Flow Diagram

47. The overall fund flow for the additional financing is illustrated in the figure below.

Figure 4: Fund Flow Diagram



ADB=Asian Development Bank; AF-HSEP = Additional Financing for Health System Enhancement Project; CBSL=Central Bank of Sri Lanka; MOH-PMU=Ministry of Health, Project Management Unit; MOF=Ministry of Finance; WA=withdrawal application.
Source: Asian Development Bank.

V. FINANCIAL MANAGEMENT

A. Financial Management Assessment

48. The financial management assessment (FMA) was conducted in June 2021 in accordance with ADB guidelines on Financial Management Assessment[7] and Financial Due Diligence: A Methodology Note.[8] The FMA evaluated the financial management capacity of the Ministry Health, Nutrition, and Indigenous Medicine, presently re-designated as Ministry of Health (MOH) as the executing agency and the existing PIUs in the provinces as the implementing agencies. The assessment was based on desk review, evaluation of the original project's financial management performance, review of recently completed FMA report, interviews with the government counterparts, and drawing lessons from ongoing ADB experience in Sri Lanka. The MOH and the four provinces have experience in implementing donors funded projects including those funded by ADB. The ongoing project has an established staff capacity. Both the PMU at Ministry level and PIUs at the provincial level are adequately staffed. FM consultant will be supplemented, if necessary. Overall, the MOH-PMU and PIUs have satisfactorily complied with ADB's FM requirements. All the actions outlined in the agreed original project financial management action plan including the establishment of management and implementing units, recruitment of an internal auditor, procurement of an accounting software, set up of a separate fixed asset register, etc. have been complied. The FMA found that the MOH have adequate financial management capacity to: (i) record the required financial transactions, (ii) prepare and report reliable financial information, (iii) safeguard the assets and (iv) manage the advance account and the statement of expenditure (SOE) procedures based on ADB's disbursement requirements. There is a structured FM arrangement in the ongoing project which the additional financing will build on. The assessment indicated that MOH financial management capacity, systems and procedures are acceptable for the proposed additional financing.

49. There are notable improvements in the capacity and systems of MOH-PMU and PIUs since 2018, the pre-mitigation FM risk for the additional financing is rated "Moderate," which is mainly due to the budget allocation for the additional financing that has not yet been made. This may cause possible delays in the release of budget funds impacting project implementation. This FM risk will be mitigated through, (i) establishment of a separate budget code and timely budget allocation for the additional financing scope, and (ii) regular monitoring and reporting of the counterpart financing which will be reported as part of the quarterly progress reports. The FMA concludes that with the risk mitigation measures and the adoption of the financial management action plans the financial management systems are acceptable for the proposed additional financing.

50. The executing agency and the implementing agencies have agreed to implement an action plan which describes the key measures to strengthen the financial management arrangements, which are detailed in Tables 14 and 15 below.

[7] ADB. 2015. *Financial Management Technical Guidance Note: Financial Management Assessment*. Manila.
[8] ADB. 2009. *Financial Due Diligence: A Methodology Note*. Manila.

Table 14: Financial Management and Internal Control Risk Assessment

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plans
Inherent Risk		
Country Specific		
Public Financial Management. Overall, the government has adequate PFM systems in place. However, there is scope for improving compliance with the national systems and regulations as well as the FM capacity at various levels. Also, an ADB report on the PFM systems of Sri Lanka identified risk related to timely availability of project funds.	Substantial	ADB to closely monitor the ongoing PFM reforms and initiatives including the launch of the Integrated Treasury Management Information System (ITMIS). Budgetary allocations, budget details and progress of budget utilization were included in the original project's QPRs. Closely monitoring of budgetary allocations and project activities to reduce country specific risk in the project will also be performed for the additional financing.
Entity Specific		
The involvement of multilayer (ministry and provinces) agencies complicates the overall project implementation process.	Moderate	A high-level national Project Steering Committee under the Chairmanship of the Secretary, MOH was formed for the original project, the same will monitor and oversee the additional financing. The provincial project coordination committees chaired by the chief secretaries were formed at the respective province for the original project, and the same will monitor the additional financing.
Overall Inherent Risk	**Moderate**	
Project Risk		
Staffing. The extended scale of activities and financing through the additional financing may overstretch the capacity of MOH-PMU.	Moderate	The PMU and PIUs were formed for the original project, fully staffed, and has satisfactory FM track record in complying with ADB's FM and disbursement requirements. The capacity of the PMU may need to be further strengthened. Efficient coordination and flow of information between the different entities involved in the project implementation must be ensured. An additional FM staff to be hired to support the PMU. The same consultant will support the additional financing and RECOVER Project. Continuous trainings on ADB's financial management and disbursements processes and procedures will be provided.
Fund flow. The budget allocation for the additional financing has not been transferred to MOH. Delays in allocation and release of budget may lead to inadequate project financing and implementation delays.	Substantial	A separate project budget head has been established with timely allocations of funds for the original project. MOH has established separate advance accounts for the loan and grant and the required sub-accounts were opened for the original project.

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plans
		MOF to provide a firm commitment that budget allocation is transferred to MOH by loan effectiveness. MOF to also provide assurances that counterpart funds will be released in a timely manner. The availability of counterpart financing will be monitored regularly through QPRs.
Accounting policies and procedures. No separate accounting records for the project and non-compliance with prescribed accounting standards.	Low	MOH currently maintains separate accounting records for the projects and adopts the Sri Lanka Accounting Standards which are consistent with international accounting standards. No mitigation measures needed as the risk is low.
Reporting. Inadequate information in the financial reports may result to untimely detection and resolution of issues.	Moderate	The QPRs for the original project included financial information details and were timely reported to ADB. Likewise, for the additional financing, comprehensive financial information will be part of the QPRs in a format agreed with ADB within 45 days after the end of each quarter. The PMU is to prepare the project financial statements within two months after the end of the fiscal year to ensure auditors can start the audit process on time.
Internal audit. MOH currently has an internal audit unit. In addition, as part of the original project design an internal audit staff specifically for the original project was hired. Non-inclusion of the additional financing in the internal audit plan may result to weaknesses in internal controls not being detected.	Moderate	Internal audit unit shall include the additional financing in the annual internal audit plan and shall evaluate the effectiveness of controls and processes for the project. MOH and IAs shall promptly act on the observations and recommendations of the internal audit unit as included in the internal audit report. All internal audit findings shall also be reported as part of QPRs
External audit. Delays in submission of audited project financial statements to ADB.	Moderate	Similar to the original project, the PMU must liaise with NAO to ensure the proposed project is part of NAO's annual audit plan and that the Audit process is commenced in a timely manner. The audit observations to be resolved in a timely manner. The status of audit observations to be included in the QPR.
Overall Project Risk	**Moderate**	
Overall (Combined) Risk	**Moderate**	

ADB = Asian Development Bank, DMA = Department of Management Audit, IA = Implementing Agency, ITMIS = Integrated Treasury Management Information System; MOH = Ministry of Health, NAO=National Audit Office, PIU = Project Implementing Units, PMU = project management Unit, PFM = Public Financial Management, PFS = project financial statements, QPR= quarterly progress reports, SLAS = Sri Lanka Accounting Standards
Source: Asian Development Bank.

Table 15: Financial Management Action Plan

Key Risk Area	Risk Mitigating Activity	Timeline	Entity
Staffing and FM capacity support	Appoint an additional FM staff to support the PMU.	By loan effectiveness	MOH/ PMU
	Provide training to PMU staff in ADB's FM and disbursement procedures and systems.	By loan effectiveness	ADB
Flow of funds	Establish a dedicated budget code for the additional financing and transfer the required budget allocation to MOH/PMU.	By loan effectiveness	MOF
	Regular monitoring and reporting of the availability of counterpart financing will be part of the quarterly progress reports.	Quarterly	MOH
	Ensure timely release of counterpart funds.	Annually (by start of each fiscal year) throughout project implementation period	MOF
Internal audit	Include the project in the internal audit plan to ensure proper controls and processes are in place.	Q4-2021	MOH, Internal Audit Unit
	PIARC shall review and monitor implementation of the internal audit findings.	Annual and update on status of observations every quarter.	MOH/ PIARC
	Internal audit observations and status of recommendations are to be included in the Quarterly Progress Reports submitted to ADB.	Annual and update on status of observations every quarter.	MOH
External audit	Coordinate with NAO to ensure the proposed additional financing is part of NAO's annual audit plan.	By loan effectiveness date	MOH/ PMU
	Timely submission of unaudited project financial statements to NAO	On or before 31 March after each fiscal year (Annually during project implementation)	MOH/ PMU
	Timely submission of audit report and project financial statements to EA.	15 June after each fiscal year (Annually during project implementation)	NAO
	The APFS is submitted to ADB by due date.	Annually and within 6 months after the end of the fiscal year	MOH/ PMU
Financial reporting	Include comprehensive FM information including detailed comparison of physical and financial progress, status of implementation of FM action plan, and status of resolutions of internal and external audit observations in the quarterly progress reports and submit to ADB	Within 45 days from the end of each quarter	MOH/ PMU

Key Risk Area	Risk Mitigating Activity	Timeline	Entity
Information systems	Modify the accounting software to accommodate the proposed additional financing and its financing and expenditure structure.	By loan effectiveness	MOH/ PMU
	Ensure fixed asset registers are maintained for the project.	By loan effectiveness	MOH, PMU, PIUs

ADB = Asian Development Bank, APFS= audited project financial statements, FM = financial management, FY = fiscal year, LFIS=loan financial Services information system, IA = Implementing Agencies, MOH = Ministry of Health, NAO=National Audit Office, PIARC = Project Internal Audit Review Committee, PMU = project management Unit, PFS = project financial statements, Q= Quarter, QPR= quarterly progress reports.
Source: Asian Development Bank.

B. Disbursement

1. Disbursement Arrangements for ADB Funds

51. The loan and grant proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time)[9] and detailed arrangements agreed upon between the government and ADB.

52. The project may make use of the advance account procedures, direct payment, reimbursement procedure and commitment procedure. The MOH through its PMU will be responsible for (i) preparing disbursement projections, (ii) requesting budgetary allocations for ADB and counterpart funds, (iii) collecting and retaining supporting documents, (iv) preparing withdrawal applications, and (v) submission of withdrawal applications and other relevant documents to ADB.

53. **Direct payment.** Direct payment procedures may be used for large foreign currency contracts under the project. Suppliers/contractors/consultants are required to submit approved invoices and other supporting documentation to ADB in accordance with the ADB's Loan Disbursement Handbook (2017, as amended from time to time).

54. **Advance fund procedure.** After the loan effectiveness date, dedicated advance accounts in USD will be opened for the project at Central Bank of Sri Lanka (one for the loan and one for the grant). Separate accounts will be maintained for each funding source. In addition, sub-accounts in local currency (LKR) will be established at a commercial bank and maintained by the PMU (one for the loan and one for the grant). The advance and sub-account are to be used exclusively for ADB's share of eligible expenditures. MOH through its PMU is accountable and responsible for proper use of advances to the advance and sub-account.

55. The total outstanding advance to the advance accounts should not exceed the estimate of ADB's share of expenditure to be paid through the advance accounts for the forthcoming 6 months. The MOH-PMU may request for initial and additional advances to the advance accounts based on an Estimate of Expenditure Sheet[10] setting out the estimated expenditures to be financed through the accounts for the forthcoming 6 months. Supporting documents should be submitted to ADB or retained by the MOH-PMU in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) when liquidating or replenishing the advance accounts.

[9] The handbook is available electronically from the ADB website at http://www.adb.org/documents/loan-disbursement-handbook.
[10] ADB. 2017. Loan Disbursement Handbook. Manila.

56. **Statement of expenditure procedure**. [11] The SOE procedure may be used for reimbursement of eligible expenditures or liquidation of advances to advance accounts. Supporting documents and records for the expenditures claimed under the SOE should be maintained and made readily available for review by ADB's disbursement and review mission, upon ADB's request for submission of supporting documents on a sampling basis, and for independent audit.

57. Before the submission of the first withdrawal application, the borrower should submit to ADB sufficient evidence of the authority of the person(s) who will sign the withdrawal applications on behalf of the government, together with the authenticated specimen signatures of each authorized person. The minimum value per withdrawal application is set $200,000. Individual payments below such amount should be paid (i) by the MOH-PMU or (ii) through the advance fund procedure, unless otherwise accepted by ADB. The borrower should ensure sufficient category and contract balances before requesting disbursements.

58. The PHC innovation fund from the additional financing will be centrally managed, monitored and administered by PMU of the MOH. Eligible expenditures financed by the grant are given in the PHC innovation fund guideline and will be supported by adequate documents in accordance with ADB's Loan Disbursement Handbook (2017, as amended from time to time). Detailed and updated guidelines on the PHC innovation fund under the additional financing are provided in **Annex 4**.

2. Disbursement Arrangements for Counterpart Fund

59. Disbursement for counterpart funds will be carried out in accordance with guidelines and practices of the government. The government counterpart funds will be sufficiently allocated in the budget annually. MOH will be responsible for preparing disbursement projections and requesting budgetary allocations for counterpart funds to the Ministry of Finance. MOH-PMU and Province-PIUs shall open separate accounts for the use of counterpart funding.

C. Accounting

60. The MOH-PMU will maintain separate project accounts and records by funding source for all expenditures incurred on the project. The Project accounts will follow the Sri Lanka Accounting Standards, an accrual-based accounting. MOH through its PMU will prepare annual consolidated project financial statements in accordance with government's accounting laws and regulations, which are consistent with international accounting principles and practices.

61. **Financial reporting.** The MOH-PMU will prepare project financial statements in accordance with the government's accounting laws and regulations, which are consistent with international accounting principles and practices. The Project Financial Statements will include at least the following:

(i) Statement of Financial Position;
(ii) Statement of Financial Performance;
(iii) Statement of Cash Flow;
(iv) Statement of Advance Account Reconciliation;
(v) Statement of Budgeted vs Actual Expenditures; any significant deviations must be sufficiently explained in the notes;
(vi) Statement of Disbursement;
(vii) Detailed notes to the financial statements including significant accounting policies.

[11] SOE forms are available in Appendix 7B and 7D of ADB's *Loan Disbursement Handbook* (2017, as amended from time to time).

Furthermore, the notes of the financial statements must provide a detailed breakdown of withdrawal applications submitted to and the amounts paid by ADB under each loan as follows: (a) WA number, (b) the amount claimed and currency, (c) date submitted, (d) disbursement method, (e) the amount disbursed by ADB, and (f) the applicable exchange rate.

62. The expenditure categories and outputs used in the financial reports will be aligned with the structure outlined in the PAM. Moreover, to allow for timely and efficient monitoring, MOH, will ensure that comprehensive financial information is included in the quarterly progress reports to be submitted to ADB within 45 days after the end of each quarter. The ongoing project has a comprehensive quarterly progress report, the additional financing will be following the same information and content, additional details may be requested by ADB during project implementation. The financial report to be included in the quarterly progress report template is included in **Annex 7.**

63. **Periodic reconciliations**. To ensure the correctness and completeness of the project's books of accounts and financial reports, MOH through its PMU shall conduct:

(i) Monthly reconciliations of the advance account and sub-accounts; and
(ii) Quarterly reconciliation of the project book of accounts, and ADB's disbursement data available in the LFIS.

64. Any discrepancies and/or reconciliation items will be followed up to ensure these are resolved in a prompt manner. The differences between amounts claimed from ADB and the amounts disbursed by ADB will be disclosed and explained in the withdrawal application register to be included in the financial reports.

D. Auditing and Public Disclosure

65. The MOH will cause the detailed project financial statements to be audited in accordance with International Standards on Auditing and government's audit regulation, by an independent auditor[12] acceptable to ADB. The APFS together with the auditor's opinion will be presented in the English language to ADB within 6 months from the end of the fiscal year.

66. The audit report for the project financial statements will include a management letter and auditor's opinions, which cover (i) whether the project financial statements present a true and fair view or are presented fairly, in all material respects, in accordance with the applicable financial reporting standards; (ii) whether the proceeds of the loan were used only for the purpose(s) of the project; and (iii) whether the borrower or executing agency was in compliance with the financial covenants contained in the legal agreements (where applicable). The management letter will include from the second year onwards, a follow-up on previous years audit observations. In case the auditor does not issue a management letter, the auditor must issue a written confirmation that no internal control issues were identified as part of the audit.

67. Compliance with financial reporting and auditing requirements will be monitored by review missions and during normal project supervision, and followed up regularly with all concerned, including the external auditor.

68. The government, MOH have been made aware of ADB's approach to delayed submission,

[12] The project is expected to be audited by National Audit Office (NAO).

and the requirements for satisfactory and acceptable quality of the APFS.[13] ADB reserves the right to require a change in the auditor (in a manner consistent with the constitution of the borrower), or for additional support to be provided to the auditor, if the audits required are not conducted in a manner satisfactory to ADB, or if the audits are substantially delayed. ADB reserves the right to verify the project's financial accounts to confirm that the share of ADB's financing is used in accordance with ADB's policies and procedures.

69. Public disclosure of the APFS, including the auditor's opinion on the project financial statements, will be guided by ADB's Access to information Policy 2018.[14] After the review, ADB will disclose the audited project financial statements and the opinion of the auditors on the project financial statements (APFS) no later than 14 days of ADB's confirmation of their acceptability by posting them on ADB's website. The management letter and additional auditor's opinions will not be disclosed.

VI. PROCUREMENT AND CONSULTING SERVICES

70. All procurement of goods, works, non-consulting and consulting services for the proposed additional financing will be carried out in accordance with the ADB Procurement Policy and Procurement Regulations for ADB Borrowers (2017, as amended from time to time). Unless otherwise agreed with ADB, the ADB standard bidding documents and requests for proposals will be used for all procurement.

71. In case of conflict contradiction between ADB procurement procedures and any national rules and regulations, ADB procurement procedures would take precedence. The general descriptions of various procurement items under different expenditure categories are described below. The major procurement items, estimated costs, and methods of procurement are shown in the tables below. For each contract to be financed under the Project, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frames are agreed between the Borrower and ADB and included in the initial Procurement Plan.

72. In case JFPR grant-financed goods, works, non-consulting and consulting services will be procurement through United Nations agencies, the universal procurement will not be allowed as instructed by the Government of Japan in 2016.

A. Advance Contracting

73. The Borrower may proceed with the initial steps of procurement before signing the financing agreement. Such contracts will be eligible for financing under the project, only if the

[13] Following is ADB's policy on delayed submission of audited project financial statements:
(i) When audited project financial statements are not received by the due date, ADB will write to the executing agency advising that (a) the audit documents are overdue; and (b) if they are not received within the next 6 months, requests for new contract awards and disbursement such as new replenishment of advance accounts, processing of new reimbursement, and issuance of new commitment letters will not be processed.
(ii) When audited project financial statements are not received within 6 months after the due date, ADB will withhold processing of requests for new contract awards and disbursement such as new replenishment of advance accounts, processing of new reimbursement, and issuance of new commitment letters. ADB will (a) inform the executing agency of ADB's actions; and (b) advise that the loan may be suspended if the audit documents are not received within the next 6 months.
(iii) When audited project financial statements have not been received within 12 months after the due date, ADB may suspend the loan.

[14] Available at https://www.adb.org/documents/access-information-policy.

procurement procedures including advertising is consistent with the Procurement Policy and Regulations mentioned above. Any concurrence by ADB on procedures, documentation or contract award will not constitute a commitment by ADB to finance the project.

B. Retroactive Financing

74. Withdrawals from the loan account may be made for reimbursement of reasonable expenditures incurred under the project before effective date, but not earlier than 12 months before the date of the loan and grant agreements in connection with procurement of goods, works and consultancy services under the project, subject to a maximum amount equivalent to 20% of the loan amount.

C. Procurement of Goods, Works, and Consulting Services

75. **Civil works.** All civil works contracts will be conducted through open competitive bidding (OCB) advertised nationally or Request for Quotation (RFQ). Foreign bidders are not expected to be interested because: (i) the value of the contract is small; (ii) works are scattered geographically; and (iii) works are labor intensive. To ensure efficiency and economy in contract administration, small contracts at various construction sites may be grouped together to obtain higher value, wherever feasible and invite bids under the provision of multiple contracts to attract both small and large scale contractors. The summary of civil works to be undertaken at primary care facilities is attached at **Annex 3**.

76. **Equipment and materials.** Vehicles, medical equipment and supplies, medical furniture will be procured through the methods namely (i) OCB advertised internationally/nationally; (ii) RFQ; and (iii) direct contracting including UN agencies involvement.

77. **Consulting services.** A design and supervision consultant for all civil works to be carried out under the project will be engaged using the quality- and cost-based selection (QCBS) method with a standard quality cost ratio of 90:10. All consulting services will be engaged in accordance with the ADB Procurement Policy (2017, as amended from time to time) and Procurement Regulations for ADB Borrowers (2017, as amended from time to time).

78. **Bid security.** Where required, bid security shall be in the form of a certified cheque, a letter of credit or a bank guarantee from a reputable bank. Bid securing declaration may be accepted for smaller value works contracts.

79. **ADB policy clauses.** A provision shall be included in all contracts financed by ADB requiring suppliers and contractors to permit ADB to inspect their accounts and records and other documents relating to the bid submission and the performance of the contract, and to have them audited by auditors appointed by ADB.

80. **ADB review of procurement decisions.** First two procurements in RFQ to be carried out by PMU and PIUs are subject to prior review by ADB. Afterwards post review (sampling) will be conducted. All other contracts will be subject to prior review as described in Appendix 6 of the Procurement Regulations and agreed in the Procurement Plan.

81. **Capacity building.** The newly recruited procurement staff and other relevant officials including evaluation committee members of the Borrower would require a comprehensive training program on ADB procurement regulations and procedures to conduct procurement tasks. This program will be carried out by ADB.

D. Procurement Plan

82. The initial procurement plan is presented in **Annex 8**. The information in the procurement plan is indicative and will be further detailed once further details are confirmed.

VII. SAFEGUARDS

83. **Prohibited investment activities.** Pursuant to ADB's Safeguard Policy Statement (SPS) 2009, ADB funds may not be applied to the activities described on the ADB Prohibited Investment Activities List set forth at Appendix 5 of the SPS 2009.[15]

84. In compliance with ADB SPS 2009, the project's safeguard categories are as follows.

85. **Environment (Category B).** The additional financing shall support the original project in improving the health care services offered by PHC facilities in four provinces of Central, North Central, Uva and Sabaragamuwa. Adverse environmental consequences of the project will be largely restricted to output 1 which will continue to support renovation and refurbishment of selected PHC under the ongoing project and improvements to nine BHs identified within above four provinces which shall be improved as apex hospitals to provide more effective and efficient health care service. Proposed improvements to the ambulance service under JFPR grant shall not create any significant adverse environmental impact.

86. An updated Environmental Assessment and Review Framework (EARF) is available for the project to guide in screening, categorizing, and preparation of required environmental assessment reports for the subprojects under the additional financing. An Initial Environmental Examination (IEE) Report including an Environmental Management Plan (EMP) and Environmental Monitoring Plan (EMoP) has been prepared based on preliminary designs for the proposed improvements within the nine BHs, provision of oxygen plants and improvements to the ambulance service. The IEE shall be updated based on detailed design, incorporating audit findings and any corrective actions identified in the environmental audit of existing facilities prior to contract award.

87. Environmental impacts of the construction phase will be typical construction-related issues such as dust, noise, waste disposal, sourcing of construction material, occupational health and safety, etc. Some of the upgrading involves removal and disposal of asbestos roofs, for which guidelines for removing asbestos cement sheets has been included in the IEE report. An asbestos management plan shall be prepared by a competent person/contractor and incorporated into site specific environmental management action plans (EMAPs). Occupational health and safety issues, risks in operating the oxygen plants could be considered as the key issues during operational phase of the project.

88. In addition to the above, the MOH is responsible for ensuring that the project is implemented in compliance with laws applicable to health care waste management (HCWM), as specified in the EARF. Each health care facility will prepare its own HCWM plan (as part of the EMP process) which will be validated and endorsed by the provincial health services and the central ministry. The health care waste management plan will also address training needs of hospital staff and the financial allocations necessary for its implementation. For all kinds of civil works, the implementing agency will ensure that mitigation measures related to environment are incorporated in the tender documents.

[15] ADB. 2009. *Safeguard Policy Statement*. Manila

89. The Grievance Redress Mechanism (GRM) implemented in the ongoing project shall continue into the additional financing project. Details are in **Annex 9** of this PAM.

90. **Involuntary resettlement (category C).** The additional financing will not require land acquisition. The civil works related to construction of new buildings and reconstruction/ refurbishment of existing government health facilities are limited to the available land within these health facilities owned by the Ministry of Health and which will not result to any involuntary resettlement (IR) impacts. The ambulance stations that will be renovated are within the police stations which are government owned land. Therefore, the renovation works will not have any IR impacts as well. An IR screening checklist is included in the EARF to screen each subproject after the completion of detail designs to confirm any IR impacts.

91. **Indigenous Peoples (category C).** The proposed project activities are confined to existing health care facilities which are government owned land and are not located within or near the Indigenous Peoples (IPs) domain. The proposed activities will not have any adverse impact on IPs and their communities. The interventions do not directly target IPs as a group, but individual IPs may benefit from seeking medical assistance from these hospitals.

VIII. GENDER AND SOCIAL DIMENSIONS

92. The project aims to strengthen the provision of PHC to identified vulnerable groups living in geographically remote areas of Sri Lanka, thereby, addressing regional disparities within the country. The project is categorized *effective gender mainstreaming* (EGM) to address issues related to gender inequality and inequity among women and men and for achieving positive health outcomes and universal human rights. These are to be achieved through the adoption of a gender transformative approach, design and implementation of policies and programs that recognize the importance of gender equality and women's empowerment.

93. The beneficiaries of the proposed project are users of public health services in the selected provinces. At a macro-level, these provinces were selected for the relatively high number of 'hidden poor' who face multiple (income and non-income) deprivations. Human development indicators for the region are not on par with national averages. Inability to access services and sub-optimal utilization (owing to limitations in existent physical facilities) has contributed to poor health outcomes. Multiple sub-components of this action support improvements in social welfare and protection. Its target of vulnerable groups using a multidimensional poverty lens heightens the focus on vulnerable population. The project focuses on rebuilding /upgrading infrastructure, provision of a combination of medical and non-medical equipment and supplies, systems strengthening, behavior change communication and support to policy development, to improve outcomes for the poor across both preventive and curative care. The project will address development and long- term poverty reduction through a 'package of complementary services' infrastructure development, and provision of supplies. This action will support human development at multiple levels—household, community, and district—enhancing productivity and their ability to contribute to the local economy.

94. Gender norms, roles and relations have influenced health of both men and women differently. Women's gender roles have expanded to include productive roles which were traditionally men's, leading to an increase in the work burden of women, affecting their health and nutrition and that of the family. Further, in the plantation sector cultural norms and food habits adversely affect child and maternal nutrition. In addition, both women and men spend long hours in the field exposing them to number of occupational health hazards. The timely utilization of PHC

facilities and family planning services by men and youth remained a major challenge, due to patriarchal norms and attitudes. High prevalence of gender-based violence (GBV) in the communities and inadequate staff capacity and structures at the primary level have resulted in the continuation of the issue. The lack of gender disaggregated data in the current e-Health surveillance system has affected its efficiency.

95. Further, to address issues such as GBV, a national resource pool comprising of gender experts will be established by the Gender and Women's unit of the Family Health Bureau. The body will provide technical inputs in the development of capacity for PHC staff. A dedicated capacity development program in the context of GBV will be implemented to strengthen the capacities of health staff. The project plans to introduce new guidelines to Public Health Inspectors (PHIs) to address occupational health issues faced by both women and men engaged in field-based occupations. Approaches to engagement men and boys in promoting gender equality will be piloted and established. Gender disaggregated data will be included in e-Health surveillance system to strengthen the capacity of the health and disease surveillance mechanisms. The activities outlined in the GAP will be supervised and executed by different entities of the Ministry of Health (MOH), Project Management Unit (PMU), the four Project implementation Units (PIUs) in the target provinces. The focal point for the implementation of the GAP will be the Gender and Women's Health unit, Family Health Bureau (FHB) of the MOH. The resource persons for the implementation of planned activities will be from the Health Promotion Bureau (HPB), Education, Training and Research Unit (ETRU), Epidemiology Unit, the four PDHS and the respective Planning units, the nine RDHS and all Medical Officers of Health in the nine districts.

96. **Gender and social dimensions monitoring.** The responsibility for monitoring output and activity related indicators of the gender action plan lies with the MOH and the Project Implementation Units. Quarterly reports on progress are required to be submitted covering the activities in the work plans of the Gender and Women's Health unit, FHB, HPB, the Education, Training and Research Unit (ERTU), Epidemiology Unit, respective planning units, the nine RDHS and the medical officers of health.

97. The prevalence of HIV/AIDS in Sri Lanka is low and does not warrant a dedicated focus in the context of the project. There are no social risks identified a part of the intervention which is centered on reconstruction of PMCUs/DHs and an allied package of services. In line with a C categorization for IR and IP a C and P plan was not initiated; noting however, that mechanisms are in place for continued due diligence and reporting; oversight for which is vested in the PMU and designated safeguard consultants.

98. **Labor issues**. Core labor standards will be implemented. Workers hired will have: (i) written terms of employment, (ii) equal wages for work of equal value, (iii) women's and men's wages are paid directly to them with distribution of pay slips, and (iv) not employ children or forced labor.

99. **Gender Action Plan.** In the original GAP, out of 17 targets, 1 has been completed and 6 are ongoing, and out of 12 activities, 4 are ongoing. Several activities have yet to begin, and the PMU require additional human resources to fully and effectively implement the GAP. PMU will recruit a gender officer with experience in working with men and boys to promote gender equality to complete remaining activities. The GAP is carried out as part of a requirement of ADB gender policy for 2020. This will enable the Ministry to mainstream gender into its project activities. The focal point for the activities will be the Gender and Women's Health unit, Family Health Bureau of the MOH and the activities will be supported by the PMU, and the four PIUs in the four target provinces (Central, North Central, Sabaragamuwa, and Uva), the Health Promotion Bureau,

Education, Training and Research Unit, Epidemiology Unit, the four Provincial Directors of Health (PDHS) and the respective Planning units, the nine Regional Directors of Health Services (RDHS), the Planning units of the districts and all Medical Officers of Health in the nine districts. The PMU will submit quarterly updates of GAP implementation to ADB.

Table 16: Gender Action Plan

Activities	Targets and Indicators	Responsible Agency	Timeframe
Output 1: Primary and secondary health care services enhanced in Central, North Central, Sabaragamuwa, and Uva provinces			
1.1 Incorporate gender responsive construction features into all upgraded or renovated PMCUs and divisional hospitals	1.1.1 At least 80% PMCUs and divisional hospitals upgraded or renovated under the project have separate toilets for male and female patients 1.1.2 All cluster linked facilities have gender responsive designs with facilities for privacy during patient examination and for changing clothes (Baseline: less than 10%)	PIU	By 2025
1.2 Integrate gender-responsive and inclusive PHC services with the implementation of the essential service package for outpatient and clinic services in the nine newly established clusters	1.2.1 At least 90% of cluster linked facilities in target provinces provide a gender responsive and inclusive essential services (Baseline: 0) 1.2.2 All staff in cluster linked facilities are trained on gender sensitivity and responsiveness when providing essential services (Baseline: 0) 1.2.3 Over 75% of women and men are reporting satisfaction over the gender response health care services provided at PHC facilities	PIU and/or gender expert	By 2025
1.3 Increase the utilizations of the PHC facilities by women and men	1.3.1 BCC campaign strategy and materials (such as leaflets, video clips, and/or street dramas) developed and implemented. 1.3.2 Use of PHC facilities is increased by 20% each for women and men	PIU, communication expert, gender expert	By 2025
1.4 Encourage Establish partnerships with local organizations for gender responsive and inclusive services at the PHC level	1.4.1 At least 30% of the medical officer of health areas will establish partnerships with local organizations for encouraging male participation in PHC utilization (Baseline: 0) 1.4.2 Annually at least 10 awareness creation sessions for local organizations conducted on the advantages of PHC utilization for encouraging male participation 1.4.3 At least 75% of medical officer of health areas are provided with gender responsive and inclusive nutrition services	PIU, FHB, gender expert	By 2025
1.5 Strengthen male engagement to promote reproductive health, maternal and child health/nutrition, PHC, and diminish violence against women	1.5.1 A male engagement approach is designed to promote reproductive health, maternal and child health, nutrition, PHC for men, and diminish violence against women 1.5.2 At least 50 health officials and/or local organizations who can transfer knowledge to men at PHC facilities trained in TOT programs 1.5.3 Over 1,500 men reached through training and awareness	PIU, gender expert	By 2025
Output 2: Health information system, disease surveillance capacity, and COVID-19 response strengthened			
2.1 Provide sex-disaggregated data in health information systems	2.1.1 Sex-disaggregated data included in the eRHMIS and Annual Health Bulletin of FHB (Baseline: 0) 2.1.2. Sex-disaggregated data included in the e-Health surveillance system on the 29 notifiable diseases in Sri Lanka (Baseline: 0)	FHB, Gender and Women's Health Unit and Epidemiology Unit	2022

Activities	Targets and Indicators	Responsible Agency	Timeframe
	2.1.3 Sex-disaggregated data analyzed, and gender related health issues identified for programming in the FHB and Epidemiology Unit (Baseline: 0)		
Output 3: Policy development, capacity building, and project management supported			
3.1 Integrate gender mainstreaming into all operation policies and guidelines developed for health sector	3.1.1 A team of experts on health and gender are consulted during the preparation of policies 3.1.2 Comments of the expert/s are documented and incorporated. 3.1.3. All medical health officers and relevant officials are sensitized on the revised operational policies.	PIU/FHB, gender expert	By 2025
3.2 Integrate gender dimensions into policies and strategic plans of the FHB and the existing package for newly married couples	3.2.1 By 2023, operational guidelines with gender dimensions are developed for delivering a comprehensive package of PHC, and management and functioning of cluster hospitals 3.2.2 By 2022, 11 units of the FHB of the ministry that have integrated gender dimensions into all their policies and strategic plans (Baseline: 0) 3.2.3 By 2022, the package for newly married couples is reviewed and finalized 3. 2.4 By 2024, nine advocacy workshops conducted as one per district (nine districts) with registrars of marriages (Baseline: 0)	FHB, Gender and Women's Health Unit	2019–2025
3.3 Conduct a gender training needs assessment to identify training gaps, develop a gender TOT module and roll out a training program for the PHC staff	3.3.1 By 2021, a gender expert recruited 3.3.2 By 2021, a gender training needs assessment conducted and a TOT training module for PHC staff developed (Baseline: 0) 3.3.3 By 2022, nine TOTs on gender conducted as one per district (at least 40% women) (Baseline: 0) 3.3.4 At least 30% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in the target provinces with increased knowledge on PHC (family medicine). (2018 baseline: 0)	Gender and Women's Health Unit of the FHB, gender expert	2019–2025
3.4 Introduce an updated training program on gender sensitive nutrition counselling and PHC	3.4.1 At least 75% of PHMs trained on gender sensitive nutrition counselling program (Baseline: 0) 3.4.2 At least 30% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in target provinces with increased knowledge on gender sensitivity, and gender related policies and interventions (2018 baseline:0)	Gender and Women's Health Unit of the FHB, gender expert	2025
3.5 Strengthen the capacity of PHMs and PHIs respond to GBV	3.5.1 The life skills training course for PHMs and PHIs is gender mainstreamed 3.5.2 A basic family counselling module developed for PHMs and PHIs (Baseline: Not available) 3.5.3 75% of PHMs and PHIs trained on life skills and family counselling (at least 50% women) (Baseline: 0)	Gender and Women's Health Unit of the FHB	2019–2025
3.6 Address occupational health issues faced by men and women engaged in precarious work.	3.6.1 New guidelines developed for field-based staff to address occupational issues faced by men and women engaged in unskilled labor and high risk occupations including those in tea plantations.	Gender and Women's Unit of the FHB	2023

BCC = behavior change communication, eRHMIS = electronic reproductive health management information system, ESP = essential services package, FHB = Family Health Bureau, GIS = geographic information system, GBV = gender-based violence, MOH = medical officer of health, NGO = non-government organization, PHC = primary health care, PHM = public health midwife, PHI = public health inspector, PIU = project implementation unit, PMCU = primary medical care unit, TOT = training of trainers.
Source: Asian Development Bank.

IX. PERFORMANCE MONITORING, EVALUATION, REPORTING, AND COMMUNICATION

100. The original project and the additional financing both support vulnerable geographical areas in Sri Lanka to achieve three main outputs defined by a set of performance indicators. The design and monitoring framework (DMF) (**Annex 1**) which summarizes the project result will guide the overall project throughout. The aggregate impact of the original and the additionally financed projects continue to be aligned with the original project impact: a healthier nation ensured with a more comprehensive primary health care (PHC) system. Similarly, the project outcomes continue to ensure that efficiency, equity, and responsiveness of the PHC system is improved. The project outcome of the additional financing will continue to be measured via the original project outcome indicators; (I) outpatient utilization at PHC facilities (Primary Medical Care Units and Divisional Hospitals) (disaggregated by age, sex, place of residence, district, and province) increased by at least 20%, (ii) patients reporting knowledge of and satisfaction with PHC services (disaggregated by age, sex, district) increased by at least 20%, (iii) notifiable diseases notified by cluster linked hospitals to the medical officers of health offices, within the stipulated time, in the target provinces increased to at least 90%, and (iv) cluster system reform implemented and evaluated in all nine clusters.

101. The original project and the additional financing intend to improve the efficiency, equity, and disease surveillance capacities of the health system through (i) strengthening PHC in the target provinces; (ii) strengthening health information system and disease surveillance capacity; and (iii) supporting policy development, capacity building, and project management.

A. Monitoring

102. **Project performance monitoring.** The PMU at central level will be entrusted with the monitoring responsibility while PIUs at provincial level assisting the PMU by providing necessary data. The PIUs will collect analyze and share information specific for provinces. PMU has the responsibility of tracking progress in terms of specific indicators defined in the DMF and guiding the project for smooth implementation and sustainability. Information generated in the monitoring process will identify gaps in the primary care service provision which are useful in improving the project performance.

103. Indicators specified in the M&E framework are measured by existing secondary data sources of the health sector and by primary data collection from health facilities and from households. The proposed electronic health information system of the original project and GIS system will synergize the monitoring process by providing real time data at the latter 3 years of the project. Micro data sets from the Department of Census & Statistics will also be accessed. An independent firm will carry out baseline and end -line surveys to generate sex-disaggregated, socio economic and health related data for monitoring.

104. Data pertaining to maternal health, nutrition and notifiable disease investigation will be retrieved from National health information system (HIS) which is an integral part of the government health care delivery framework. It is designed to provide uniform set of data to the whole government health sector. Provincial level administrative data available in provincial director's office will provide data necessary to produce indicators on infrastructure, services availability and human resources in primary health care facilities.

105. However, national HIS has drawbacks in producing timely data, capturing private health care utilization data and provision of disaggregated data for sex, urban, rural and estate strata.

Certain data necessary to monitor the original project such as functionality of electronic health information system, the cluster related information, are also not being captured by the national HIS. Hence, an independent research firm or institute will be hired to conduct baseline and endline surveys which will provide comprehensive picture of the project's target achievements and impact evaluation.

106. The survey team will conduct household surveys and health facility surveys using quantitative methodology. Household survey will be carried out using Grama Niladhari (GN) divisions included in the vulnerability mapping as the sampling frame. List of primary care institutions and field health clinics planned to be improved by the project will be the sampling frame for the health facility survey. The GIS tool will be utilized in the sampling procedure[16] to identify catchment areas of selected health facility. Information gathered out of these surveys will be used to i) track progress and to provide feedbacks, ii) evaluate impact of the project at community level in terms of improved utilization, behavior change, comprehensiveness of primary care and reduction of health expenditure (iii) improvements in health seeking behavior and outcomes iv) evaluate the project sustainability, replicability and post project asset management.

107. Field visits, review meetings and missions arranged by the PMU will routinely collect data for monitoring. Check lists will be designed to retrieve data during these activities. Data will be useful in monitoring physical progress, financial progress and procurement status of the project.

108. **Compliance monitoring.** The status of compliance with loan covenants (financial, safeguards, and others) will be monitored and reported in the progress report and during ADB review missions. Any non-compliance issues will be specified in the quarterly progress reports together with remedial actions.

109. The *ADB Safeguard Policy Statement* (SPS) 2009 serves as the overarching policy guidance on environment, safeguards and related compliance monitoring. National building/ construction laws and ADB edicts such as equitable wages and zero child labor will be built into the bid documents with the PIUs checking for implementation compliance. As per the SPS 2009 for category B projects, initial environmental examinations will be conducted for all developments with the potential to cause adverse environmental, health and safety risks.

110. **Safeguards monitoring and evaluation.** The PMU at the central level and PIUs at the provincial level will manage screening, evaluation, and reporting of environmental and social safeguard measures at site level with the support of assigned safeguards consultants and oversight by the PIU Project Engineers and MOH. These measures shall comply with the EMPs for civil works which will be included in the bid documents. Areas of concern on impacts of ongoing works and projected work streams will be included in monitoring reports. For environmental safeguards, submission of monitoring reports shall be semiannual during the construction phase and annual during the operations phase until a project completion report is issued. For social safeguards, a section on social safeguards implementation shall be included in the environmental monitoring report. The reports shall be prepared by the PMU and submitted within 30 days from the end of each reporting period to ADB for review and disclosure. The monitoring reports shall be disclosed on the MOH website as well. The midterm and project completion report will contain dedicated sections on both social and environment safeguards.

111. **Gender and social dimensions monitoring.** The GAP highlights the following main areas

[16] Stratification will look at variables such as peri-urban, rural, estate, staffing (optimum/ below average), connectivity, those used by a large cohort of poor/vulnerable, ethnic groups etc.

to focus in gender mainstreaming: (i) strengthening health sector capacities to address gender issues, (ii) improving primary care facilities to provide gender services with good coordination and continuity, (iii) development of male engagement strategies in primary care and preventive care, (iv) design and implementation of gender and ethnic sensitive behavior communication strategies, and (v) reduction of inequalities in sex-disaggregated health indicators. The responsibility for monitoring output and activity related indicators of the GAP lies with the MOH and the PIUs. Quarterly reports on progress are required to be submitted covering the activities in the work plans of the Gender and Women's Health unit, Family Health Bureau, Health Promotion Bureau, the Education, Training and Research Unit, Epidemiology Unit, respective Planning units, the nine Regional Directors of Health Services (RDHS), and the Medical Officers of Health. Information retrieved from quarterly reports will update indicators defined in the GAP.

B. Evaluation

112. An inception mission will be scheduled shortly after loan effectiveness.[17] Implementation review missions will be held every 3 to 6 months. A midterm review is scheduled midway into the project.

113. Results of the baseline survey of households and health facilities carried out during the first 6 months of the project will serve as the project's baseline indicators. Endline survey of households and health facilities will assess project outcomes and impact.

114. Within 6 months of physical completion of the project, MOH will submit a project completion report (PCR) to ADB, according to ADB guidelines. A Project Performance Evaluation Report (PPER) based on documentations and field surveys will be prepared complying with ADB guidelines. The overall project will be rated on (i) relevance, (ii) effectiveness, (iii) efficiency, and (iv) sustainability as per ADB guidelines.

C. Reporting

115. MOH will provide ADB with (i) quarterly progress reports in a format consistent with ADB's project performance reporting system; (ii) consolidated annual reports including (a) progress achieved by output as measured through the indicator's performance targets, (b) key implementation issues and solutions, (c) updated procurement plan, and (d) updated implementation plan for the next 12 months; and (iii) a PCR within 6 months of physical completion of the project. To ensure that projects will continue to be both viable and sustainable, project accounts and the executing agency audited financial statement together with the associated auditor's report, should be adequately reviewed.

D. Stakeholder Communication Strategy

116. The project will comply with the policy of transparency and accountability of the Access to Information Policy of the ADB. To facilitate this, the project will develop and implement a communications strategy that will ensure an efficient and continuous two-way communication about the additional financing project and the ongoing ADB-financed Health System Enhancement Project with all stakeholders. Efforts will be taken to focus on managing stakeholders' expectations during all phases of the project implementation.

117. Based on the ADB public communication policy and ADB safeguard policy statement, the

[17] Online meetings will be considered if quarantines due to COVID-19 persist.

project will assist the executing agency to prepare a stakeholder communication strategy. To ensure effective communication with stakeholders and to supplement the project outcome, the project will adopt following strategies: (i) delivery of timely project information to all levels of stake holders in culturally appropriate and gender sensitive manner; (ii) secure a two-way flow of information sharing and consultation between project implementers and relevant stake holders; (iii) develop capacities of the project staff in handling stake holder communication; and (iv) support sustained information, education and advocacy about the project to foster positive public behavior change. Key stakeholders of the project include project beneficiaries, MOH, Provincial Councils, civil servants, plantation managers, Epidemiology Unit, FHB, Health Promotion Bureau, Education training and research unit of the MOH, Quarantine Unit of MOH, academia, civil society, and the media.

118. In the provision of timely information, quarterly reports, annual reports, survey reports, PCR, and PPER will be made available on the project website. Reports in printed form will also be disseminated among key stake holders. The PAM will be posted on the ADB website. Project description summary and data sheets, including timetable, status, project safeguard documents and implementation progress, will also be posted on ADB website and be translated into Sinhala and Tamil to be disseminated locally in printed format. These activities will ensure transparency and accountability of information.

119. Stakeholder feedbacks are encouraged in stake holder meetings, hospital civil society meetings and during review activities. Patient satisfaction surveys routinely carried out in health care institutions will be utilized to obtain feedbacks from project beneficiaries. Stakeholders will have communication access through ADB website and project website which will serve as the main information sharing channel. Direct communication with PMU and PIU is also possible for public and other stake holders. A grievance redress mechanism has been established for the project and will be the same mechanism that will be used under the additional financing.

120. Project staff including PMU and PIU staff will receive a short training on stakeholder communication. Subsequently, the trained staff will act as mediators of communication. Constant awareness activities and regular advocacy forums will help all stakeholders to better understand the project.

X. ANTICORRUPTION POLICY

121. ADB reserves the right to investigate, directly or through its agents, any violations of the *Anticorruption Policy* (1998, as amended to date) relating to the project.[18] All contracts financed by ADB shall include provisions specifying the right of ADB to audit and examine the records and accounts of the executing/implementing agency and all project contractors, suppliers, consultants, and other service providers. Individuals and/or entities on ADB's anticorruption debarment list are ineligible to participate in ADB-financed, -administered or -supported activities and may not be awarded any contracts under the project.[19]

122. To support these efforts, relevant provisions are included in the loan agreements and the bidding documents for the project. ADB's Anticorruption Policy was explained to and discussed with the government and MOH. The risks and mitigation measures identified focused on anticorruption and integrity are provided in Table 17.

[18] ADB. 1998. *Anticorruption Policy.* Manila.
[19] ADB Anticorruption Sanctions List. http://sanctions.adb.org

Table 17. Corruption and Integrity Risks and Mitigation Measures

Risk Description	Rating	Mitigation Measures	Responsibility
Procurement Overall procurement delayed due to numerous COVID related ad-hoc procurement transactions in health sector	M	Project engaging with UNOPS and UNICEF to expedited procurement.	PMU and MOH
Delayed delivery of medical equipment due to global pandemic.	M	Project engaging with UNOPS and UNICEF for fast delivery	PMU and MOH
Governance Possible integrity issues might be encountered during procurement, distribution, allocation, and administration contracts during project implementation.	M	ADB's Anticorruption Policy and whistle blowing mechanisms will be introduced to MOH Units, MSD, SPC, and PMU staff engaged under the project to ensure that they are equipped with sufficient knowledge and aware of the policy from the very early stage of project implementation. The project National Steering Committee provides oversight and supervision for the project, and the National Audit Office will conduct both financial and performance audits of the project on a regular basis. ADB under its technical assistance will conduct integrity knowledge management sessions for MOH/MSD/PMU and other project stakeholders to increase the awareness and compliance with ADB's Anticorruption Policy.	MOH, MSD, SPC, PMU and ADB

ADB = Asian Development Bank, COVID-19 = coronavirus disease, M= moderate, MOH = ministry of health, MSD = medical supply division, PMU = project management unit, SPC = State Pharmaceuticals Corporation of Sri Lanka, UNICEF = United Nations Children's Fund, UNOPS = United Nations Office for Project Services
Source: Asian Development Bank.

123. The project incorporates several specific anticorruption measures, including (i) strict financial management with full adherence to monitoring and reporting systems; (ii) strict compliance with local laws and procurement regulations/ guidelines published by the Department of Public Finance; (iii) the financial audit by the Auditor General's office of all subprojects; and (iv) random and independent spot checks of implementation by ADB. Furthermore, PMU will maintain a project webpage that will be updated regularly and will include (i) bidding procedures, bidders, and contract awards; (ii) use of funds disbursed under the project; and (iii) physical progress.

XI. ACCOUNTABILITY MECHANISM

124. People who are, or may in the future be, adversely affected by the project may submit complaints to ADB's Accountability Mechanism. The Accountability Mechanism provides an independent forum and process whereby people adversely affected by ADB-assisted projects can voice, and seek a resolution of their problems, as well as report alleged violations of ADB's operational policies and procedures. Before submitting a complaint to the Accountability Mechanism, affected people should make an effort in good faith to solve their problems by working with the concerned ADB operations department. Only after doing that, and if they are still dissatisfied, should they approach the Accountability Mechanism.[20]

XII. RECORD OF CHANGES TO THE PROJECT ADMINISTRATION MANUAL

125. During the loan negotiation, the government informed ADB that, as per the directions of Sri Lanka's Cabinet of Ministers as part of its approval to proceed with negotiations, it is desirable that additional resources be made available under the project for the purposes of supporting the government's COVID-19 pandemic response. In this regard, ADB clarified that, during implementation of the project, the government and ADB can discuss from time to time the processing of changes to the project to include additional support for Sri Lanka's response to the COVID-19 pandemic as the situation evolves, including the possible financing of additional medical supplies and equipment. This may include utilization of the unallocated (contingency) funds under the project, and potential reallocation of loan savings as it relates to the amounts allocated for civil works, consulting services and the PHC Innovation Fund, for purposes of supporting COVID-19 emergency response. The ADB noted that minor changes to the project can be approved in an expedited manner.

126. All revisions and/or updates during the course of implementation shall be retained in this section to provide a chronological history of changes to implemented arrangements recorded in the PAM, including revision to contract awards and disbursement S-curves.

Revisions	Date	Revisions
First revision	October 2021	Updated Table A2.2: List of Field Health Centers for Civil Works Development

[20] ADB Accountability Mechanism. http://www.adb.org/Accountability-Mechanism

ANNEX 1: REVISED DESIGN AND MONITORING FRAMEWORK

The revised design and monitoring framework strikes out content for deletion and underlines content to be added.

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**	**Data Sources and Reporting Mechanisms**	**Risks and Critical Assumptions**
Outcome Efficiency, equity, and responsive-ness of the PHC system improved	By ~~2024~~ 2026 for all indicators: a. Outpatient utilization ~~(for each female and male)~~ at PHC facilities (PMCUs and ~~district~~ divisional hospitals) (disaggregated by age, sex, place of residence, district, and province) increased by at least 20.0% (~~2015~~ 2021 baseline: ~~62% for both sexes [sex-disaggregated data to be collected in baseline survey]~~ 28.4% of females and 22.0% of males)[b] (OP 1.1 and OP 1.1.2)	a. Annual health bulletins published by ~~MOHNIM~~ MOH (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, and district) increased ~~to~~ by at least 20.0% ~~(disaggregated by age, sex, district)~~ (~~2018~~ 2021 baseline: 28.5% of females and 19.5% of males reported knowledge of PHC services, and 61.0% of females and 63.2% of males reported satisfaction with PHC services)[b] (OP 1.1)	b. Baseline and endline surveys	
	c. Notifiable diseases[bc] notified by cluster linked hospitals to the medical officers of health offices, within the stipulated time, in the target provinces increased to at least 90% (2018 baseline: Not available) (OP 6.1)	c. Routine data from a 25% sample of cluster linked medical officers of health areas in the provinces	
	d. Cluster system reform implemented and evaluated in all nine clusters[cd] (2018 baseline: 0) (OP 5.1.3 and OP 6.2)	d. Evaluation report at end of project	
	e. The average response time of 1990 Suwa Seriya ambulance system in all districts reduced by 25% (2021 baseline: 11 minutes 41 seconds) (OP 5.1.3 and OP 1.1.2)	e. MOH data	
Outputs 1. ~~PHC~~ Primary and secondary health care enhanced in Central,	1a. By ~~2023~~ 2025, PMCUs and ~~district~~ divisional hospitals in target provinces upgraded and renovated with gender responsive designs[de] reached at least ~~30%~~ 40% (2018 baseline: 0) (OP 2.3.2, OP 3.1 and OP 6.1)	1a. PMU, project implementation unit, and planning unit data	

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
North Central, Sabaragamuwa, and Uva provinces	1b. By ~~2023~~ 2025, gender responsive and inclusive essential service package for outpatient and clinic services provided by at least 75% of PHC facilities supported in target provinces (2018 baseline: 0) (OP 1.1.2, OP 2.2.2, OP 5.1.3 and OP 6.2))	1b. PMCU and ~~district~~ divisional hospital data records and routine provincial administrative data	
	1c. By ~~2023~~ 2025, gender responsive and inclusive nutrition services provided in at least 75% of cluster linked medical officer of health areas (2018 baseline: 0) (OP 1.1.2, OP 2.2.2, OP 5.1.3 and OP 6.2)	1c. Medical officer of health data records and routine provincial data	
	1d. By 1 July 2024, a gender sensitive behavior change communication plan to increase PHC utilization initiated by all target provinces (2018 baseline: Not available) (OP 2.3.2)	1d. Health Promotion Bureau, PMU, and provinces to monitor agreed interventions; baseline and endline surveys	
2. Health information system, ~~and~~ disease surveillance capacity, and COVID-19 response strengthened	2a. By ~~2023~~ 2025, electronic patient information sharing system across cluster facilities used by at least 25% of PMCUs and ~~district~~ divisional hospitals and medical officers of health areas in all target provinces[f] (2018 baseline: 0) (OP 6.1)	2a.–b. Provincial administrative data; data to be reported by the PMCUs and ~~district~~ divisional hospitals using the new data format developed for target provinces and districts	Further surge in COVID-19 cases leads to more lockdowns and delays timely delivery of some medical equipment and furniture.
	2b. By ~~2023~~ 2025, notifiable disease surveillance information via an electronic system sent to medical officers of health areas by at least 25% of PMCUs and ~~district~~ divisional hospitals in target provinces[f] (2018 baseline: 0) (OP 6.1)		
	2c. Core capacities to carry out quarantine services increased 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) (OP 6.2)	2c. ~~MOHNIM~~ MOH quarantine unit administrative data; joint external evaluation report 2021/2022 (or whenever next available)	
	2d. By December 2020, capacity to screen and diagnose COVID-19 (infectious diseases) increased by 90% from the baseline (April 2020 baseline: 4,000) (OP 6.2 and OP 7.3.3)	2d. ~~MOHNIM~~ MOH data	
	2e. By 2025, at least 25% of secondary and tertiary level hospitals' capacity to treat and	2e. Routine data from MOH, Medical	

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
	manage COVID-19 patients upgraded[g] (2021 baseline: 0) (OP 6.2)	Supplies Division, Bio Medical Services Unit, and PMU progress reports	
	2f. By 2025, the 1990 Suwa Seriya ambulance system in all districts upgraded[h] (2021 baseline: Not upgraded) (OP 1.1.2)	2f. 1990 Suwa Seriya Foundation data	
3. Policy development, capacity building, and project management supported	3a. By ~~2023~~ 2025, operational policies and guidelines with gender dimensions are completed for (i) delivering a comprehensive package of PHC (incorporating the essential service package), (ii) management and functioning of cluster hospitals, and (iii) geographic information system based planning and monitoring in health sector (2018 baseline: Not available) (OP 2.3.2, OP 6.2.1)	3a.–b. ~~MOHNIM~~ MOH Planning Unit and Family Health Bureau administrative data	~~Delay in approval and implementation of national policy and management reforms~~
	3b. By 2020, 11 units of Family Health Bureau have integrated gender dimensions into all their policies and strategic plans (2018 baseline: 0) (OP 2.3.2)		Changes in the administrative procedures because of COVID-19 restrictions limits participation in planned training or delays completion of some policies.
	3c. By ~~2023~~ 2025, at least ~~25%~~ 30% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in target provinces ~~are trained~~ with increased knowledge in PHC (family medicine) (2018 baseline: 0) (OP 6.1.1)	3c. ~~MOHNIM~~ MOH Education, Training, and Research Unit administrative data	
	3d. By ~~2023~~ 2025, at least ~~25%~~ 30% of PHC staff from PMCUs, divisional hospitals, and medical officer of health areas (of whom 35% are women) in the target provinces ~~are trained~~ with increased knowledge in gender sensitivity, and gender related policies and interventions (2018 baseline: 0) (OP 6.1.1)	3d. Provincial administrative data	
	3e. By 2025, National Institute of Health Sciences upgraded and renovated to provide distance learning to provinces and district-based staff (2021 baseline: Not upgraded) (OP 6.2)	3e. PMU progress reports	

Key Activities with Milestones

1. **~~PHC~~ Primary and secondary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces**

1.1 Complete civil works for developing physical infrastructure in selected PMCUs (43 ~~PMCUs and district hospitals~~ in round 1 under the original project, 50 in round 2 under the original project, and 42 under additional financing PMCUs) and divisional hospitals (round 1 under the original project completed by Q3 2021, round 2 under the original project completed by Q3 2022, and additional financing round completed by Q1 2023).

1.2 Complete physical infrastructure designs for all PMCUs, divisional hospitals, field health centers, and nine base hospitals ~~facilities~~ (~~Q4 2019~~ completed by Q3 2022).
1.3 Complete civil works of the nine base hospitals (completed by Q4 2024).
1.4 Complete the provision of medical equipment to PMCUs, ~~and district~~ divisional hospitals, and nine base hospitals (first round under the original project completed by Q4 2021, second round under the original project completed by Q1 2023, and additional financing round completed by Q4 2024).
1.5 ~~Develop physical infrastructure in selected field health centers (Q2 2021)~~ (incorporated into 1.2).
1.6 Provide (replace) vehicles for PHC services (completed by ~~Q2 2019~~ Q31 2022).
1.7 Finalize the communications strategy and terms of reference for the behavior change communication marketing firm and the nutrition firm (Q4 ~~2019~~ 2020) (completed).
1.8 Award at least one innovative project by cluster via the PHC innovation fund financed under the original project (Q4 2019) (completed).
1.9 Award at least one innovative project by cluster via the PHC innovation fund financed under additional financing (Q4 2021).
1.10 Select the construction supervision consultancy firm for nine base hospital construction repairs and renovations (Q1 2022).
2. **Health information system, ~~and~~ disease surveillance capacity, and COVID-19 response strengthened**
2.1 Finalize the rollout plan to introduce the health information system to nine cluster hospitals (Q1 2020) (completed).
2.2 Establish geographic information system units in provinces and districts (Q4 ~~2019~~ 2022).
2.3 Design and layout local area internet connection and purchase computers and peripherals for two clusters in phase 1 and seven clusters in phase 2 (~~Q2 2020~~ phase 1 completed by Q3 2022 and phase 2 initiated by Q2 2023).
2.4 Provide the equipment and vehicles for ports of entry under the original project (round 1) and for two additional ports of entry under additional financing (round 2) (~~Q2 2019~~ round 1 completed in Q1 2021 and round 2 completed by Q3 2022).
2.5 Complete first round of training for quarantine teams (Q4 2019) (completed).
2.6 Conduct second round of training for quarantine teams (completed by Q3 2025).
2.7 Engage an individual consultant to carry out an International Health Regulations-related legal review (Q2 2019) (completed).
2.8 Procure essential medical equipment and consumables to combat COVID-19 pandemic under the original project reallocation (Q2 ~~2020~~ 2021) (completed).
2.9 Establish polymerase chain reaction testing laboratory at Mulleriyawa Base Hospital, Colombo east (Q2 2020) (completed).
2.10 Establish molecular biology laboratory at national infectious disease hospital, Colombo (~~Q3 2022~~ Q4 2023).
2.11 Renovate and refurbish isolation facilities at ports of entry at Colombo and Trincomalee (~~Q2 2021~~ Q3 2022).
2.12 Hire transportation services for home care, quarantine, and intermediate care (Q4 2021).
2.13 Complete the first round of procurement of emergency medical equipment and furniture under additional financing (by Q3 2021).
2.14 Complete the second round of procurement of emergency medical equipment and furniture under additional financing (by Q1 2022).
2.15 Establish an oxygen concentration plant, wall oxygen outlets, and liquid oxygen tanks in selected secondary and tertiary hospitals in all nine provinces (by Q2 2022).
2.16 Support PCR laboratory testing and other equipment (Q4 2021).
2.17 Complete the procurement of ambulances for emergency medical services (50) and prehospital service (25) (by Q4 2022).
2.18 Complete the renovation of 20 ambulance stations (by Q4 2024).
2.19 Complete the procurement of training equipment for the training of prehospital staff (by Q3 2022).
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) (completed).
3.2 Hire consultant (local) to support policy development for cluster hospital reforms (Q1 2019) (completed).
3.3 Hire consultants (local) to review and monitor environmental and social safeguards (Q1 2019) (completed).

3.4	Develop the physical infrastructure and equip a distance learning center at the National Institute of Health Sciences in Kalutara and selected distance learning centers in nine provinces (Q2 ~~2020~~ 2023).
3.5	Complete regular training annually in relevant PHC areas (Q4 each year).
3.6	Conduct baseline (~~Q1 2019~~ completed in Q3 2021) and endline (~~Q1 2023~~ Q2 2025) surveys.
3.7	Recruit the consulting firm to develop and support e-learning modules (Q1 2022).
3.8	Hire consultant (local) to support the implementation of gender action plan (Q1 2022).
Inputs	
ADB: ~~$50~~ $163.0 million ($12.5 million Asian Development Fund grant, $37.5 million concessional ordinary capital resources lending, $110.0 million ordinary capital resources lending, and $3.0 million ADB-administrated Japan Fund for Poverty Reduction grant) ($113.0 million additional) Government of Sri Lanka: ~~$10~~ 20 million ($10 million additional)	

ADB = Asian Development Bank; COVID-19 = coronavirus disease; MOH = Ministry of Health; MOHNIM = Ministry of Health, Nutrition, and Indigenous Medicine; OP = operational priority; PHC = primary health care; PMCU = primary medical care unit; PMU = project management unit; Q = quarter.

[a] Government of Sri Lanka, MOHNIM. *Sri Lanka National Health Policy 2016–2025.* Colombo.

[b] Baseline figures are obtained from the preliminary results of the baseline survey. Because of the COVID-19 pandemic, the initiation of the baseline survey was delayed, and the survey was completed in July 2021. The updated baseline figures of outcome indicator "a" are much lower than the initially proposed figure, which is because the unit of initially proposed figure is household. As the outcome indicator "a" aims to capture the increase in the number of individuals using outpatient services at PHC facilities instead of household, the mismatch of unit of measurement has been corrected in the updated baseline figures.

[~~b~~c] Government of Sri Lanka, Ministry of Health, Epidemiology Unit. 2005. *Surveillance Case Definitions for Notifiable Diseases in Sri Lanka.* Colombo.

[~~c~~d] In each of the nine project districts, a cluster of PHC facilities will be functionally linked to one apex secondary care facility wherein provincial and regional health staff propose and implement strategies to strengthen PHC management for continuity of care.

[~~d~~e] Separate toilets for male and female patients; separate examination and changing areas for improved privacy.

[f] The adoption of an electronic patient information sharing system and notifiable disease surveillance information system, including the procurement of required hardware, will be implemented in a phased approach. The first phase will roll out the systems in two selected shared care clusters. The second phase of the rollout will be implemented in the remaining seven shared care clusters conditional to successful integration and implementation of the first phase following the clearance of initiating the second phase made by the project steering committee in consultation with ADB. The decision on whether the second phase will be initiated should be made before the midterm review of the project.

[g] The upgrade of secondary and tertiary level hospital capacity to treat and manage COVID-19 patients includes the provision of emergency medical equipment; increasing access to intensive care units, high dependency units, and emergency treatment unit beds; expanding access to oxygen; and procuring ambulances for home care.

[h] The upgrade of the 1990 Suwa Seriya ambulance system includes procuring 25 ambulances, renovating 20 ambulance stations, and developing locally appropriate protocols to create a real time link with ambulances and the receiving emergency treatment units in selected secondary and tertiary care hospitals.

Contribution to Strategy 2030 Operational Priorities:

Expected values and methodological details for all OP indicators to which this operation will contribute results are detailed in Contribution to Strategy 2030 Operational Priorities (accessible from the list of linked documents in Appendix 2 of the report and recommendation of the President).

Source: Asian Development Bank.

ANNEX 2: UPDATED LIST OF PRIMARY HEALTH CARE HOSPITALS TO BE DEVELOPED AND LIST OF FIELD HEALTH CENTERS TO BE RENOVATED UNDER THE ADDITIONAL FINANCING

Table A2.1: List of Primary Health Care Hospitals to be Developed

No.	Province	District	Hospital	Type (PMCU/DH)
1	Central	Kandy	Digana Rajawella	PMCU
2			Katugastota	DHA
3			Mrassana	DHB
4			Morahena	DHC
5			**Muruthalawa**	DH
6		Matale	**Muwandeniya**	DH
7			Dullewa	PMCU
8			**Aluthwewa**	PMCU
9		Nuwareliya	**Ginigathhena**	DHC
10			**Kandapola**	DHA
11			**Watawala**	DH
12			**Ragala**	PMCU
13			Hangarapitiya	PMCU
14	Uva	Monaragala	Kotiyagala	PMCU
15			Okkampitiya	DHC
16			Bakinigahawela	PMCU
17			Dewathura	PMCU
18			Buddhama	PMCU
19		Badulla	Kirkils	DHC
20			Spring Valley	DHC
21			Udaweriya	DHC
22			**Uraniya**	DHB
23			**Bathalayaya**	PMCU
24	Sabaragamuwa	Kegalle	**Karadupona**	DHC
25			**Algama**	PMCU
26			**Bulathkohupitiya**	PMCU
27			Undugoda	DHA
28			**Deraniyagala**	DHC
29			**Mahapallegama**	PMCU
30		Ratnapura	**Waddagala**	PMCU
31			**Pelmadulla**	DHC
32			**Beranduwa**	PMCU
33			**Kuruwita**	PMCU
34	North Central	Anuradhapura	Mahawilachchiya	DHC
35			Poonewa	PMCU
36			Rathmalgahawewa	DHC
37			Wahalkada	PMCU
38		Polonnaruwa	Weheragala	PMCU
39			Attanakadawala	DHC
40			Manampitiya	DHB
41			Jayanthipura	PMCU
42			**Bakamuna**	DHB

DH = district hospital, DHA = district hospital type A, DHB = district hospital type B, DHC = district hospital type C, PMCU = primary medical care unit,

Note: This list of 42 PMCUs coming under the additional financing is from the original 135 PMCUs. However, based on the requests received from provincial authorities, ADB fielded missions and after ensuring the compliance of all required eligibility criteria's set in the original loan, agreed to consider acceptable replacements, and updated the list of PMCUs. Nineteen (19) hospitals (in **bold**) have been newly introduced and have replaced 19 from the original 135 hospitals (original PAM).
Source: Asian Development Bank

Table A2.2: List of Field Health Centers for Civil Works Development (Revised as of 30 Sept 2021)

SN	Province	District	MOH Area	Field Health Center
1	North Central Province	Polonnaruwa	Dimbulagala	Bamunakotuwa
2			Walikanda	Mahasenpura
3			Thamankaduwa	Singhaudagama
4			Lankapura	Somapura
5			Hngurakgoda	Kithuluthuwa
6			Medirigiriya	Veheragala
7			Elahara	Nikapitiya
8		Anuradhapura	Mihinthale	Katukeliyawa
9			Thalawa	Ihalahalmillewa
10			Kahatagasdigiliya	Kekirawa Junction
11			Medawachchiya	Rambakulama
12			Palagala	Upulwehera
13			Galenbidunuwewa	Gatalawa
14			Kekirawa	Murungahitikanda
15			Galnewa	Bulnewa
16			Kabithigollawa	Halmillawetiya
17			Nochchiyagama	Sinharagama
18			NPE	Bandialankulama
19			NPC	Halambewa
20			Rajanganaya	Track 13 & 14
21			Padaviya	D 10 PHM Area
22			Horowpothana	Anawolendewa
23			Thambuththegama	Thelhiriyawa
24			Thirappane	Kattamurichchana
25			Ipalogama	Dampalassagama
26			Rambewa	Sangalikanadarawa
27	Uva	Monaragala	Buttala	Maligawila
28			Bibile	Eethanawatta
29			Monaragala	Horombuwa
30			Siyambalanduwa	Samanalabedda
31			Thanamalwila	Aluthwewa
32			Badalkumbura	Alupotha
33			Medagama	Bandiyaawa
34			Madulla	Rathmalgahaella
35			Wellawaya	Randeniya
36			Sevanagala	MOH Office (Central Clinic)
37			Kataragama	Detagamuwa
38		Badulla	Haldummulla	Kolongasthenna
39			Kandaketiya	Maliyadde
40			Passara	Goonakele
41			Soranathota	Pussalakanda
42			UvaParanagama	Udaperuwa
43			Haliela	Uduwara
44			Welimada	Hgurugamuwa
45			Rideemaliyadda	Kadubadda
46			Bandarwela	Liyanghawela watta
47			Haputhle	Kahagolla
48			Ella	Hidagala Estate Clinic Center
49			Lunugala	Cocagala Estate Clinic Center
50			Meeghakuila	Ballagolla 2 Clinic Center
51			Mahiyangana	Dehigolla
52			Girandurukotte	Belaganwewa
53	Sabaragamuwa	Kegalle	Aranayake	Uggoda

SN	Province	District	MOH Area	Field Health Center
54			Mawanella	Makadawara
55			Rambukkana	Rambukkana
56			Kegalle	Athurupana
57			Galigamuwa	Galigamuwa
58			Warkapola	Bopitiya
59			Ruwanwella	Ruwanwella
60			Dehiovita	Dehiovita
61			Deraniyagala	Udabage
62			Yatiyanthota	Yatiyanthota
63			Bulathkohupitiya	Bulathkohupitiya
64		Ratnapura	Balangoda	GHC Thalangama
65			Eheliyagoda	GHC Hindurangala
66			Embilipitiya	GHC Diulangate
67			Udawalawa	GHC Panahaduwa
68			Nivithigala	GHC Colombugama
69			Godakawela	GHC Makandura
70			Pelmadulla	GHC Pathakada
71			Kuruwita	GHC Hemenfort (Estate)
72			Imbulpe	GHC Cesilton (Estate)
73			Kalawana	GHC Rabuka
74			Ratnapura (PS)	GHC Banagoda
75			Ratnapura (MC)	GHC Mihindugama
76			Elapatha	GHC Niriella
77			Kiriella	GHC Epitawela
78			Kolonna	GHC Abagahayaya
79			Kahawatta	GHC Gabbela
80			Weligepola	GHC Ammaduwa
81			Openayake	GHC Hallinna
82			Ayagama	GHC Gawaragiriy
83	Central	Nuwara Eliya	Ambagamuwa	Abotsleigh
84			Ambagamuwa	Strathdon.
85			Bogawanthalawa	Ingestry
86			Bogawanthalawa	Kirkoswald
87			Hanguranketha	Hope
88			Hanguranketha	Rammalakandura
89			Kotagala	Chrystler’s farm
90			Kotagala	Mayfield
91			Kothmale	Labukele
92			Kothmale	Wedamulla
93			Maskeliya	Norwood
94			Maskeliya	Strathspey
95			Mathurata	Kabaragala
96			Lindula	Radella
97			Nuwaraeliya	Pedro
98			Ragala	Liddesdale
99			Ragala	Ragala
100		Kandy	Akurana	Dunuwila
101			Bamberdeniya	Clinic at Bamberdeniya MOH
102			Doluwa	Pupuressa Clinic Center
103			Galagedara	Central Clinic Galagedara
104			Galaha Deltota	Kolabissa
105			Gangalhala	Central Clinic at Gangalhala MOH office
106			Ganagawata Korale	Central Clinic at Gangawata Korale MOH
107			Gampola	Central Clinic at Udapalatha MOH office
108			Hasalaka	Handaganawa
109			Hatharaliyadda	Aludeniya Clinic Center
110			Kundasale	Janasavigama
111			Menikhinna	Central Clinic at Manikhinna office
112			Medamahanuwara	Karalliysadda new Clinic Center

SN	Province	District	MOH Area	Field Health Center
113			Nawalapitiya	Central Clinic at Nawalapitiya MOH Office
114			Panvila	Gomare Clinic Center
115			Poojapitiya	Marthugoda Clinic Center
116			Udunuwara	Central Clinic at Udunuwara
117			Werallegama	Enigala New Clinic Center
118		Matale	Matale	Kandegedara
119			Ukuwela	Katudeniya
120			Rattota	Dankanda
121			Ambanganga	Narangolla
122			Naula	Habaragahamada
123			Dambulla	Welihena
124			Galewela	Aluthwewa
125			Pallepola	Kadewatta
126			Wilgamuwa	Sonutthara
127			Yatawatta	Deevilla

GHC = general health clinic, MCH = maternal and child health, MOH = Ministry of Health, NPC = Nuwaragam-Palatha-Central, NPE = NuwaraGamapalatha East PMCU = primary medical care unit.
Source: Asian Development Bank.

ANNEX 3: CIVIL WORKS SUPPORT TO CLUSTER APEX HOSPITALS AND LIST OF CLUSTER FACILITIES

Civil Works Support to Cluster Apex Hospitals

1. The following scope has been identified as the priority requirements to develop the infrastructure facilities of Cluster Apex Hospitals (agreed 9 Base Hospitals of Thambuthegama, Medirigiriya, Rikilagaskade, Dambulla, Theldeniya, Welimade, Bibile, Kahawatte and Karawanella in each of the 9 districts in all 4 provinces of Central, North Central, Sabaragamuwa, and Uva) to deliver the essential service package and to support the cluster implementation under the original project.

Construction Activity	**Scope of Work/ Services to be Provided**	**Location/ Access**	**Approximate Area** (Sq ft)*	**Estimated Cost** (LKR Mn)
North Central Province (NCP)				
BH Thambuttegama				
New Construction	i) A complete 3 story building with foundation laid only for 3 stories (including a lift) that will be linked to the existing clinic building. The building shall include ETU and OPD Services, Physiotherapy and other rehabilitation services, radiology services, Surgical theatre, Dental services, and all Eye care services including an eye theatre.	Location is identified adjacent to the existing clinic building. A new entrance identified via current MOH building from the main road. In addition, the current side entrance will be utilized.	Maximum of 25000 (Complete 03 story building)	225
Renovation/New Construction	Existing Sewerage System of the hospital is old and malfunctioning. Hence an expert review is required to check the capacity and functional errors of the system. If the existing system cannot be rehabilitated, a new system will be designed and constructed to cater to the entire hospital sewer requirement (both grey and black water).	Location to be identified	Capacity to be determined with the hospital requirement	90
Repairs/Renovation/ Additions to overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Repairs to Wards/Clinics and all buildings as required ii) Repairs nd replacement of the corridor systems linking overall services of the hospital iii) Improving disability access within the entire hospital iv) Color washing of all buildings, Placing new name boards etc.	Entire hospital	As required	45
Total estimated allocation via the additional financing for BH Thambutthegama				**360**
BH Medirigiriya				

Construction Activity	**Scope of Work/ Services to be Provided**	**Location/ Access**	**Approximate Area** (Sq ft)*	**Estimated Cost** (LKR Mn)
New Construction (Building extensions as upper floors to existing buildings)	The first floor of the current drug store (next to the OPD building) will be constructed to include the clinic services, laboratory services for the patients. The building was designed by CECB and for the first floor there are no architectural/structural drawings available in the hospital. Hence following tasks to be done prior to start of the design work. i) Obtaining architectural and structural drawings for the first floor of the Drug Store building from CECB ii) If drawings are not available, structural conditional assessment to be done by a Structural Engineer to check the structural adequacy	Building next to the entrance OPD and upper floor of the current drug store. Access for this floor can be via a staircase and also via a 2 story ramp already in place for the OPD/Entrance building. For disability access, disability railing will be fixed.	6200 (Complete first floor)	117
	The first floor of the current Haemo-Dialysis unit will be constructed to include eye clinic and eye ward. If the ground floor has provision to extended to far end, that will be constructed to include eye clinic and for some radiology services. For the first floor, there are no architectural/structural drawings available in the hospital. Hence following tasks to be done prior to start of the design work. i) Obtaining architectural and structural drawings for the first floor of the Drug Store building from the original designer/Engineer ii) If drawings are not available, structural conditional assessment to be done by a Structural Engineer to check the structural adequacy.	Expanding the building in front of the hospital (opposite end to the Drug store, near the old MOH office) by constructing the upper floor. The access to upper floor via a ramp between the current eye theatre and the new construction.	2500 (Complete first floor)	
	The first floor of the PBU building will be constructed to include PBU and supportive services. The building was designed by Provincial Engineering Department and already architectural/structural design drawings are available.	Upper floor of the newly constructing PBU near the newly constructing surgical complex	7500 (Complete first floor)	
Sewerage system	A new sewerage system will be designed and constructed to cater to the entire hospital sewer requirement (both grey and black water).	Location to be finalized, Land extent available	Capacity to be determined based on the hospital bed strength and utilization capacity.	90
Repairs/Renovation/Additions of overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not	Entire Hospital	As required	27

Construction Activity	Scope of Work/ Services to be Provided	Location/ Access	Approximate Area (Sq ft)*	Estimated Cost (LKR Mn)
	necessarily limited to the following categories. v) Repairs to Wards/Clinics and all buildings as required vi) Repairs and replacement of the corridor systems linking overall services of the hospital vii. Improving disability access within the entire hospital. Color washing of all buildings, Placing new name boards etc.			
Total for BH Medirigiriya				**234**
Central Province (CP)				
BH Dambulla				
New Constructions	A complete 5 story building including OPD and ETU facilities, Clinic area, Eye services, Physiotherapy, Medical wards (to be linked to the dialysis building) and Theatres	Near the existing ETU and Bikku ward	35000 (5 stories)	270
	Staff quarters and on call rooms for different categories of staff	Location to be identified	10000 (3-4 stories)	67.5
	Hospital drainage system will be completely redesigned and constructed to manage the surface water system.	Entire hospital	As required	18
Repairs/Renovation /Additions of overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Large scale repairs / expansion to mental health area ii) Repairs to wards, clinics and all buildings iii) Repairs to the administrative staff areas, drug stores iv) Repairs to water tanks v) Repairs to corridor system linking all services vi) Improving disability access of the hospital vii) Color washing of all buildings viii) Placing new name boards etc.	Entire hospital	As required	67.5
Sewerage system is included under the APVAX RECOVER Project of ADB				
Total for BH Dambulla				**423**
BH Theldeniya				
New Construction	A complete 3 story building including Eye services including Eye	Free land behind the existing OPD,	22000 (3 stories)	157.5

Construction Activity	Scope of Work/ Services to be Provided	Location/ Access	Approximate Area (Sq ft)*	Estimated Cost (LKR Mn)
	theatre, Physiotherapy, Medical wards and Clinic facilities.	Clinic and admin building available.		
	Staff quarters and on call rooms for different categories of staff	Location to be finalized	8000 (2-3 stories)	54
Repairs/Renovation /Addition of overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Repairs to medical wards, clinics and all buildings ii) Renovation of kitchen area iii) Repairs to the corridor system linking all services iv) Improving disability access of the hospital v) Color washing of all buildings vi) Placing new name boards etc.	Entire hospital	As required	45
Sewerage system is functional.				
Digna Rehabilitation Hospital (as a functional part of BH Theldeniya Cluster)				
New Construction	Establish Physiotherapy and Occupational therapy unit with inward facilities at Digana Rehabilitation Hospital. The following order of services shall be followed in each floor i) Ground floor and First floor: Inward facilities ii) Second floor: Occupational Therapy Unit iii) Third floor: Occupational + Physiotherapy units	Location to be identified	10-12,000 (3-4 stories)	90
Total for BH Theldeniya Cluster (and for Digana Rehabilitation Hospital)				**346.5**
BH Rikilagaskade				
New Construction	A complete 3 story building including Eye services, Theatre, Medical ward, Drug Stores and Laboratory services	Free land behind the current drug store. Access for the ground floor is from main entrance and for the 1st floor separate access can be given from main road	20000 (3 stories)	162
	Mortuary area with JMOs office and Police office	Free land Infront of current mortuary building	3800 (single story)	27

Construction Activity	Scope of Work/ Services to be Provided	Location/ Access	Approximate Area (Sq ft)*	Estimated Cost (LKR Mn)
Repairs/Renovation / expansion of overall hospital	The entire hospital irequires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Renovations at OPD area, clinic areas, dental area, administrative staff area ii) Renovation of kitchen area iii) Repairs to medical wards, clinics and all buildings iv) Construction of a corridor system linking all services v) Improving disability access of the hospital vi) Color washing of all buildings vii) Placing new name boards etc.	Entire hospital	As required	67.5
Sewerage System	A new sewerage system will be designed and constructed to cater to the entire hospital sewer requirement (both grey and black water).	Location to be identified	Capacity to be determined based on the hospital bed strength and utilization capacity	90
Total for BH Rikilagaskade				**346.5**
Uva Province				
BH Welimade				
New Construction	A complete 3 story building including Medical wards, Drug Stores, Mental Health services, Clinic area and Eye/ENT Services	Location to be finalized	22000 (3 stories)	198
	Staff quarters and on call rooms for different categories of staff	Location to be identified	8000 (2-3 stories)	67.5
Repairs/Renovation /Addition of overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Renovations and repairs at OPD area, dental area, administrative staff area ii) Repairs to wards, clinics and all buildings iii) Repairs and construction of the corridor system linking all services iv) Improving disability access of the hospital v) Color washing of all buildings vi) Placing new name boards etc.	Entire hospital	As required	54
Sewerage system	A new sewerage system will be designed and constructed to cater to the entire hospital sewer requirement (both grey and black water).	Location to be identified	Capacity to be determined based on the hospital bed strength and utilization capacity	90
Total for BH Welimade				**409.5**
BH Bibile				
New Construction	A complete 3 story building including Clinic areas, Medical	Location to be identified	15000 (3 stories)	135

Construction Activity	Scope of Work/ Services to be Provided	Location/ Access	Approximate Area (Sq ft)*	Estimated Cost (LKR Mn)
	wards, Drug stores and Eye services			
	Staff quarters and on call rooms for different categories of staff	Location to be identified	8000 (2-3 stories)	54
Repairs/Renovation /Addition of overall hospital	The entire hospital requires substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Repairs to wards, clinics and all buildings ii) Renovation of Nurses and other staff quarters iii) Repairs and construction of corridor system linking all services iv) Improving disability access of the hospital v) Color washing of all buildings vi) Placing new name boards etc.	Entire hospital	As required	45
Sewerage System	A new sewerage system will be designed and constructed to cater the entire hospital sewer requirement (both grey and black water).	Location to be identified	Capacity to be determined based on the hospital bed strength and utilization capacity	90
Total for BH Bibile				**324**
Sabaragamuwa Province				
BH Kahawatte				
New Construction	A complete 3 story building including Laboratories, Mental health care and Eye/ENT care	Location to be identified	15000 (3 stories)	135
Repairs/Renovation /Additions of overall hospital	The entire hospital is required substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Repairs to wards, clinics and all buildings ii) Corridor system linking all services iii) Improving disability access of the hospital iv) Painting of all buildings, Placing a new name board etc.	Entire hospital	As required	27
Sewerage system will be funded by the PSDG, GOSL.				
Total for BH Kahawatte				**162**
BH Karawanella				
New Construction	Front of the current OPD building area – Current OPD area will be expanded towards the road level to include the facilities of A&E or ETU, Eye care, Physiotherapy services	Extensions to the front - In front of the building (where there is currently a shed	15000	135

Construction Activity	Scope of Work/ Services to be Provided	Location/ Access	Approximate Area (Sq ft)*	Estimated Cost (LKR Mn)
	Bac of the current OPD building – Current OPD building will be expanded at the back of the building to include the surgical theatres, new eye theatre, A corridor and an old surgical ward will need to be demolished for this purpose.	for patient waiting area) Extensions to the back – At the back of the building (to the left side when facing the building) Access to the building extensions will be from the existing building.		
	Staff quarters and on call rooms for different categories of staff	Location to be identified	8000 (2-3 stories)	54
Repairs/Renovation of overall hospital	The entire hospital is required substantial amount of renovation works. This shall include but not necessarily limited to the following categories. i) Renovations to the current OPD building, ii) Repairs to wards, clinics and all buildings iii) Repairs to the drainage system iv) Corridor system linking all services v) Improving disability access of the hospital vi) Painting of all buildings vii) Placing a new name board etc.	Entire hospital	As required	36
Sewerage system will be funded by the PSDG, GOSL.				
Total for BH Karawenella				**225**
Total civil works for developing all 9 cluster apex hospitals:				**2830.5**

Note: The areas mentioned in the table is approximate and final area shall be decided at the requirement identification and detailed design stage.

LIST OF HOSPITALS AND MEDICAL OFFICER OF HEALTH AREAS THAT WILL BE LINKED TO EACH OF THE 9 CLUSTERS TO BE ESTABLISHED IN THE 9 DISTRICTS

List of Cluster Facilities

No	Province/District	Cluster Name	Institution Name
1	North Central Province/ Polonnaruwa District	Medirigiriya	BH Medirigiriya
2			PMCU Ambagaswewa
3			PMCU Meegaswewa
4			PMCU Wijepura
5			PMCU Divulankadawala
6			MOH Medirigiriya
7	North Central Province/ Anuradhapura District	Thambuththegama	BH Thambuththegama
8			DHB Thalawa
9			DHB Eppawala
10			Galnewa DHC
11			Rajanganaya tract 5 DHC
12			Rajanganaya tract 11 DHC
13			Kattiyawa DHC
14			Negampaha DHC
15			MOH area Thalawa
16			MOH Area Galnewa
17			MOH area Rajanganaya
18	Uva Province/ Monaragala District	Bibile	BH Bibile
19			PMCU Godigamuwa
20			PMCU Nannapurawa
21			DHB Medagama
22			DHC Pitakumbura
23			PMCU Rathmalagehaella
24			PMCU Kotagama
25			MOH Medagama
26			MOH Bibile
27			MOH Madulla
28	Uva Province/ Badulla District	Welimada	BH Welimada -B Type
29			DHB Uva paranagama
30			DHC Wewegama
31			CD Pannalawela
32			DHC Bogahakumbura
33			DHC Boralanda
34			DHC Haggala
35			PMCU Keppetipola
36			DHC Downside
37			DHC Kirkeels
38			DHC Mirahawatta
39			DHC Nadungamuwa
40			DHC Udaweriya
41			PMCU-Hevanakumbura
42			MOH Uva Paranagama
43			MOH Welimada
44	Sabaragamuwa Province/ Kegalle District	Karawanella	BH Karawanella
45			DHA Kithulgala
46			DHA Deraniyagala
47			DHC Amithirigala
48			DHC Higuralakanda
49			DHC Gonagaldeniya
50			DHC Maliboda (Estate)
51			DHC Panawatta (Estate)
52			DHC Nagastenna (Estate)

No	Province/District	Cluster Name	Institution Name
53			DHC Halgolla (Estate)
54			DHC Sapumalkanda (Estate)
55			DHC Amanawala
56			PMCU Pothdenikanda
57			PMCU Boralankada
58			PMCU Basnagala
59			PMCU Atala
60			PMCU Yatiyantota
61			PMCU Kiriporuwa (Estate)
62			PMCU Bulathkohupitiya
63			PMCU Dedugala
64			MOH Dehiovita
65			MOH Yatiyantota
66			MOH Deraniyagala
67			MOH Ruwanwella
68			MOH Bulathkohupitiya
69	**Sabaragamuwa Province/ Ratnapura District**	**Kahawatte**	BH Kahawatte
70			DHA Godakawela
71			PMCU Hiramadagama
72			PMCU Atakalanpanna
73			DHC Madampe
74			PMCU Babaragasthenna (Welkeniyaya)
75			DHA Rakwana
76			DHC Palmadulla
77			ERH Haupe
78			PMCU Kalallela
79			DHC Endana
80			DHC Ranwala
81			PMCU Udawela
82			DHC Hunuwala
83			PMCU Narissa
84			PMCU Palamkotte
85			MOH Kahawatte
86			MOH Opanayake
87			MOH Godakawela
88			MOH Weligepola,
89			MOH Pelmadulla
90	**Central Province/ Nuwera Eliya District**	**Rikillagaskada**	BH Rikillagaskada
91			DHC Gonagantenna
92			DHC Gonapitiya
93			DHC Hanguranketha
94			DHC Madulla
95			DH? Mandaramnuwara
96			DHB Mathurata
97			DHC Muloya
98			DHC Nildandahinna
99			DHC Theripeha
100			DHA Walapane
101			PMCU Kurupanawela
102			PMCU Keerthibandarapura
103			PMCU Manakola
104			PMCU Rupaha
105			DHB Udupussellawa
106			PMCU Kalaganwatte
107			PMCU Munwatte
108			MOH Hanguranketha
109			MOH Maturata

No	Province/District	Cluster Name	Institution Name
110			MOH Ragala
111			MOH Walapane
112	Central Province/ Matale District	Dambulla	BH Dambulla
113			DHC Galewale
114			DHB Madipola
115			DHC Sigiriya
116			PMCU Aluthwewa
117			PMCU Dewahuwa
118			PMCU Wahakotte
119			PMCU Kalundawa
120			PMCU Wewalawewa
121			DHA Laggala
122			DHC Hattota amuna
123			DHC Illukumbura
124			DHA Hettipola
125			DH Maraka
126			DH Handungamuwa
127			DHC Lendora
128			MOH Dambulla
129			MOH Galewela
130			MOH Laggala
131			MOH Wilgamuwa
132	Central Province/ Kandy District	Teldeniya	BH Teldeniya
133			DHA Menikhinna
134			PMCU Digana Rajawella
135			DHC Dunhinna
136			DHC Narampanawa
137			PMCU Rangala-Makuldeniya
138			PMCU Sandasiridunuwila
139			DHB Medamahanuwara
140			PMCU Meemure
141			DH Ududumbara
142			Digana Rehabilitation Hospital
143			DHB Kolongoda
144			DHC Minipe Morayaya
145			DHC Ambagahapelessa
146			DHC Batumulla
147			DHA Hasalaka
148			MOH Ududumbara
149			MOH Menikhinna
150			MOH Kundasale
151			MOH Medamahanuwara
152			MOH Hasalaka

DH = district hospital, DHA = district hospital type A, DHB = district hospital type B, DHC = district hospital type C, PMCU = primary medical care unit,
Source: Asian Development Bank

ANNEX 4: UPDATED GUIDELINES FOR UTILIZATION OF THE PRIMARY HEALTH CARE INNOVATION FUND OF THE ADB-FINANCED HEALTH SYSTEM ENHANCEMENT PROJECT, SRI LANKA (REVISED TO INCLUDE THE ADDITONAL FINANCING)

A. General Instructions

1. The Primary Health Care (PHC) Innovation Fund (PIF) is made available for provincial and regional health offices in Central, North Central, Sabararagamuwa, and Uva Provinces to use their own insights to improve PHC in terms of access, range, quality, or efficiency of services.

2. The PIF will be managed by the Project Management Unit (PMU) in close collaboration with each of the Central, North Central, Sabararagamuwa, and Uva Province Project Implementation Units (PIU/s) of the ADB-financed Health System Enhancement Project.

3. The focus of the PIF will be on PHC development and 6 groups of interventions have been identified as eligible areas for project funding. The PIF grant of $1.5 million (the original project had $2 million which was reduced to $1.5 million with the reallocation in April 2020), is increased via the additional financing by another $1.5 million; is provided to **prepare, implement, and monitor** a grant-financed project within the approved scope and conditions as provided. The grant applicant may want to be informed about, take advantage of, and build on **ongoing initiatives** and experiences in and outside the 4 provinces. Approximately a total of $330,000 is made available per district for proposals during the project period via the original project and via the additional financing.

4. The six groups of interventions eligible for project funding are:

(i) **Improving PHC management**, including cluster management, a supervisory system, performance monitoring, gender promotion, and environmental and social safeguards;
(ii) **Human resources development** including training doctors in family medicine, training midwives in field health stations in preventive care, nutrition counselling;
(iii) **Information technology** for better patient management and disease control, including e-Health cards, linking preventive and curative care, referral systems, medical supplies, geographic information systems, distance learning services, and disease surveillance**;**
(iv) **Scaling up services** including health and nutrition promotion, diagnostic services, emergency services, family medicine, NCD services, and infection prevention and control;
(v) **Rehabilitation of facilities** including roofs, electricity, sanitation, water supply, and waste management (no new constructions);
(vi) **Operational costs** for operations related payments for cluster implementation and management. Funds for this activity can only be approved if the applicant has made prior arrangements and received approval with the respective provincial council to share costs on a reducing proportion (PHC fund: Provincial funds; [100%:0 in 2022, 80%:20% in 2023, 60%:40% in 2024 and 50%:50% in 2025 and 0%:100% in 2026 onwards.]) only.

5. The Provincial Directors of Health Services of the four provinces will invite eligible government health officials from the 4 provinces to submit grant proposals, on a rolling basis, of up to US$100,000 to explore innovative strategies for PHC improvement under areas 3(1) to 3(5)

and for area 3(6) total monthly payment per district (on sharing basis as indicated in 3(6) can be released only for cluster implementation support, up to the limit of $100,000 per proposal).

6. The PIU will issue approved guidelines and application forms (version updated as of July 2021) to potential grant applicants and assist these applicants with the preparation of proposals. The PIF guidelines and application forms are available for prospective applicants via the project website: www.original project.lk.

7. Any eligible office / officer can submit a proposal for grant financing, up to US$100,000 for projects / activities that fall within areas 3(1) to 3(6). When submitting proposals under 3(6), only PDHS, RDHS, Cluster Head/ Deputy RDHS, Hospital MS, Hospital MOIC or MOHs are eligible for receiving funding. The proposals for 3(6) can only be submitted in close collaboration with the Chief Secretary / Deputy Chief Secretary Finance and Provincial Health Secretary's, PDHS and RDHS clearance for creating necessary allocations / budget lines in the provincial budgets for sharing of operating costs in 2023 -2025 and beyond. The Applicant applying for the grant will be accountable for its proper use. The applicant may seek information and assistance from the PIU for completing the application (email addresses and contact information is given below). Except for training programs, other subprojects duration has to be not longer than one year and the applicants should provide monthly reports to the PMU through DPD and M&E Officer of the PIU which is needed for the monthly financial forecast of the project.

8. The approved Project Application Form (version July 2021) is in Attachment 1. The proposal will basically state the problem(s) statement/s, proposed project description, key activities and key results to be achieved, and how much it would cost. The following are eligible expenditures:

(i) Salaries of the proposed project staff1
(ii) Workshops/meetings
(iii) Travel costs and per diem
(iv) IT and other system design
(v) Facility repairs and waste disposal
(vi) Facility equipment and furniture
(vii) Community based program costs
(viii) Research and Survey
(ix) Operational costs as defined in paragraph 4(vi)

9. The projects should preferably take less than 3 months to prepare and be implemented within one year. Progress is reported by the Applicant on a quarterly basis to the PIU using the Project Progress Form (in Attachment 4). The Final Project Completion Form (in Attachment 5) should be submitted within 3 months of completion of the project.

10. The applicant will assess if there are any major feasibility issues or implementation risks and, if so, propose how these shall be mitigated, in the project description section of the application. The following project risks may be considered:

(i) Requires regulation or other legal requirement
(ii) Completion depends on other funding

[1] Project staff are persons not already paid for services by MOH either as regular or contractual staff. MOH pensioners are eligible as project staff.

(iii) Requires skilled persons which may not be available
(iv) Requires behavioral change
(v) Requires physical facilities that may not be available
(vi) Project is technically complex
(vii) Project may face strong objections from certain stakeholders
(viii) Project may negatively affect certain populations
(ix) Obtaining Ethical Clearance

11. The Project Administration Manual (PAM) of the original project and the PAM of the additional financing are accessible from www.original project.lk, provide details on gender action plan and safeguards requirements[2] which are also applicable for the use of the PIF.

12. The PMU will (i) inform potential grant applicants regarding ADB's gender action plan and social and environmental safeguards including the applicable PAM for each of the approved proposals; (ii) assist in compliance with the gender action plan and environmental and social safeguards; (iii) ensure that ADB gender dimensions and safeguards are adequately addressed in the proposals; and (iv) monitor and report compliance. Rehabilitation works to be funded by the PIF will be subject to ADB's Safeguards Policy Statement (SPS) 2009 even if they may be exempted from national environmental regulations.

1. Grant Application and Review Process

13. All completed applications (as 3 hard copies and a soft copy), should be recommended and forwarded via the respective RDHS/s of the respective province to the Provincial Director (who is also the Deputy Project Director of the Project Implementation Unit (PIU)). The PD/DPD recommended application will be officially submitted by the PIU to the, the Project Secretary, and it is his/her duty to follow the procedure to get the approval from the PCC within two weeks from the date of submission of the application. Applications will be accepted by the PIU on a rolling basis.

14. Acknowledgement of the receipt of the application has to be informed in writing to the applicant and to relevant authorities. Secretary (PIU) should maintain a separate file for each proposal and an electronic database.

15. Deputy Project Director in each of the 4 provinces will appoint a 3 or 4-member permanent Technical Review Committee for the PIF proposals submitted within the respective provinces. The Committee will be chaired by a Regional Director of Health Services of his/her province. The permanent members of the committee could include a minimum of 2 officials from the officers mentioned below:

(i) Regional Director of Health Services
(ii) Consultant Community Physician from the Province / District
(iii) Provincial Medical Officer Planning
(iv) Medical Superintendent from a Base Hospital or above in the Province.

16. The Technical Review Committee will also invite any of the following officials, as invitees to the committee, based on the technical area / operational costs [Area4(iv) above] of the proposals that are to be reviewed.

[2] ADB. 2009. *Safeguard Policy Statement.* Manila.

(i) Deputy Chief Secretary (Finance), Health Secretary, Provincial, District Accountants, or other relevant budgeting / financing related officers
(ii) Deputy Chef Secretary Engineering, Engineering Officers and Biomedical Engineers.
(iii) Regional Epidemiologist or the Medical Officer Malaria, Tuberculosis
(iv) Regional Dental Surgeon,
(v) Medical Officer Maternal and Child Health,
(vi) Medical officer Mental Health,
(vii) Medical Officer Non-Communicable Diseases
(viii) Medical Officer Public Health
(ix) Medical Officer Quality
(x) Medical Officers, Bio informatics
(xi) Other relevant regional Medical Officer
(xii) Specialist Medical Officer from the Province
(xiii) Other relevant technical staff member such as a Matron, Nursing Staff, Public Health Inspector, Public Health Nursing Officer, Public Health Nursing Sister
(xiv) Other relevant technical experts from Universities, Ministry of Health
(xv) Any other Government Department representative from Nutrition and Indigenous Medicine.
(xvi) Community Based Organization (CBO)

17. The PIF Review Committee will meet monthly or as required (facilitated by the PIU) to review all proposals received by the PIU within the preceding month. The PIF Review Committee, in addition to reviewing the application, may decide to invite the applicant to present the proposal. The PIF Review Committee members will complete a Proposal Review Form (in Attachment 2) for each reviewed proposal with its recommendations for funding.

18. The PIU will submit all reviewed proposals (including proposals approved, proposals which require resubmissions, and the rejected proposals) by the Proposal Review Committee to the PMU of the original project for verification of cost eligibility and for prevention of duplication of activities funded by the central MOH or other donors. The PMU will review and provide its recommendations signed by the Project Director or the Deputy Project Director, to the respective PIU within 5 working days. The PIU will thereafter submit the proposal, with the PMU comments, to the Provincial Coordination Committee (PCC) chaired by the Chief Secretary, which meets every quarter or as required. The PIU ensures that all PCCs will have an Agenda item for PIF proposal Discussion / Approval.

19. The decision of the PCC shall be in the PCC minutes. The PCC approved proposals signed by the Chief Secretary (Attachment 3) are considered as final.

20. After PCC approval, the project is eligible to receive money from the fund via the PMU. The PIU will submit a copy of the approved PIF proposal to the Project Director of the Health System Enhancement Project for release of funds to the PIU.

21. The applicant will submit, every quarter, a completed Project Progress Reporting Form (Attachment 4) to the PIU. At completion of the project, the Applicant will submit a Project Completion Form (Attachment 5) to the PIU, for forward transmission to the PMU within 3 months of project completion.

22. PIU should submit a summarized quarterly report of all approved or ongoing projects to the PMU. The PMU will table the ongoing projects at the National Steering Committee. The focal

point for facilitating the implementation of the PIF from the Project Management Unit is the Project Coordinator. The PIU will table all progress reports and project completion reports at the PCC and keep all documents at the PIU for review by the PMU and/or by the auditors.

23. The PCC can at any time decide to terminate the project on the basis of redundancy, poor performance, or with evidence of fraud or malpractices. Even if the project is terminated, the Applicant must comply with the final technical, administrative, and financial project completion reporting obligations. Such decisions taken by the PCC should be informed to the PMU immediately.

24. The overall responsibility of successful use of funds and project implementation is with the Project Director of the PMU.

B. Implementation Arrangements

25. Implementation arrangements for the PIF will use the overall project management structure, in the case of civil works may also use the Ministry of Local Government and Provincial Council and in the case of operational costs (area 4(iv), will coordinate with the Provincial and Regional Health Office and the Chief Secretaries Offices. Project could obtain procurement services from UNICEF and UNOPS as the need arises via the PMU. The grant applicant is responsible for project implementation and progress reporting while PIU is responsible for monitoring and reporting to the PU and the PCC. The grant Applicant will request all procurements in the approved proposal to be carried out by the PMU via the PIU and is authorized to seek cash advances for programs and to make payments for operational costs identified in area 4(iv) and for training, on the submission of expenditure details to the PMU via the PIU. Additional training advances will be provided only following the submission of expenditures to the earlier advance by the Applicant.

26. The project accountant of the PMU will provide oversight of all PIF related activities and will manage the reconciliation and replenishment with the PIUs based on each approved activity in the proposal (on a quarterly basis so that cashflow for project implementation is ensured) based on approved ADB guidelines.

27. PMU will use statement of expenditures (SOE) for liquidation of expenditures of $100,000 equivalent per individual proposal. Supporting documents and records for the expenditures claimed under the SOE should be maintained at the PMU level and made readily available for ADB review, upon ADB's request for submission of supporting documents on a sampling basis, and for independent audit.

28. The PMU is responsible for supervision to ensure proper use of grant and loan funds made available in the PIF. All procurement related activities will be managed by the PMU at the request of the Applicant of the approved project. All procurement of works, goods and services under the PIF will follow ADB procurement guidelines (like the rest of the project). All eligible expenses are given in Para 8 above. Procurement under PIF will be for minor civil works, equipment and furniture, and/ or services including for training and IT system design. These items will be small in value and may follow nationally advertised bidding or shopping procedures. Any consulting services required for PIF will be engaged by PMU in accordance with ADB’s Guidelines on the Use of Consultants (March 2013) and ADB’s procurement regulations and policy.

29. The quarterly progress report (Attachment 4) will be submitted by the Applicant to the PIU and the PIU will forward it to the PMU. The funds release will be based on the performance of the previous progress reports and fund utilization and reporting of the achievement of results.

30. A project is considered as successful based on completion of project activities, substantive and demonstrable results, meeting administrative and safeguard requirements, and timely reconciliation of expenditures.

Attachment 1
Grant Application Form for the PHC Innovation Fund under the ADB Health System Enhancement Project

Section A: General Information

1	Title of the Proposed Grant Project	
2	Estimated Budget (LKR an in USD)	
3	Date of Application	
4	Province	
5	District	
6	Please indicate the project area.	
	· Cluster (if the proposed project is within a Cluster hospital or hospitals or it's catchment population/s)	
	· Hospital/s (if proposed project is for a single or a few hospital/s or their catchment population/s)	
	· MOH area/s or GN areas (if proposed project is not a cluster activity or not a hospital based or related catchment population activity)	
7	Proposed project duration	

A.2 Applicant's Information

Full Name of the Project Applicant	Designation	National ID No

Office Address	
Office Phone Number	
Office Fax Number	
Mobile Phone Number	
Email Address	

Section B

B.1 Problem Statement (Please provide a short description of the problem that is proposed to be addressed via the PIF)

B.2 Project Description (Please provide a brief description of the proposed project)

B.3 Key Results to be achieved at end of project period (Please give the results that are expected at the end of implementation of the proposed project)

B.4 Proposed Activities and estimated budget

	Activity Description	Estimated Budget	
		LKR	USD
1			
2			
3			
4			
5			
6			
7			
	TOTAL		

(Please insert the conversion rate used for LKR/USD)

B.5 Detailed Cost estimates of the proposed budget

Cost Items		Quantity	Rate		Amount	
			LKR	USD	LKR	USD
1.	Personnel					
	Salary					
	Travel allowance					
	Other					
2.	Civil Works					
	Repair facility					
	Water supply					
	Waste management					
	Other					
3.	Transport					
	Fuel					
	Motorcycle					
	Vehicle hiring charges					
4.	Equipment					
	Medical					
	Laboratory					
	Other equipment					
5.	Furniture					
6.	Workshops / Programs					
7.	Training					
8.	Services					
9.	Information Technology					
10.	System development					
11.	Recurrent expenses					
12.	Other (specify)					
	TOTAL					

(Please insert rows as required, budget to be included in LKR and USD (please insert the conversion rate used for LKR/USD)

B.6 Project Financing

Total project cost (From B.4)				
Total Amount Requested for ADB PHC innovation fund financing including taxes (From B.4 and B.5)				
Total Government contribution excluding in kind				
Total Amount from other sources of financing*				
Period of funding from other sources	From	Year	Month	Day
	To	Year	Month	Day

* Attach documentation confirming funding from other sources

Section C: Declaration and Recommendations

C.1 Declaration of the Applicant

Declaration of the Applicant

I hereby agree to the terms and conditions laid down under the PHC Innovation Fund of the ADB supported Health System Enhancement Project and that the declared details furnished above by me are true and correct.

…….

Date: …….. Signature of the Applicant

C.2 Observations and Recommendations of the District/s Regional Director/s of Health Services where the project is implemented

Observations and Recommendations of the District/s Regional Director/s of Health Services where the project is proposed to be implemented

I hereby recommend and forward the above Application for funding under the PHC Innovation Fund of the ADB Health System Enhancement Project.

…….

Date: …….. Signature, Stamp, and Designation of the ***all*** relevant District or Districts Regional Director/s of Health Services

C.3 Observations and Recommendations of the Provincial Director of Health Services where the project is implemented

Observations and Recommendations of the Provincial Director of Health Services

I hereby recommend the above Application for funding under the PHC Innovation Fund of the ADB-financed Health System Enhancement Project.

……

Date: ……..

Signature, Stamp, and Designation of the relevant Provincial Director of Health Services

Attachment 2
Form for PHC Innovation Fund Proposal Review
(To be used by the Proposal Review Committee of the relevant Province)

Section A: Proposed Project Thematic Area/s

Please insert 'x' to the applicable thematic areas based on the submitted project proposal

PIF Project Areas		Please mark 'x' for applicable areas
A.	PHC management and monitoring	
1.1	Cluster management	
1.2	Services promotion and performance sharing	
1.3	Cluster facilities supervision	
1.4	Work force planning	
1.5	Participatory planning and team work	
1.6	Performance Monitoring	
1.7	Gender training	
1.8	Environmental examination and monitoring	
1.9	Engagement of vulnerable populations	
1.10	Patient satisfaction monitoring	
1.11	Other	
B.	Information technology	
2.1	IT connectivity among health facilities	
2.2	Health management information system	
2.3	Patient e-Health card system	
2.4	Referral system	
2.5	Diagnostic services	
2.6	Medical supplies	
2.7	Geographical information system	
2.8	Distant learning services	
2.9	Disease surveillance	
2.10	Quarantine services	
2.11	Disability and rehabilitation services	
2.12	Other	
C.	Scaling up services	
3.1	Community Nutrition promotion	
3.2	Child nutrition clinics	
3.3	Nutrition interventions	
3.4	School reproductive health promotion	
3.5	Community vector and infection control	
3.6	Family medicine	
3.7	Community MCH / NCD prevention	
3.8	NCD services (specify)	
3.9	Emergency services	
3.10	Hospital infection prevention and control	
3.11	Laboratory services	
3.12	Ultrasound and other imaging and radiology services	

3.14	Other	
D.	Rehabilitation of facilities	
4.1	Roof repair or replacement	
4.2	Electricity repair or replacement	
4.3	Sanitary facilities repairs	
4.4	Water supply repair	
4.5	Waste management repair	
4.6	Waste management transport	
4.7	Equipping field health stations	
4.8	Replacement of essential equipment	
4.9	Replacement of motorcycle / three-wheeler for outreach	
4.10	Other	
E.	HRH Development and training	
5.1	PHC training	
5.2	Training needs assessment	
5.3	HRH Review for PHC	
5.4	Addressing HRH vacancies	
5.5	Advocacy	
5.6	Training on Emergency care	
5.7	Training on Health communications	
5.8	Other	
F. Operational Costs (cost sharing basis with provincial councils)		
6.1	internet connectivity charges	
6.2	internet data charges	
6.3	vehicle hires	
6.4	Other Operations related charges for clusters	

Section B: Relevance and Feasibility of the Proposed Project to the District/s team

Section C: Recommendation of the PHC Innovation Fund, Proposal Review Committee

We have reviewed the project proposal submitted by the Applicant ……..., (please insert Applicant's name) on…… (please insert date of the application) for consideration under the PHC Innovation Fund.

We approve / request to resubmit / reject (please circle as appropriate) the proposed project for funding under the PHC Innovation Fund of the ADB-financed ORIGINAL PROJECT.

PIF Proposal Review Committee of the North Central / Uva / Sabaragamuwa / Central Province (please circle as appropriate)

Name and Designation…… Signature:……..

Name and Designation…… Signature:…….

Name and Designation…… Signature:……

Name and Designation…… Signature:……

Date:……

Attachment 3
Form for Approval of the Proposal by the Project Coordinating Committee (PCC) of the ADB HSEP
(To be managed by the PIU of the HSEP of the Respective Province)

Observations and Recommendations of the Provincial Coordinating Committee

I hereby recommend the above Application for funding under the PHC Innovation Fund (PIF) of the ADB-financed Health System Enhancement Project based on the comments / reviews received from the Project Proposal Review Committee.

……

Date: ……..

Signature, Stamp, and Designation of the relevant Chief Secretary or Health Secretary

Attachment 4
PIF Project Progress Reporting Form
(To be submitted by the Applicant to the Project Implementation Unit of the Relevant Province on a quarterly basis)

4.1 Project Name: ……..
4.2 Project Applicants Name: ……..
4.3 Project Budget…….....

Section 4A: Summary of project achievements, challenges and issues faced at end of Quarter 1/2/3/4/…. (circle as appropriate) of project implementation

Section 4B: Summary of Project Fund utilization by activity at end of Quarter 1/2/3/4/…. (circle as appropriate) of project implementation

	Activity Description	Estimated Budget		Actual Budget utilized	
		LKR	USD	LKR	USD
1					
2					
3					
4					
5					
6					
7					
	TOTAL				

Date…….. Signature:……..

Attachment 5
Project Completion Form
(To be submitted by the Applicant to the Project Implementation Unit of the Relevant Province within 3 months of project)

5.1 Project Name: ……..
5.2 Project Applicants Name: ……..
5.3 Project Budget…….....

Section 5A: Summary of project achievements, challenges and issues faced during project implementation

Section 5B: Results Achieved (please insert an update on the key results identified at project design)

Section 5C.1: Summary of Project Fund utilization by activity

	Activity Description	Estimated Budget		Actual Budget utilized	
		LKR	USD	LKR	USD
1					
2					
3					
4					
5					
6					
7					
	TOTAL				

Section 5C.2: Summary of Project Fund utilization by Cost categories

Cost Items		Quantity		Rate				Amount			
		Planned No	Actual No	Estimated		Actual		Estimated		Actual	
				LKR	USD	LKR	USD	LKR	USD	LKR	USD
1.	Personnel										
	Salary										
	Travel allowance										
	Other										
2.	Civil Works										
	Repair facility										
	Water supply										
	Waste management										
	Other										
3.	Transport										
	Fuel										
	Motorcycle										
	Vehicle hiring charges										
4.	Equipment										
	Medical										
	Laboratory										
	Other equipment										
5.	Furniture										
6.	Workshops / Programs										
7.	Training										
8.	Services										
9.	Information Technology										
10.	System development										
11.	Recurrent expenses										
12.	Other (specify)										
	TOTAL										

(Please insert rows as required, budget to be included in LKR and USD (please insert the rate for USD/LKR)

Section 5C.3: Description of using Project Funds (please provide a summary of your experience of using PHC Innovation funds)

Section 5D: Your (Applicant) Recommendations and Suggestions

Date…….. Signature:……..

ANNEX 5: ACTIVITIES CARRIED OUT USING THE REALLOCATED $15 MILLION OF THE ORIGINAL HEALTH SYSTEM ENHANCEMENT PROJECT(LOAN AND GRANT)

1. The global public health emergency due to the coronavirus disease 2019 (COVID-19), characterized by the World Health Organization as a pandemic, called for urgent measures to respond to the disease in Sri Lanka. The Government of Sri Lanka (GOSL) has given high priority for strict and urgent measures to arrest importation of the disease to the country and spread of virus within the country.

2. The government has decided to strengthen the capacity and facilities of the Quarantine Unit, Infectious Disease Hospital, National Reference Lab (the Medical Research Institute), and 28+17? peripheral hospitals. Government requested ADB to provide immediate financial assistance through the ongoing loan (L3727) and grant (G0618-SRI(SF) to support the government's response to this pandemic. The expanded scale of activities required additional procurement of goods and consumables, i.e., medical supplies, diagnostic test kits, reagents, personal protective equipment (PPE), and other needed supplies. In addition, it includes renovations and refurbishment of isolation rooms at the port of entries and construction of a laboratory at the National Institute of Infectious Diseases (IDH) in Colombo with facilities to run high risk samples for IDH, and construction of a PCR laboratory at Mulleriyawa Base Hospital of Colombo East. Medical equipment and supplies were procured following request for quotations, repeat orders, and/or direct contracting. Mode of procurement for construction of PCR laboratory will be direct contracting due to urgent need of testing facilities.

3. To respond to the government's request, ADB, on 25 March 2020 and 10 April 2020, approved the minor changes in the original Health System Enhancement Project (the original project) to create a civil works and equipment category under the grant and reallocate loan and grant proceeds to enable the executing agency (EA) to cover essential procurement of civil works and equipment related to implementation of the government's urgent response plan on combating COVID-19 pandemic under output 2 (health information system and disease surveillance capacity strengthened). The changes resulted to $10 million of the original loan being reallocated to medical equipment category and $5 million of the original grant to civil works and equipment category. The DMF was revised to accommodate these approved changes to the project. See the list of COVID-19 emergency activities from the reallocated $15 million in the table below.

4. The minor changes did not result in a change to impact and project outcome as the Government of Sri Lanka has already agreed to fill the financing gap due to this reallocation from a suitable funding source. This additional financing of the original project will cover this gap.

COVID-19 Emergency Activities under Original PROJECT (Loan and Grant)

Activity Number	Package Number	Activities	Loan	Grant	Status
1		**Construction of PCR lab at Colombo East Base Hospital with a capacity to perform 500 tests for 12 hours including equipment, reagents and consumables to perform 30000 tests with training**			
	G28.1	Signing the contract agreement - PCR laboratory equipment with a capacity to perform 500 test per 12 hours for Colombo East Base Hospital (BGI)		x	Completed
	W28	Signing the contract agreement for Construction of PCR Lab (LHP)		x	Completed
	W28	Addendum 1-CEB		x	Completed
		Canopy		x	Completed
		AC Plant -12000 BTU		x	Completed
	W28.1	Office Space		x	Completed
		Procurement activities for the PCR Lab at CEBH			
	G28	Pharmaceutical Refrigerator, Chest Freezer		x	Completed
	G28.2	Refrigerator - 2 Door with Inverter Technology		x	Completed
	G28.4	PCR Laboratory - Desktop Computer and Black and White Printer		x	Completed
	G28.5	PCR Laboratory Furniture		x	Completed
	G28.11	Sample Preparation Table		x	Completed
	G28.7	Internet Networking (RFQ)		x	Completed
	G28.3	Supply of Generator		x	Completed
	G28.3	Generator Room		x	Completed
	G28.8	UPS for PCR Lab		x	Completed
		Repeat Order -UPS		x	Completed
	G28.8.1	Repeat Order -UPS		x	Completed
	G28.6	PPE		x	Completed
	G28.12	Regents and Consumables- BGI and MGI		x	Completed
		Regents and Consumables -To be Committed	x		**To be Committed**
	G34	NGS	x		Processing
	G33	Rapid Antigen Test Kits	x		Completed
	G33.2	Test Kits- Kuliyapitiya	x		Completed
	G33.3	Radiographic Panels-Awissawella	x		Processing
	G33	Rapid Antigen Test Kits- Repeat Order	x		Processing
	G34	300000 Test Kits	x		Processing

Activity Number	Package Number	Activities	Loan	Grant	Status
2		**Construction of Laboratory Complex (Biosafety level 3 at National Institutes of Infectious Diseases (NIID))**			
	W29.1	Construction of Laboratory Complex		x	Processing
3		**Refurbishment of isolation rooms at point of entries (Harbours) Colombo (MRI Q Sub office) Galle, Hambantota and Trincomalee**			
	W30.1	Refurbishment of isolation rooms at point of entries Colombo		x	Processing
	W30.2	Refurbishment of isolation rooms at point of entries Galle		x	Processing
	W30.3	Refurbishment of isolation rooms at point of entries Hambanthota		x	Processing
	W30.4	Refurbishment of isolation rooms at point of entries Trincomalee		x	Processing
	W30.5	Refurbishment of isolation rooms at point of entries MRI Quarantine Sub office		x	Processing
5		**Refurbishment of isolation rooms at NIIDH (Requested by quarantine unit)**			
	W30.6	Refurbishment of isolation rooms at NIIDH (Requested by quarantine unit)		x	Processing
6		**Refurbishment and procurement of medical equipment of ICUs at BH Thambuththegama, Madirigiriya**			
	G26.1	Supply of ICU Equipment (LCB) -Ventilators	x		Completed
	G26.2	CRRT machines, DVT pumps, Defibrillators with face mask,		x	Completed
	G26.5	Portable Ultrasound Scanner		x	Completed
	G26.6	Mobile X-ray Machines		x	Completed
	G26.7	ABG blood Gas analyzer and Pharmaceutical Refrigerator		x	Completed
	G26.8	Bed head tables, Bed side lockers, Crash cart/ Emergency trolly, Oxygen cart		x	Completed
	G26.9	Mapleson C circuits, Pediatric Circuits, Laryngoscope Adult and Pediatric, Adult and Pediatric Circuits Ambu Bag, Forced air patient warmers		x	Completed
	G26.10	Central Air Condition System		x	Completed
	G26.11	Medical Gas pipeline extender Thambuttegama		x	Completed
		Addendum 1		x	Completed
	W27.3	Additional works for Thambuttegama		x	Completed
	W27.2	Medical Gas Supply Air Distribution System -Medirigiriya		x	On Going
	W27.1	Gas and Oxygen Storage Room- BH Medirigiriya		x	Completed
	G26.10.1	Central Air Condition System Medirigiriya	x		Completed

Activity Number	Package Number	Activities	Loan	Grant	Status
7		**Allocation for emergency procurement for provinces**			
	G27.2	Central Province		x	Completed
	G27.3	North Central Province		x	Completed
	G27.4	Sabaragamuwa Province		x	Completed
	G27.1	Uva Province		x	Completed
10	**G30.4**	**Procurement of Medical Equipment, Reagents and Consumable for MOHIMS**	x		Completed
10.1		**Equipment for Molecular Biology Laboratory**			
	G29	Real time PCR Machines 5	x		Completed
	G29.1	Auto Nucleic Acid Extraction Machine 5	x		Completed
	G29.2	Safety Cabinet (BSL2)-Vortex, PCR hoods / Work Station 10	x		Completed
	G29.3	Mini-centrifuge for 1.5ml and 0.5ml, Bench top Centrifuge 14000 rpm (for 1.5ml tubes)	x		Completed
	G29.4	Cold boxes, Pharmaceutical Refregirator,20 C Freezers,20 C Freezers	x		Completed
	G29.4.1	-80 Freezers	x		Completed
	G29.5	Heat block, Thermo mixer, Mini Spinner, Digital thermo meters	x		Completed
	G29.6	Refrigerated Centrifuge-14000 rpm (24 – Epindof)	x		Completed
	G29.7	Medical Supplies Division (-20 Freezers)	x		Completed
	G25.1	Procurement of Nanopore Sequencer Including all accessories and special training Autoclave, Real Time PCR Machine, Biosafety cabinet Class II (BSL2), Densitometer/ Turbidity Meter	x		Completed
	G4.5.1	Microscope - extended procurement	x		Completed
	G7.1	Nebulizer (BED)	x		Completed
12		**Refurbishment of ICU GH Kalutara**			
	W 29	Refurbishment of HDU		x	Completed
	G30.3	Extension of Medical Gas Supply to ICU -Kalutara		x	Completed
13		**Procurement of Medical Equipment of General Hospital Kaluatara**			
	G25.4	Procurement of Video, Laryngoscope for GH Kalutara		x	Completed
14		**Refurbishment of Non-functional cool rooms 2**		x	Processing
15		**Procurement for Medical Equipment for Provincial Hospitals**			
	G31	Medical Furniture	x		Completed
	G31.1	Surgical Equipment and Consumables	x		Completed
	G31.1.1	Surgical Equipment and Consumables	x		Completed
	G31.2	Pulse Oxymeters	x		Completed

Activity Number	Package Number	Activities	Loan	Grant	Status
	G31.3	Basic and ICU Multipara monitors	x		Completed
		Procurement of PPE for Family Health Bureau			
	G30.1	Material for Usable Apron Gown	x		Completed
	G30.2	Cost of tailoring charges for PPE	x		Completed
		Procurement of 360 Handheld dopplers one for each MOH			
	G25.11	Handheld Dopplers	x		Processing
19		**Supply of Personal Protective Equipment**			
	G14.2	Quarantine Unit, North Central Provincial Council, LRH and MSD	x		Completed
20	W	**Refurbishment of CSSD**			
	W 29.2	Refurbishment of CSSD		x	Completed
	G30.6	Medical Furniture for CSSD	x		Completed
	W 32	Iodine Therapy Unit- Anuradhapura		x	Processing
	W 31	Iodine Therapy Unit- Ratnapura		x	Processing
	W	Refurbishment of COVID19 Ward- DH Kurunegala			
	W 29. 3	Refurbishment of COVID 19 Ward- DH Kurunegala		x	Processing
		Anthropometric Equipment -FHB			
	G25.9	Beam Balance, Spring balance, Bathroom scale	x		Processing
	G25.10	Hight Rod, Leanth Board	x		Processing
	W29.4	Construction of Virology Lab at Karapitiya		x	Processing
	G35	Lab Furniture -Virology Lab	x		Processing
	W33	ICU Kahawatta		x	Processing
	W34	ICU Karawanella		x	Processing
	W35	Batticaloa Hospital- COVID Ward		x	Processing
	W37	Expansion of Virology Lab at NH Kandy		x	Processing
	G36	Lab Furniture Virology Lab at NH Kandy	x		Processing

ANNEX 6: LIST OF CANDIDATE PLACES WHERE 25 AMBULANCES TO BE DEPLOYED, AND LIST OF CANDIDATE AMBULANCE STATIONS WHERE 20 STATIONS TO BE RENOVATED UNDER JFPR GRANT WILL BE SELECTED FROM

The JFPR grant will support to expand the ambulance fleet by 8% to improve the service capacity of 1990 Suwa Seriya to provide timely prehospital services in identified underserved areas through the procurement of 25 ambulances. The places where the 25 ambulances to be procured will be deployed will be selected from the 45 identified locations in the below table A6-1. The 45 locations are the most underserved areas identified by the MOH and the 1990 Suwa Seriya Foundation based on GIS based mapping of demand and population and involving COVID-19 as well as timing analysis. The 20 ambulances to be procured under the JFPR grant might also be deployed in a rotation basis to stations in the Table A6-1 to allow certain flexibility of ambulance deployment to enable more flexible pandemic response to address the rapidly evolving COVID-19 pandemic on the ground. The selection of places where the JFPR financed ambulances will be deployed will be done through participatory consultations with the MOH and 1990 Suwa Seriya Foundation during the project implementation.

Table A6-1: List of Candidate Places Where the 25 Ambulances to be Deployed will be Selected from

Dist No	District	Proposed Locations	Total
1	**Colombo**	Pettah Police Station	5
		Dematagoda Police Station	
		Padukka Police Station	
		Agulana South Police Station	
		Kahathuduwa Divisional Secretariat	
2	**Gampaha**	Kochchikade Police Station	5
		Katunayaka Police Station	
		Raddoluwa Police Station	
		Ja ela Police Station	
		Weliweriya Police Station	
3	**Kalutara**	Wadduwa Police Station	4
		Moragahahena Police Station	
		Kaluthara North Police Station	
		Tebuwana Police Station	
4	**Galle**	Neluwa Police Station	2
		Yakkalamulla Police Station	
5	**Matara**	Malimbada Police Station	2
		Hakmana Police Station	
6	**Hambantota**	Weeraketiya Police Station	1
7	**Badulla**	Haldummulla Police Station	1
8	**Monaragala**	Gonaganara Police Station	1
9	**Anuradhapura**	Thalawa Police Station	1
10	**Polonnauruwa**	Dimbulagala Police Station	1
11	**Kurunegala**	Maho Police Station	4
		Pothuhara Police Station	
		Giriulla Police Station	

		Alawwa Police Station	
12	**Puttalam**	Dankotuwa Police Station	1
13	**Kandy**	Manikhinna Police Station	1
14	**Matale**	Alawathugoda Police Station	1
15	**Nuwaraeliya**	Mandaramnuwara Police Station	1
16	**Ratnapura**	Kiriella Police Station	5
		Weligepola Police Station	
		Panamure Police Station	
		Rakwana Police Station	
		Pinnawala Police station	
17	**Kegalle**	Dedigama Police Station	1
18	**Batticalo**	Vellavelly Police Station	1
19	**Ampara**	Damana Police Station	1
20	**Trincomalee**	Lankapatuna Police Station	1
21	**Jaffna**	Kankesanthurai Police Station	1
22	**Mannar**	Silawathurai Police Station	1
23	**Vavuniya**	Poovarasankulam Police Station	1
24	**Mullaitivu**	Pudukuddiruppu Police Station	1
25	**Kilinochchi**	Akkarayankulam Police Post	1
		Total	**45**

The JFPR grant will improve the efficiency of the 1990 Suwa Seriya ambulance system by improving the staff and center facilities through renovating 20 ambulance stations for 1990 Suwa Seriya staffs who are located at local police stations. The 20 stations to be renovated will be selected from 48 stations identified by the MOH and the 1990 Suwa Seryia foundation that lack adequate space for vehicle parking and for emergency medical technician teams to rest, stand by, and coordinate with call centers. The selection of stations to be renovated will be done through participatory consultations with the MOH and 1990 Suwa Seriya Foundation during the project implementation.

Table A6-2: List of Candidate Ambulance Stations Where the 20 Stations to be Renovated will be Selected from

No	District	Location	Location Address
1	Putlam	Putlam	Putlam Police Station
2		Marawila	Marawila Police Station
3		Karuwalagaswewa	Karuwalagaswewa Police Station
4	Kurunegala	Galgamuwa	Galgamuwa Police Station
5		Gokarella	Gokarella Police Station
6		Hettipola	Hettipola Police Station
7	Kandy	Galagedara	Galagedara Police Station
8		Kadugannawa	Kadugannawa Police Station
9	Matale	Mahawela	Mahawela Police Station
10	Nuwaraeliya	Maskeliya	Maskeliya Police Station
11	Anuradhapura	Kebitigollawa	Kebitigollawa Police Station

12		Thirappane	Thirappane Police Station
13	Polonnaruwa	Medirigiriya	Medirigiriya Police Station
14	Kegalle	Kegalle	Keagalle Police Station
15	Ratnapura	Embilipitiya	Embilipitiya Police Station
16		Samanalawewa	Samanalawewa Police Station
17		Ratnapura	Ratnapura Police Station
18	Monaragala	Ethimale	Ethimale Police Station
19	Badulla	Passara	Passara Police Station
20	Killinochchi	Killinochchi	Killinochchi Police Station
21	Jaffna	Jaffna town	Jaffna Police station
22		Mulaankavil	Mullankavil police Station
23	Mullativu	Mulliyavalai	Mulliyavalai Police Station
24	Mannar	Madhu	Madhu Police Station
25	Colombo	Mulleriyawa	Mulleriyawa Police Station
26		Nawagamuwa	Nawagamuwa Police Station
27		Bambalapitiya	Bambalapitiya Police Station
28		Homagama	Homagama Police Station
29	Gampaha	Ragama	Ragama Police Station
30		Minuwangoda	Minuwangoda Police Station
31		Mirigama	Mirigama Police Station
32		Biyagama	Biyagama Police Station
33	Kalutara	Beruwala	Beruwala Police Station
34		Kalutara South	Kalutara South Police Station
35		Horana	Horana Police Station
36		Bandaragama	Bandaragama Police Station
37	Galle	Ahungalla	Ahungalla Police Station
38		Poddala	Poddala Police Station
39		Mahamodara	Mahamodara Police Station
40	Hambantota	Hambantota	Hambantota Police Station
41		Ambalanthota	Ambalanthota Police Station
42		Tangalle	Tangalle Police Station
43	Matara	Akuressa	Akuressa Police Station
44		Morawaka	Morawaka Police Station
45		Kamburupitiya	Kamburupitiya Police Station
46	Ampara	Ampara	Ampara Police Station
47	Trincomalee	Kuchchaweli	Kuchchaweli Police Station
48	Baticalo District	Karadiyanaru	Karadiyanaru Police Station

ANNEX 7: INDICATIVE QUARTERLY FINANCIAL INFORMATION INCLUDED IN QUARTERLY PROGRESS REPORT

I. General Instructions

1. The financial information in the format outlined below are to be included in the quarterly progress reports (QPRs) to be submitted to ADB within 45 days after each quarter. In case of delays or incomplete information, ADB will submit a reminder to the EA/IA. Repeated delays or incomplete information may have a negative impact on the project performance ratings and may be discussed during review missions and TPRMs.

A. Section A. Introduction and Basic Data

i. ADB loan number, project title, borrower, executing agency, implementing agency(ies)
ii. Dates of approval, signing, and effectiveness of ADB loans;
iii. Original and revised (if applicable) ADB loan closing date and elapsed loan period based on original and revised (if applicable) loan closing dates; and
iv. Date of last ADB review mission.

B. Section B. Utilization of Funds (ADB Loan, and Counterpart Funds)

2. This section shall include at a minimum, the following information:
i. Estimated project costs and financing plan.
ii. Overall status of project financing including adequacy and timeliness of counterpart funds.
iii. Cumulative contract awards financed by the ADB loan, and counterpart funds (commitment of funds to date), and comparison with time-bound projections (targets – for ADB financing compare the actual contract awards with the contract award curve included in the PAM). Include an analysis of significant variances between planned and actual contract awards. Provide contract-wise details as per Annex 3.
iv. Disbursements: cumulative disbursements from the ADB loan, and counterpart funds (expenditure to date), and comparison with time-bound projections (targets – for the ADB financing compare the actual disbursement with the disbursement projections as per the S-curve included in the PAM). Include an analysis of significant variances between planned and actual disbursements.
v. Reconciliation of project records and ADB disbursement records (LFIS/GFIS) for the reporting period and cumulative from project inception to end of the reporting period. Explain reasons for discrepancies and outline follow-up actions required (if any).
vi. Re-estimated costs to completion, need for reallocation within ADB loan categories, and whether an overall project cost overrun is likely.

C. Section C. Financial Management

i. Summarize the status of financial management in the project including a) any problems in the existing FM arrangements and /or flow of funds and b) any significant changes occurred during the reporting period (e.g., FM staff turnover, implementation of new financial systems, emerging FM related risks etc.).
ii. Summarize the status of FM action plans outlined in the PAM. Attach a detailed log as per Annex 5.

iii. Outline the status of recommendations and immediate actions provided by ADB as part of the APFS/AEFS review (if any) and FM related recommendations agreed during ADB review missions (if any).
iv. Summarize the status of past audit observations (resolved/ pending) as well as internal audit findings.

C. Annexes

3. Attach the FM annexes to the QPR when submitting it to ADB:
   1. Statement of Cash Receipts and Payments by Category
   2. Detailed reconciliation (by Withdrawal application) of project records and ADB disbursement records (LFIS/GILFIS) for the fiscal year to date and cumulative
   3. List of signed contracts
   4. Status of past audit observations (resolved/ pending)
   5. Status of FM action plan (complied/ongoing)
   6. Status of FM related actions agreed during ADB review missions (if any).

QPR ANNEXES

Annex 1: Statement of Cash Receipts and Payments by Category

	Reporting Period (Quarterly/Semi-annually)	Year to date	Cumulative	Hard commitments (contracts signed not paid)
	In the currency of the financial statements			
Cash receipts				
ADB Advance/Replenishments	**Q**	**Q***	**Q^**	
ADB Direct Payments	**P**	**P***	**P^**	
ADB Reimbursement/Retroactive Financing	**U**	**U***	**U^**	
Government	**S**	**S***	**S^**	
Total	**T=Q+P+S+U**	**T*=Q*+P*+S*+U***	**T^=Q^+P^+S^+U^**	
Payments				
Eligible expenditure #1	A	A*	A^	A**
Eligible expenditure #2	B	B*	B^	B**
Eligible expenditure #3	C	C*	C^	C**
Eligible expenditure #4	D	D*	D^	D**
Total expenditures	**E=A+B+C+D**	**E*=A*+B*+C*+D***	**E^=A^+B^+C^+D^**	**E**=A**+B**+C**+D****
Opening cash balance	**H**	**H***	**H^**	
Closing cash balance	K=H+T-E	K*=H*+T*-E*	K^=H^+T^-E^	

Annex 2. Detailed Reconciliation (by Withdrawal Application) of Project Records and ADB Disbursement Records (LFIS/GILFIS) for the Fiscal Year to Date and Cumulative

WA Details			Per project records/APFS (Amount recorded in the project Financial statements as reimbursement, direct payment, etc..)				Per ADB disbursement records LFIS/GFIS (actual Paid)			
Withdrawal application No (WA)	Disbursement method (reimbursement, direct payment, etc..)	Time period covered in the WA	Date	In local currency (as recorded in project records/ financial statements)	exchange rate	USD equivalent (A)	Value date	In USD (B)	Difference (A-B)	Reason for difference (i.e. timing forex. Pending rejected)
1 2 3 etc..										
Total										

Annex 3: Status of Signed Contracts - Cumulative to date

Contract Information											
Description*	**Contract Description**	**Contract Start**	**Contract End**	**Supplier/ Contractor Name**	**Contract No.**	**Total Contract Value**	**Total Contract Amount Invoiced to date**	**Total Disbursed on Contract**	**Total Undisbursed Amount**	**Responsible entity**	**Financing source (ADB loan, etc.)**
1. Civil works											
2: Equipment/ supplies											
3. Consulting services											
Total											

Annex 4: Status of External Audit Observations – Cumulative from Inception to End of Reporting Period

Recommendation/ Audit Observation	External Audit Recommendation	Date of the Recommendation	Planned Actions to Address the Recommendation	Responsibility	Current Status of the Planned Action (pending /resolved)	Remarks

Annex 5: Status of Internal Audit Observations – Cumulative from Inception to End of Reporting Period

Recommendation/ Audit Observation	External Audit Recommendation	Date of the Recommendation	Planned Actions to Address the Recommendation	Responsibility	Current Status of the Planned Action (pending /resolved)	Remarks

Annex 6: Status of Financial Management Action Plan

Key Risk	Risk Mitigating Activity	Timeline	Responsible Entity	Current status (implemented/Pending)	Remarks (including an action plan in case of non-compliance)

ANNEX 8: PROCUREMENT PLAN

Basic Data		
Project Name: Health System Enhancement Project (Additional Financing)		
Project Number: 51107-003	Approval Number:	
Country: Sri Lanka	Executing Agency: Ministry of Health	
Project Procurement Classification: A Procurement Risk: Moderate	Implementing Agency: Provincial Councils of Central, Sabaragamuwa, Uva and North Central provinces	
Project Financing Amount: ADB Financing $113 million Ordinary Capital Resources (concessional loan): $110 million JFPR Grant: $3 million Government of Sri Lanka: $10 million	Project Closing Date: November 30, 2025	
Procurement Plan Duration: 18 months	Advance contracting: Yes	eGP: Partial

A. Methods, Review and Procurement Plan

Except as the Asian Development Bank (ADB) may otherwise agree, the following methods shall apply to procurement of goods, works, non-consulting services, and consulting services.

Procurement of Goods, Works, and Non-consulting Services

Method	Comments
Open Competitive Bidding for Works	Nationally advertised, Prior Review.
Request for Quotations for Works	First two procurement activities carried out by each PIU and PMU are subject to Prior Review, afterwards post review (sampling)
Open Competitive Bidding for Goods	Internationally advertised. Prior Review.
Open Competitive Bidding for Goods	Nationally advertised. Prior Review.
Request for Quotations for Goods	First two procurement activities carried out by each PIU and PMU are subject to Prior Review, afterwards post review (sampling)
Direct Contracting for Goods	All procurement activities carried out by PMU and/or PIU are subject to Prior Review. Procurements through UN agencies are subject to Prior Review.

Consulting Services

Method	Comments
Quality and Cost-Based Selection (QCBS)	All procurement activities carried out by PMU and/or PIU are subject to Prior Review.
Quality Based Selection (QBS)	All procurement activities carried out by PMU are subject to Prior Review.
Consultants' Qualifications Selection (CQS)	All procurement activities carried out by PMU are subject to

Method	Comments
	Prior Review.
Least-Cost Selection (LCS)	All procurement activities carried out by PMU are subject to Prior Review.
Fixed Budget Selection (FBS)	All procurement activities carried out by PMU are subject to Prior Review.
Competitive for Individual Consultants (ICS)	All procurement activities carryout by PMU and/or PIU are subject to Prior Review.

B. List of Active Procurement Packages (Contracts).

The following table lists goods, works, non-consulting services, and consulting services contracts for which the procurement activity is either ongoing or expected to commence within the procurement plan duration.

Goods, Works, and Non-consulting Services

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
G-1	**Medical Equipment for COVID care - Phase 1 Package (multiple contracts)**	16.46	RFQG/OCB/ Direct	Prior	1S1E	Q3/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) RFQG/Goods Bidding Document; d) Advance contracting; e) e-GP (partial) f) Bidders from all eligible countries are permitted. g) Multiple contracts
G-2*	**Medical Equipment for COVID care - Phase 2 Package (multiple contracts)**	18.50	RFQG/OCB/ Direct	Prior	1S1E	Q3/2021	a) Nationally advertised; ; or procured through UN b) No PQ and No domestic preference; c) RFQG/Goods Bidding Document; d) Advance contracting; e) e-GP (partial) f)Bidders from all eligible countries are permitted. g) Multiple contracts
G-3*	**Oxygen concentration Plants with associated facilities (multiple contracts)**	2.63	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; or procured through UN b) No PQ and No domestic preference; c) Plant Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted. g) Multiple Contracts
G-4	**Medical supplies and consumables for COVID Care (many Packages for MSD)**	11.53	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted.
G-5	**25 ambulances for 1990 Suweseriya service financed by the JFPR grant**	1.25	OCB	Prior	1S1E	Q4/2021	a) Internationally advertised. b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							f) Bidders from all eligible countries are permitted.
G-6	**50 Ambulances for improving Home care (via Hospitals in all 9 provinces) (30 Ambulances for MOH districts (inter-hospital transfer) and 20 Ambulances to Suweseriya to reduce response time)**	2.51	OCB	Prior	1S1E	Q4/2021	a) Internationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted.
G-7*	**Lab Equipment for SLIBTEC (multiple equipment)**	1.62	OCB	Prior	1S1E	Q3/2022	a) Nationally advertised; or procured through UN b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted.
G-8*	**Establishing and supporting PCR Labs point of care test and other equipment (multiple packages)**	1.33	OCB	Prior	1S1E	Q1/2022	a) Nationally advertised; or procured through UN b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted. g) Package contains multiple lots and will be evaluated as multiple contracts.
G-9*	**Wall oxygen pipes and oxygen outlets and Establishing HDUs with wall oxygen**	1.18	OCB	Prior	1S1E	Q1/2022	a) Nationally advertised; or procured through UN b) No PQ and No domestic preference; c) Plant Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted.
G-10	**Liquid Oxygen Tanks**	1.18	OCB	Prior	1S1E	Q1/2022	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted.
G-11	Quarantine unit Support - package 3 (furniture, multiple items)	0.05	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-12	Quarantine unit Support - package 4 (electronic items, multiple items)	0.05	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-13	Quarantine unit Support - package 5 (Disease surveillance equipment, multiple items)	0.05	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-14	Computers and Peripherals for Quarantine unit Software	0.10	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted. Package contains multiple lots and will be evaluated as multiple contracts.
G-15	**Hiring transport for COVID care (multiple contracts)**	1.25	RFQG	Post	1S1E	Q4/2021	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document;
G-16	Vehicles (3 Vans) for MOH Quarantine unit of the Ministry of Health, Port health offices of Trincomalee and port of Hambantota	0.15	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-17	**Procurement of training equipment (JFPR Grant)**	0.3	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-18	**Procurement of equipment (Audio Visuals/IT) for receiving hospitals under JFPR grant**	0.25	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-19	Printing communication and training materials for gender-based violence prevention in all three languages (non-consulting services)	0.14	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-20	**Establishing the LAN connectivity and upgrading audio visual system at NIHS (multiple equipment)**	0.4	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-21	**Establishing the LAN connectivity and upgrading audio visual system at 9 regional training (multiple equipment)**	0.23	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-22	**Equipment for regional training centers and other training centers**	0.20	RFQG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted.
G-23	**Hiring of Liquid Oxygen Capsules**	0.75	Direct	Prior	NA	NA	a) Bidding Documents: OCB Goods or RFQ
G-24	**Supply of Basic Life support equipment for Ambulances (for suweriya and MOH**	1.00	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
	ambulances)						e) No e-GP f) Bidders from all eligible countries are permitted.

Note: Packages highlighted in bold are for COVID-19 pandemic response.
* Could be procured through UNICEF/UNOPS as direct contracting.

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
W-1	Procurement of Works – Round 2 (5 PMCU, Kandy District)	0.36	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-2	Procurement of Works – Round 2 (5 PMCU, Matale District)	0.68	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-3	Procurement of Works – Round 2 (5 PMCU, Nuwara Eliya, District)	0..68	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-4	Procurement of Works – Round 2 (5 PMCU, Monaragala District)	0.76	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-5	Procurement of Works – Round 2 (5 PMCU, Badulla District)	0.72	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-6	Procurement of Works – Round 2 (6 PMCU, Kegalle District)	0.74	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-7	Procurement of Works – Round 2 (2 PMCU, Rathnapura District)	0.27	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-8	Procurement of Works – Round 2 (4 PMCU, Anuradhapura District)	0.53	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-9	Procurement of Works – Round 2 (5 PMCU, Polonnaruwa District)	0.53	OCB	Prior	1S1E	Q4/2021	a) Nationally advertised; b) No PQ and No domestic preference; c) Bidding Document for small works; d) Advance contracting; e) No e-GP f) Package contains multiple lots and will be evaluated as multiple contracts.
W-10	Procurement of Works – Renovation of field health care centers (127 facilities in all 9 districts)	3.69	RFQ	Post	1S1E	Q1/2022	(a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (d) Advance contracting; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							multiple contracts.
W-11	Procurement of Works – Construction of Hospital buildings with sewerage facilities and repairs to Strengthen Apex Hospitals in nine project districts.	14.19	OCB	Prior	1S1E	Q3/2022	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for works; (d) Advance contracting; (e) No e-GP (f) Package contains multiple lots and will be evaluated as multiple contracts.
W-12	**Procurement of Works – PCR Laboratory renovations**	0.13	RFQ	Post	1S1E	Q4/2021	(a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.
W-13	**Procurement of Works – establishment of high dependency unit in Secondary level hospitals**	0.64	RFQ	Post	1S1E	Q4/2021	(a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (d) Not under Advance contracting; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.
W-14	**Procurement of Works – Improving the facilities of the Suweseriya Paramedical staff based at selected 20 regional stations (selected police stations in Sri Lanka)**	0.60	RFQ	Post	1S1E	Q4/2021	(a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (d) Not under Advance contracting; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.
W-15	**Procurement of Works – Upgrading national Institute of health sciences**	0.93	RFQ	Post	1S1E	Q4/2021	a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (e) e-GP (partial) (f) Package contains

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
							multiple lots and will be evaluated as multiple contracts.
W-16	**Procurement of Works – Development of the Regional Training Centers in all 9 provinces**	0.68	RFQ	Post	1S1E	Q4/2021	a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.
NC 1	**Improving transport facilities for outreach care of COVID-19 patients and contacts**	1.26	RFQ	Post	1S1E	Q4/2021	a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.
W-17	Establishment of Gender-Based violence prevention support Centers	0.11	RFQ	Post	1S1E	Q4/2021	a) RFQW; (b) No PQ and No domestic preference; (c) Bidding Document for RFQW; (e) e-GP (partial) (f) Package contains multiple lots and will be evaluated as multiple contracts.

Note: Packages highlighted in bold are for COVID-19 pandemic response.

Consulting Services

Package Number	General Description	Estimated Value	Selection Method	Review	Type of Proposal	Advertise-ment Date	Comments
C-1	Consultancy firm for review of local level nutrition service and material & support for training in nutrition counselling for PHC staff	0.46	CQS	Prior	STP	Q1/ 2022	Output based; National experts; CQS Advance action
C-2	Consultancy firm for reviewing, developing branding material and for rolling out communication campaign for increasing PHC utilization	0.71	QCBS	Prior	STP	Q1/ 2022	Time Based; national expert; Advance action
C-3	Consultancy firm for Design and Supervision of Apex Hospital and sewerage systems	1.45	QCBS	Prior	FTP	Q1/ 2022	Time Based; National experts; QCBS 90:10 Advance action
C-4	Quarantine MIS software development firm	0.20	CQS	Prior	STP	Q1/ 2022	Output based Based; National

Package Number	General Description	Estimated Value	Selection Method	Review	Type of Proposal	Advertise-ment Date	Comments
							experts; CQS Advance action
C-5	GIS Consultant	0.05	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-6	**Financial Management Officer**	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-7	**Consultant to Support to Pre-hospital services (JFPR Grant)**	0.05	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-8	**Environment Officer**	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-9	**Healthcare Waste management Officer**	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-10	Gender Officer	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-11	Health Communication officer	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-12	**Molecular Biologist (intermittent)**	0.12	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-13	**Monitoring and evaluation officer**	0.02	ICS	Prior	-	Q4/ 2021	Time Based; national expert; Advance action? N
C-14	Consultant to conduct feasibility and operational arrangement for investing in mobile laboratories	0.1	ICS	Prior	-	Q2/ 2022	Output based, National expert Advance action? N
C-15	Networking consultant for APVAX LAN establishment (Matale and Anuradhapura)	0.05	ICS	Prior	-	Q4/ 2021	Output based, National expert Advance action? N
C-16	Networking consultant for APVAX LAN establishment in seven clusters	0.08	ICS	Prior	-	Q4/ 2021	Output based, National expert Advance action? N
C-17	Cluster implementation consultant	0.05	ICS	Prior	-	Q4/ 2021	Output based, National expert Advance action? N
C-18	Consultant to support establishment of gender-based violence support Centers	0.11	ICS	Prior	-	Q4/ 2021	Output based, National expert Advance action? N
C-19	**Procurement Officers (2)**	0.05	ICS	Prior	-	Q4/ 2021	Output based, National expert Advance action? N

Note: Packages highlighted in bold are for COVID-19 pandemic response.

C. List of Indicative Packages (Contracts) Required under the Project

The following table lists goods, works, non-consulting services, and consulting services contracts for which the procurement activity is expected to commence beyond the procurement plan duration and over the life of the project (i.e., those expected beyond the current procurement plan duration).

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertise-ment Date	Comments
G-25	Medical equipment and furniture to 9 Base Hospitals (Cluster Apex) in each of the 9 district clusters	4.5	OCB	Prior	1S1E	Q1/2023	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) e-GP (partial) f) Bidders from all eligible countries are permitted.
G-26	Computers & Peripherals (including GIS and introduction of HIT system for seven clusters facilities)	0.88	OCB	Prior	1S1E	Q2/2022	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted. Package contains multiple lots and will be evaluated as multiple contracts.
G-27	Computers & Peripherals including GIS and introduction of HIT system for two selected cluster facilities (Matale and Anuradhapura Districts)	0.25	OCB	Prior	1S1E	Q2/2022	a) Nationally advertised; b) No PQ and No domestic preference; c) Goods Bidding Document; d) Advance contracting; e) No e-GP f) Bidders from all eligible countries are permitted. Package contains multiple lots and will be evaluated as multiple contracts.
G-28	Establishing Local Area Networking in two clusters (Matale and Anuradhapura Districts)	0.15	RFG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted. f) Multiple contracts
G-29	Establishing Local Area Networking in seven clusters	0.30	RFG	Post	1S1E	Q1/2022	a) RFQ; b) No PQ and No domestic preference; c) RFQ Bidding Document; d) e-GP (partial) e) Bidders from all eligible countries are permitted. f) Multiple contracts

D. Consultant's Terms of Reference

Consulting Firms

1) Design and Supervision of Construction Firm for 9 Base Hospitals of Thambuthegama, Medirigiriya, Theldeniya, Rikilagaskade, Dambulla, Kahawatte, Karawanella, Bibile and Welimade

Type and Source of Consultant / Package No.	Duration
Firm (National) (S-1)	36 months (2022 to 2024)

Qualification and Experience:

- The firm has to have at least 10 years' experience in design of health sector hospital buildings. The team leader and the deputy team leader have to be a Civil Engineer and an architect respectively.

Expected Output:

- Complete designs of new constructions, develop detailed Bill of Quantities of all repairs to hospitals and where necessary design sewerage systems in the 9 Base Hospitals mentioned above.
- Supervise construction and repairs at all 9 hospitals

Terms of Reference:

1. Designing new construction at 9 Base Hospitals

a) Prepare design sketches of proposed new construction based on the Client's requirements stated in Annex 4 of the PAM and detailed in Annex 1 to this TOR.
b) Provide adequate information by way of 3D views, models and drawings to convey to the Client the principles of the designs.
c) Conduct discussions with the Client to derive the final layout plans;
d) Ensure implementation of sustainable architecture components in line with the country specific standards;
e) Ensure access of disability persons to all the facilities;
f) Ensure minimum disruption to the routine health service provision to the community
g) Prepare architectural, structural and building services plans to accommodate the Client's requirements of the buildings;
h) Ensure that necessary drawings and documents are prepared and submitted, followed up and provide support so that approvals are obtained in a timely manner. The Consultant shall closely co- ordinate with the Client to ensure proper documentation,
i) submission of fees, and monitoring of correspondence is carried out;
j) Obtain approval for all structural drawings by the relevant authorities;
k) Ensure that only such approved drawings are issued at site and the work is carried out in accordance to the said approved drawings;
l) Prepare the engineering designs of all civil works in sufficient detail to ensure clarity and understanding by the Client and other relevant stakeholders. All designs should be in conformity with the best international / Construction Industry Development Authority (CIDA) standards;
m) Prepare Bills of Quantities with due diligence to establish accurate quantities;

2. Developing the bill of quantities for all repairs at the 9 Base Hospitals and at the

National Institute of Health Sciences, Kalutara

a) Reviewing the extent of repairs needed and developing the BOQs for all repairs

3. Assisting the client in the procurement process for hiring a construction firm

a) Draft bidding documents in accordance with the applicable ADB guidelines including drawings, BOQs and other technical sections for works contracts by using most appropriate sample bidding document;

b) Prepare all final detailed drawings and issue along with the bidding documents as marked as “For bidding purpose only” to the bidders; and

c) Incorporate the detailed design drawings for important elements of the structure, detailed BOQ and Specification for the Works in the bidding documents.

d) Assist the Client throughout the bidding process for all works contracts from bidding document preparation; bid evaluation, contract award. This shall include, but not be limited to, the preparation of bidder prequalification documents if relevant; attendance at the pre- bid meetings and site visits; technical and financial bid evaluation for single stage and/or two stage bid

e) procedures; and the preparation of Bid Evaluation Reports for approval by the bid evaluation committee;

4. Providing supervision and monitoring services during construction stage; this includes construction supervision, contract administration, quality monitoring, health safety and environment requirements, time management, cost management, dispute resolution, completion. The detailed TOR gives more descriptions.

2) BCCM Firm

Type and Source of Consultant / Package No.	Duration
Firm (National) (S-3)	24 months from 2022 to 2023

Qualification and Experience:

1. The company should have a proven track record and a reputation of having carried out similar integrated marketing communications services at a national or and at a provincial level in Sri Lanka. Should have been in the industry for over 5 years providing similar services. A thorough understanding of the rural consumer and their lifestyle and some knowledge on health seeking behavior is crucial.
2. Field teams should have expertise in strong strategic insights, brand building, client management, design, creative, digital, outreach, AV production, PR, research and production capabilities.
3. The company should be able to either provide all services required as per the project output as one service provider or secure services of other service providers as a part of their integrated service offer as per the TOR.
4. Support to enhance the image of PHC service providers amongst the community and the morale of PHC service providers.
5. The firm should be able to nominate a dedicated team of experts and field-based personnel.

Expected Output:

1. Inception report: Draft outline of the methodology for the review of existing material, KAP survey and the proposed approach to be taken for carrying out the BCCM campaign in the target provinces.

2. Interim report: a draft of the non-media BCCM campaign and the advocacy and awareness campaign to promote the concept of a ‘a people friendly, accessible PHC center’ for everyone in the village.
3. Final report: on the BCCM campaign with measurable changes in behavior.

Terms of Reference (Detailed TOR in Annex 11 of PAM)

1. Undertake a baseline KAP Survey that would serve as a baseline to measure current knowledge attitudes and perceptions that prevail amongst the seekers of PHC in the four selected provinces. This should also include a qualitative component that provides prevailing deeper consumer insights and barriers for change.
2. Review exiting communications material on encouraging PHC use and engage in a discussion with HPB and the HEOs to agree on future use of them for PHC utilization.
3. Engage in discussions with the Ministry of Health, Nutrition and Indigenous Medicine, Health Promotion Bureau and the 4 provinces and the respective 9 districts to seek agreement on the strategy that should be adopted to carry out a BCCM campaign for increasing PHC utilization in Sri Lanka.
4. Support to enhance the image of PHC service providers amongst the community and the morale of PHC service providers.
5. Develop an integrated communications campaign including branding, message development, IEC products, AV products, documentaries, outdoor awareness, PR, advocacy, digital marketing, Apps, social media, outreach activities to create a change of behavior amongst current users of PHC, by-passers, males, plantain sector workers, and other vulnerable population groups.
6. Coordinate with the MOH, PMU and the 4 provincial and PIU counterparts, ADB, on the timing of the BCCM campaign as branding of the PHCs are linked to refurbishment of health facilities and to the establishment of pilot clusters.
7. This campaign will be carried out with minimal mass media inclusion, but with regional media such as regional radio and other locally acceptable channels.
8. Launch a communications campaign for at least 1-year duration utilizing the material developed.
9. Train and handover the materials and methodology to the Health Education Officers at each of the districts to continue to support BCCM for PHC utilization.
10. Support to monitor the footprint at the PHCs and to assess the quality of care following the launch of the BCC campaign.

Key Personnel	Person-Months	Qualification/ Experiences	Terms of Reference
Team Leader / Communicat-ions expert	24 months	Master’s Degree in Communications or in a related field and at least 10 years of experience in non- media communications, with strong credentials in BCCM strategy planning and implementation	1. The team leader will be responsible to develop the methodology for carrying out a review of available material and to design and plan the methodology for the KAP survey and to define the approach that will be taken to increase PHC utilization. 2. Manage the team to carry out the advocacy program, the KAP survey, the communications campaign.

Key Personnel	Person-Months	Qualification/ Experiences	Terms of Reference
Public health expert	24 months	Master's Degree in Community Medicine with extensive experience in developing advocacy material/ awareness material for behavior change.	1. To review all available communications and advocacy related material, to provide input to the finalization of the communications campaign and be an active team member in the roll out of the campaign. 2. Provide input to the reports on the advocacy program to support a people friendly PHC center for everyone. 3. Carry out the advocacy program for increasing PHC utilization
Communicat-ions Monitoring expert	12 months	A Master's degree in communications/ public health/ advertising/ and experience in communications monitoring and planning. The expert should also have experience in qualitative data interpretation and analysis.	1. Develop a monitoring plan for the proposed communications program. 2. Establish ways of monitoring the communications campaign. 3. Support and enhance the capacity of the Health education officers at the districts on communications monitoring.

3) Information Technology firm for Quarantine Management Information System

Type and Source of Consultant / Package No.	Duration
Firm (National) (S...)	**24 months**

Qualifications and Experience:

1. Minimum 10 years of experience in software development in Sri Lanka.
2. Experience in development and implementation of Open Source based systems like HHMIS/DHIS in health sector; successful completion of at least 1 project that is functional.
3. Annual Turnover of more than 25 million in last 3 financial years.

Expected Outputs:

1. Submission of Inception Report (project plan, detailing work schedule, key staff deployment, methodology, etc.)
2. Submission of Software Requirement Specification (SRS) Document
3. Development of integrated software and demonstration to Health Inormation and Quarantine units
4. Completion of Software Testing- User Acceptance Testing
5. Roll out of integrated software at pilot locations
6. Roll out at all locations

Terms of Reference: (to be drafted)

Key Staff

Key Personnel	Person-Months	Qualification/ Experiences	Terms of Reference
Project Manager (Team Leader)	24 months	10 years of experience in managing projects related to the social and or health sectors	The Project Manager will be responsible to meet all above tasks identified in the firm TOR and will manage his / her team to deliver the results.
Systems Architect	12 months	A master's in computer science or equivalent qualifications with at least 10 years of experience in designing technology solutions.	The systems architect will review what is existing in the health sector and will define a solution adapting from the systems currently in use. She/he will support the integration of such a blueprint to the pilot clusters in the 9 districts and will provide technical assistance to address the issues that arise with implementation.
Software Engineers	24 months	BS/ B Tech/ BE/ MCA/ MS or similar IT professional degree with minimum 5 years of experience in design, development, and implementation of HHMIS/ DHIS systems	The Software Engineers will develop the blueprint for health IT infrastructure with the support from the systems architect and will work out details related to the platforms, hosting, training, integrating a HIT system etc.

4) Review nutrition services and assist training on nutrition counselling for PHC staff

Type and Source of Consultant / Package No.	Duration
Firm (National) (S-14)*	48 months

See detailed TOR in Annex 14 of the PAM.

Individual Consultants

1. **Cluster Implementation Support Specialist (Middle Level),** national, 24 pm (part time, 10 days a month)

Qualification and Experience

- Post Graduate degree in public health.
- At least 8 years of work experience health sector with at least 2 years of work experience in the provinces

Terms of Reference

The consultant will:

- Support the MOH, Provinces and the respective districts under the original project to formally establish the identified 9 clusters in the 9 districts.

- Engage in discussions with the MOH to develop the required MOH circulars, SOPs, and other documentation (related to sharing of human resources, use of the budgets, patient information, drugs, laboratory, imaging, clinic, OPD services, sharing of technical expertise and outreach services required for making clusters functional as a group of facilities that share care.
- Develop / Draft the SOPs, Policies and Guidelines for smooth functioning and flow of information among various facilities under a cluster
- Support the RDHS and the Cluster Head / Dep RDHS to define human resource gaps, training gaps, equipment and other requirements at each level to ensure the availability of services within the clusters.
- Support to draft the referral guidelines based on the services available at various levels of facilities for use by each of the clusters.
- Work with the RDHS and the relevant officers to estimate the drugs, reagents, imaging and lab service requirements for serving demarcated populations in each of the cluster linked facilities.
- Support to help in using the results monitoring frameworks to monitor progress of cluster implementation.
- Provide implementation support to the RDHS and the Dep RDHS / Cluster Health to establish a supervision mechanism and to function the 9 clusters in each of the 9 districts.

2. **Consultant to design a local area networks in 31 hospitals in 2 clusters in Dambulla and Thabuthegama in Mathale and Anuradhapura districts,** national, 6 person months and a repeat consultancy for other 7 clusters

TORs still being drafted.

3. **GIS based monitoring and planning,** national, 36 months (Part time, 10 days a month for 3 years)

Qualification and Experience

- Master's degree in Engineering / Public Health / related field with special training and experience in using GIS in planning in the health sector and in other sectors in Sri Lanka

Terms of Reference

The consultant will:

- Establish GIS units in the target 4 provinces and the respective 9 districts which will be linked to the MOH, to the NIHS and to the Health Information unit of the Planning unit.
- Coordinate with the MOH GIS units to consolidate the systems that will be used for updating data, for reviewing spatial related data and for reporting GIS based data and health outputs and outcomes.
- Carry out required training and support the regional GIS units to be functional.
  Establish GIS based monitoring and planning in the 9 pilot clusters that are supported under the project
- Support to develop and update health seeking behavior maps, and health indicator related maps related to clusters in the target districts.
- Provide technical assistance for the districts and the provinces to use GIS based spatial data for health planning and monitoring of cluster performance and performance of each facility.
- Develop detailed GIS maps layering different features and indicators at different levels of facilities while improving the capacity of the respective units to independently carry out these tasks at regular intervals.

- Develop GIS based dashboards for facility level monitoring and transfer the knowledge to the respective GIS units to manage the dashboards
- Develop user friendly data collection methods for updating data and the related indicators in the GIS maps.
- Develop linkages with other departments' data sources for updating the GIS maps
- Provide hands on training to all pilot hospital clusters, district and provincial facility managers in using the GIS maps as monitoring tools

4. **Individual consultant to carryout feasibility and operational arrangements for investing in mobile laboratories and radiology services to support PHC and on opting for cost per test options,** national, 3 months.

TORs still being drafted.

5. **Individual consultant to carryout feasibility and operational arrangements for investing in mobile laboratories and radiology services to support PHC and on opting for cost per test options,** national, 3 months.

TORs still being drafted.

6. **JFPR Grant - Individual consultant to lead the development of protocols and to support the rollout of the implementation of the protocol,** national, Part time, 100 days over 1 year

7. **Environment Officer,** national

TORs still being drafted.

8. **HWCM Officer,** national

Terms of Reference:
The consultant will support the PMU and the Environment Specialist on:

1. HCWM Plans
- Provide technical training to provincial, district and PHC staff for preparation of health care waste management plans for each facility and for each cluster in the 9 districts, as per the draft national policy and national guidelines.
- Lead technical discussions with provinces and districts (on determining the most cost-effective treatment and disposal strategies for HCW to be included in the final HCWM plan for each facility and for the 9 clusters.
- Review each HCWM plan and provide feedback for finalizing same.
- Provide technical training to staff of HCF in implementing the final approved HCWM plans and consultatively develop a monitoring plan to record progress of them on an annual basis.

2. Waste Management Audits
- Provide technical training and develop a written guideline to staff of PHCs on conducting waste audits.
- Provide technical assistance to PHCs to carryout regular Waste audits
- Manage the training and capacity building program on HCWM for PHC staff in the target provinces.
- Support the PMU and Env specialist to implement and oversee the HCWM improvement

measures equipment, storage space, PPEs and HCW separation furniture) that are planned to be introduced in the 9 clusters

9. **Gender Officer,** national

TORs still being drafted.

10. **Health Communications Officer,** national

TORs still being drafted.

11. **Molecular Biologist,** national

- Should be able to process gene sequencing data generated by Next Generation Sequencing (NGS) technologies. This includes,
  - Both human and pathogen genome sequences.
  - Both whole genome sequencing and target genome sequencing.
- Should be able to analyze and interpret above mentioned gene sequencing data using appropriate software tools.
- Should have the knowledge to recommend the needed software and other relevant facilities for this work.
- Competency related to the SARS-CoV-2 gene sequencing, data processing and analysis is essential to identify known and emerging SARS-CoV-2 variants and to correlate the sequence characteristics with significant phenotypic changes.
- Competency in HIV genotyping and drug resistance, Hepatitis B and C virus genotyping, Influenza virus strain typing, Adenovirus typing, Enterovirus typing, Human Papilloma Virus (HPV) typing and etc. are expected.
- Competency of processing and analysis of human genome sequencing data to for clinical decision making in cancer related management.
- Competency in preparation of phylogenic trees and databases for interpretation of genotypes to phenotypic outcomes.

Qualifications and Experience:

- Basic science degree preferably with specialization in Bioinformatics recognized by the University Grants Commission (UGC).
- Post graduate qualification (MSc/MPhil/PhD) in pathogen genome and/or human genome sequence-based data analysis.
- Research on service-oriented experience in pathogen and/or human gene sequence-based data analysis.
- Hands on experience in interpretation of sequencing data at least for 3 years.

12. **Procurement Officer (first level supervisor is the Project Procurement Specialist),** national

- Responsible for all project related procurements, including quotations, analysis and approvals for purchases / imports etc.
- Support in the execution of the procurement of Medical Equipment, Health Products, Goods, Services including Consultancy Services, Civil Works, Non-Health products and Non-Health Equipment complying with the NPA procurement guidelines and Ministry of Finance regulations on Procurement.

- Preparing necessary documentation for procurement e.g., bid documents to invite bids under International Competitive Bidding, National Competitive Bidding and National Shopping Procedures
- Ensuring that all procurements are according to ADB guidelines
- Supporting the Technical Evaluation Committee with the preparation of the Technical Evaluation Committee Report in line with the NPA guidelines.
- Support the Project Procurement Committee (PPC) with regard to the award of contracts and other issues related to procurement and ensure minutes of meeting and documentation are available
- Review the procurement activities of the PPC and Ministry Procurement Committee for compliance
- Maintain records of all items purchased and relevant details thereof with registers of assets and inventoried items.
- Preparation of contractual agreements.
- Maintain contact with supplies and ensure goods / orders are delivered on time to the correct locations as per instructions issued
- Any other tasks related to procurement designated by the Procurement Specialist, the PD and DPD.

13. **Financial Management Officer,** national, 48 months

Qualification and Experience

- Graduate degree in Accounting or Professional Accounting Qualification
- At least 5 years of relevant experience

Terms of Reference (first level supervisor is the Finance Manager (FM)of PMU)

- Assist the FM and the FM team in the preparation of cash forecasts, variance analysis, compliance with government regulations, preparation of final financial accounts, all financial monitoring systems,
- Supports the FM in overall budget monitoring and in the preparation of the monthly expenditure and allocation report
- Reviews all financial documents for accuracy
- Supports data entry of financial related systems
- Monitors the advance payment settlements and reports status to FM
- Facilitates the timely disbursement of funds for smooth project implementation
- Reviews for completeness and correct entry of all payment vouchers, journals, bank reconciliations, fixed assets register, and supporting documentation
- Assists in providing financial related information requested by all stakeholders
- Assists in developing necessary schedules and documents for reviewing, reprogramming or other purposes requested by the MOH or/and Ministry of Finance
- Any other supporting tasks related to Finance matters requested by FM and PD

14. **M&E Officer (first level supervisor is the M& E Officer/Specialist),** national, 48 months
TORs still being drafted.

ANNEX 9: GRIEVANCE REDRESS MECHANISM

1. The project expects to establish a grievance redress mechanism that is available and accessible to the community, officials from the government and non-government organizations and all citizens directly or indirectly affected or influenced by the project interventions. In addition, a grievance redress mechanism (GRM) is required for addressing grievances related to environment and social issues related to the project. A well-defined and managed grievance redress process will benefit the project implementing teams as well as the communities directly and indirectly influenced or affected by the project. It will help to address minor disputes before they are elevated to formal dispute resolution methods by complainants including to the legal system, mediation bodies or members of parliament.

2. The Health System Enhancement Project (the original project) defines a grievance as any complaint, concern, injustice, wrongdoing, accusation or queries, suggestions and comments related to the project's design, the environment and social impacts and implementation. A complainant can be a community member, a community organization or a government or non-government organization or any other individual or body. A GRM is a set of specified processes and procedures for revealing, assessing, addressing grievances or complaints and resolving disputes and monitoring. A grievance redress committee (GRC) is a special body established at the level of the project management unit of the original project to strengthen grievance redress mechanism during planning and implementation of the original project in Sri Lanka from 2018 to 2023.

3. The GRM is expected to function as a 'customer service department'. The proposed structure will have two tiers as defined below and is shown in Figure 1. The GRC must be appointed and established before commencement of construction site works and the design and supervision firm should be briefed of the GRM system for the original project. Only written grievance (format for such is attached below) will be forwarded to the GRC that will call a hearing, if necessary, with the complainant. PMU and PIUs will provide transcription services for illiterate people unable to write. The process will facilitate resolution through mediation. The GRC (both at PIU or PMU levels) will meet as required and direct the field level with clear instructions and responsibilities to resolve the agreed actions within one week of meeting. If the grievance is related to construction, the contractor will sit in the GRC as an observer.

4. Levels of GRM resolution

i. **Tier 1:** Project Implementation Unit (PIU) at the provincial level will be the first level to resolve grievances. The Deputy Project Director (DPD) who heads the PIU will be the focal point for grievance redressal and will act as the chairman of GRC at the provincial level. Its members will include the respective district director of health, the social and environment responsible officers from the PIU (secretary to the committee), one nominated officer from the provincial council, and a representative of the community.

ii. **Tier 2:** The Deputy Project Director at the PIU in consultation with the environmental specialist and/or social safeguards specialist or any other relevant official of the PMU will activate the second level for grievances that are not resolved at tier 1. In addition, via an officer of local authority, chief secretary, *Grama Niladhari*, construction site office or directly by a community member or any other individual can also directly report a grievance to the tier two. The GRC at the PMU level (Second tier) will be headed by the Project Director of the original project (Chairman of the committee) and its members will include: Deputy Director General

(Planning) of the MOH, a nominated representative of Chief Secretary of the respective province, Deputy Project Director of the respective province, environment officer and social safeguards officer (Secretary to the committee) and a representative from the respective community.

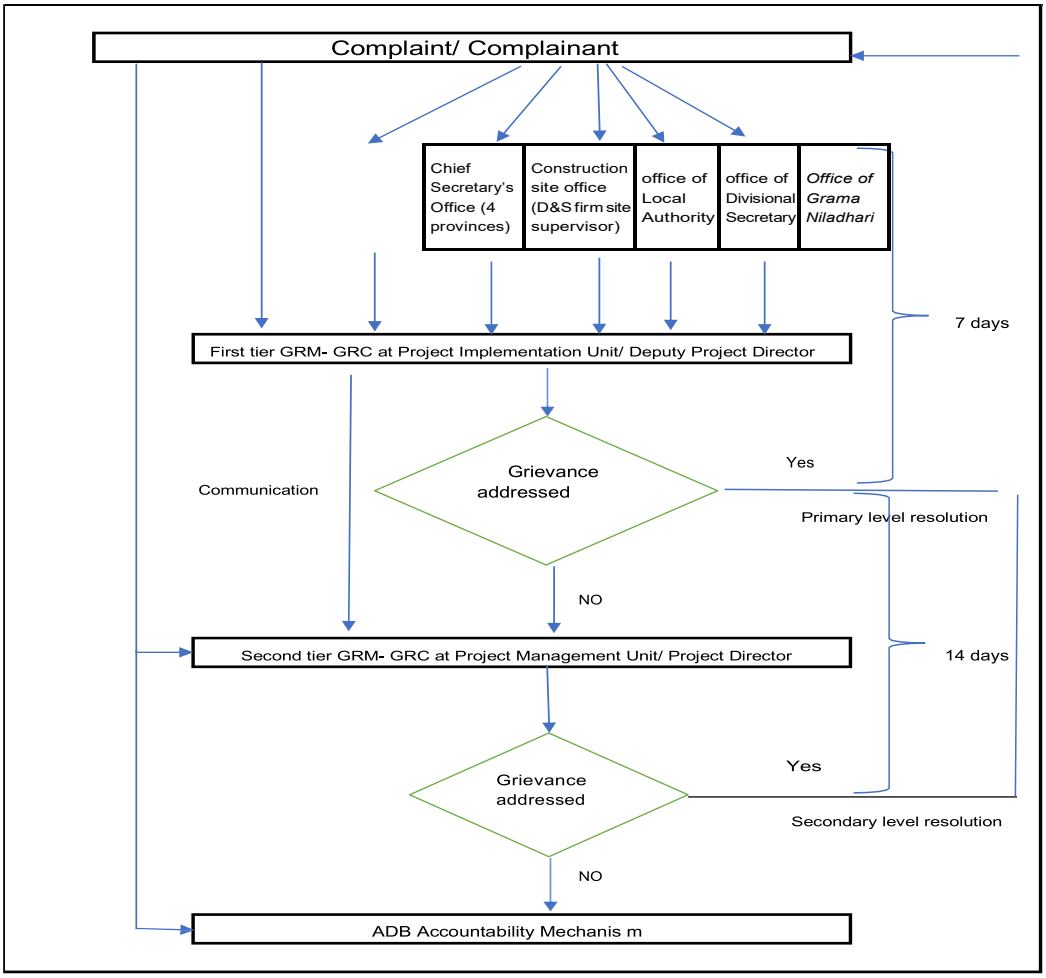
5. The GRM will not impede the AP's decision to use the legal system at any time.

6. On receiving a grievance (via an office of local authority, chief secretary, *Grama Niladhari*, construction site office or directly by a community member or any other individual), the PIU or the PMU will:

i. enter the grievance in the Complaints register of the respective PIU or the PMU;
ii. open a grievance file for the specific case;
iii. maintain records of the GRC meetings; and
iv. close the grievance filling a closure sheet that will be signed by the complainant agreeing that the concern has been satisfactorily resolved.

7. Grievances will be resolved to within 7 days based on-site investigations and consultations with relevant parties. All grievances will be properly recorded with personal details unless otherwise requested. Details on the focal person and the process of filing complaint will be posted in strategic areas at the construction site and at the project office. complaints filed/resolved will be included in the semiannual environmental monitoring report submitted to ADB and will be disclosed to ADB website as required by SPS 2009.

Grievance Redressal Mechanism



Source: Asian Development Bank

Sample GRM complaint form

GRIEVANCE REDRESS FORM **(MOH/PMU/PIU date seal)**

(Sinhala, Tamil and English)

The MOH/ADB project welcomes complaints, suggestions, queries and comments regarding project implementation. We request persons with a grievance to provide their name and contact information to enable us to get in touch with you for clarification and feedback. If it is group representation, please provide details of two contact persons.

Thank you.

Date & Place of registration of complaint:

Contact Information/Personal Details

Name Gender

Age

Home Address

GN division DS division

Occupation/ Employment:

Phone no. E-mail

Complaint/Suggestion/Comment/Question Please provide the details (who, what, where and how) of your grievance below: ……..……

If included as attachment/note/letter, please tick here:

How do you want us to reach you for feedback or update on your comment/grievance? FOR OFFICIAL

USE ONLY

Registered by: (Name of Official registering grievance) Mode of communication:

1. Note/Letter 2. E-mail

3. Verbal/Telephonic

Reviewed by: (Names/Positions of Official(s) reviewing grievance) Action Taken:

Whether Action Taken Disclosed:

4. Yes No Means of Disclosure:

.....Tear off.....

Receipt for complainant

Date and place of complaint: Name of complainant: Complaint

recorded/ registered by

ANNEX 10: CLIMATE CHANGE AND DISASTER RISK RESILIENCE

A. Climate Change

1. Ongoing Health System Enhancement Project (the original project) intends to strengthen primary health care (PHC) in four target provinces and supports initiatives related to disease surveillance, prevention and control including better implementation of the international health regulations. The Additional Financing (AF) shall continue to support the ongoing activities under the original project which includes (i) PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces; (ii) health information system, disease surveillance and coronavirus disease 2019 (COVID-19) response strengthened, and (iii) policy development, capacity building, and project management supported as outputs. Nine base hospitals (BHs) selected in the above four provinces shall be improved to operate as apex hospitals. Further the grant under Japan Fund for Poverty Reduction (JFPR) which will support the project to enhance the services by Suwaseriya ambulance service.

2. Furthermore, the project shall continue to support climate adaptation and mitigation by preventing the health and environmental hazards due to poor health care waste management; use of energy efficient lighting, ventilation, cooling systems within the refurbished and newly constructed building which shall result in a reduction of energy consumption; and procurement of Ambulance vehicles that are more efficient in fuel consumption and complying with national vehicle emission standards.

3. A building footprint of approximately 22,500 m^2 shall be included under AF through improvements to the nine BHs. This shall be in addition to the 34,490 m^2 footprint in 135 primary medical care units (PMCUs) under the ongoing project. Procurement of fuel-efficient Ambulance vehicles shall also assist in reduction of CO_2 emissions. Estimated total reduction of CO_2 emission through the AF shall be around 4,300 tons per annum.

4. Total cost for climate change for the AF is estimated at $9.96 million, with adaptation estimated to cost $6.28 million and mitigation costs estimated at $3.68 million. ADB will finance 83% of mitigation costs and 100% of adaptation costs. Details of activities contributing to climate change mitigation and adaptation and estimated cost for each item is presented under section “Disaster Risk Resilience” of this annex.

5. The project is also designed to provide proper drainage system for rainwater and wastewater management by using robust building regulations and improved enforcement, and climate resilient design standards in new and renovated buildings as a potential climate change adaptation to the project.

B. CO2 Emission Reduction Calculation for Additional Financing

6. **Reduction from Energy**

Calculation of CO_2 emission reduction = (0.76 (amount of CO_2 generated in kg per kWh) * 250 (average energy consumption in a traditional building in SL in kWh per square meter per annum) *22,500 (total PCMUs and DHs building area in square meters))/1000 = **4,275 tCO_2e/year**

7. **Reduction from AF Project (Ambulance Vehicles)**

GHG emissions reduction = 11.7 Mwh/year (Energy savings/year) x 0.6 (emission factor) = **7.02 tCO_2e/year**

C. Disaster Risk Resilience (DRR) for AF

SN	Activities that Contribute to Climate Change Adaptation and Mitigation	Total Cost of Activity ($ million)
Adaptation		
1	Improved monitoring of diseases due to changing climatic conditions via shared care services and timely reporting of the 28 notifiable diseases	0.20
2	New IT equipment for improved disease surveillance for monitoring changes in disease outbreaks	0.45
3	Acquisition of vehicles to improve the mobility and responsiveness of medical officers of health and field health officers to respond to outbreaks and to attend preventive health work including immunization of 10 vaccine preventable diseases	0.40
4	Capacity building on design, operations and maintenance of civil works/infrastructure to ensure their proper upkeep and resilience to climate change	0.10
5	Capacity building on risk communication for timely management of outbreaks, infection prevention and control to ensure all PHC providers in the rational use of antibiotics, inculcating hand washing practices, etc.	0.20
6	Incorporate climate and disaster resilient designs into new buildings designed in the Nine apex hospitals	1.50
7	Use of appropriate construction materials resilient to climate change and disaster risks	2.20
8	Construction and rehabilitation of drainage system for rainwater and wastewater to accommodate increased stormwater discharge	0.65
9	Operations and maintenance of civil works/infrastructure (outside of civil works packages, i.e., as part of regular revenue budget) to ensure their proper upkeep and resilience to climate change	0.35
10	Policy development, capacity building, and project management supported	0.23
Mitigation		
1	Improved medical waste management at PHC level which will prevent (i) indiscriminate disposal of waste such as through open burning, (ii) spread of communicable diseases, and (iii) sharps injuries	0.70
2	Energy-efficiency improvement in lighting (use of LED instead of incandescent or fluorescent bulbs), appliances and equipment, etc. in each BH selected as an apex hospital under AF. Renovation of existing buildings in above BHs including modifications that enable reduction of energy consumption (climate/ shade/wind consideration for passive design, cross ventilation, etc.)	1.10
3	Procurement of Ambulance vehicles that are more efficient in fuel consumption and complying with national vehicle emission standards	1.88
Total Cost (for AF Project)		**9.96**

ANNEX 11: BEHAVIOR CHANGE AND COMMUNITY MOBILIZATION STRATEGY TO INCREASE PHC UTILIZATION

1. The original project supports the Governments initiatives to reorganize PHC by supporting to establish 9 clusters around 9 (30%) of the Base Hospitals (secondary care hospitals) in the 9 districts in the 4 target provinces. These 9 clusters serve a geographically demarcated population in the 9 districts and include approximately 25% of all PHCs (both curative PHC facilities – PMCUs and DHs - and Medical officer of health offices that belong to the cluster population) In addition the project is supporting the development of 135 PHC institutions finalized using a vulnerability index used by the census and statistics department of Sri Lanka. These PHCs serve vulnerable populations living in the project target provinces and are therefore located in various locations across the 4 provinces.

2. With the physical infrastructure development of nearly 30% of the PHCs and secondary health care hospitals in the 4 target provinces via the original project, the original project intended to support a locally driven behavior change communication campaign, to encourage the population demarcated to clusters and the population served by the PHCs to increase utilization of these facilities. A behavior change communication strategy for this purpose was developed in consultation with the4 provinces and agreed with Health Promotion Bureau of the MOH in 2018 at project design stage.[1] The rollout of the BCC was planned to be cried out by a firm hired by the PMU via the ongoing original project. Due to the reallocation of funds for the COVID-19 crisis in Sri Lanka, this activity is included as an activity under the additional financing.

3. The BCC strategy information (Foot note 1 of this Annex) is available via the www.original project.lk site.

4. Summary of the BCC strategy, available in the PAM of the original project is given below

A. Assessment Methodology for Developing the BCC Strategy

5. The strategy was developed based on a detailed secondary and primary data analysis. The objective of the research was to a) understand peoples' perceptions, attitudes and behaviors towards PHC services and utilization by providing enablers to facilitate demand and, b) to recommend project investments in making a change of behavior towards primary preventive and curative care for increased PHC utilization.

6. The assessment undertook a qualitative methodological approach and used secondary data analysis, focus groups, in-depth interviews, and site observations for data collection. Primary data was collected from three districts out of the nine included in this project. These are Badulla, Monaragala, and Ratnapura. At the district level, a purposive sampling strategy was adopted for selecting the respondents from three groups: the community, health workers, and health administrators and policy makers.

B. Key Findings

7. The key findings of the analysis are discussed from the perspective of various stakeholders and areas related to PHC facilities. These are namely, experiences of current users of PHC facilities, experience of by-passers of PHC services, perspectives of health service

[1] A summary of the BCC strategy is given in the Original PAM Annex 10, Pages 162-165 and the detailed strategy document is available and accessible at www.original project.lk.

providers and health officials. The governance structure for health communications and gaps in communications in content, delivery and capacity are also presented.

8. The findings indicate that the Health Promotion Bureau (HPB) is mandated to support communications campaigns and in developing material and strengthening capacity of implementing teams. The HPB also have a technical oversight role to manage communications campaigns.

9. The current users of PHC facilities noted that some of the existing PHC services are appropriate, with reduced waiting times, they felt that lack of resources in terms of medical officers, laboratory facilities and other investigations in PHCs inconvenience them. They also felt that their male partners were not utilizing the PHCs due to these reasons and due to restricted times of service availability of PHCs. Patients who are already bypassing PHCs for secondary care facilities had no faith in the existing PHC services and had a perception of higher quality services at secondary care facilities. This group of users included males and were employed and had a better income than those who used PHCs. The policy makers/ managers of programs were of the view that the existing PHCs lacked a standardized visual identity as identified by the users and were of the view that if the supply side services could be strengthened with higher investments, improvements in utilization of them will be evident.

10. The report also identified many gaps in communications delivery mechanisms, content and institutional capacity gaps both at the central and regional levels. It is noted that the information, education and communications (IEC) material need to be more sensitive in language options and in having visual based material for less literate population pockets especially in estate areas. Even though there is low male participation in the health sector, it is noted that the IEC material is more focused on the female audience.

11. In terms of communications channels, the findings indicate that technology driven communications channels are yet to be explored despite a 100% household penetration of mobile phone. Furthermore, the HPB and the health education officers in the districts have had minimal exposure in newer techniques of communications. Non-availability of communications materials and lack of health promotion vehicles were noted to impact the productivity and efficiency of health communication related work in the community.

C. Recommended Strategy

12. The recommended strategy intends to support the following:

(i) To create widespread awareness on the upgraded PMCUs and DHs as the first choice for curative care for the health care seekers, by repositioning it as the '*best government health institution closest to you'.*
(ii) To reinforce the preventive health services provision via the Medical Officer of Health areas (MOHs), as the '*first point of contact for health prevention and promotion'*.
(iii) To inculcate a stronger 'preventive health seeking behavior' mind-set amongst adult males and other non-user categories in the community.

13. The primary audience to be engaged will include: (i) current users of the PMCUs/DHs and MOHs; by-passers of the government health services; (iii) non-users of preventive health services; (iv) health service providers. The secondary audience to be engaged will include: (i) key opinion

leaders and influencers; and (ii) general public in the target provinces. The following strategies are recommended to be adopted to achieve the overall objective:

(i) **Integrated marketing communications (IMC).** Branding, advocacy, use of IEC and outreach methods, location-based communications, strong outdoor visibility and information, communication, and technology (ICT) tools are proposed. These will need to be adapted from the Communication for Behavioral Impact (COMBI) Framework.

(ii) **Internal communications and capacity enhancement.** Technology to be used as a key strategy to achieve this objective.

(iii) **Social mobilization and community engagement.** These are two effective strategies to engage a wide range of traditional, community, civil society and opinion leaders around a common cause or issue. While community engagement empowers communities and their social networks to reflect on and address a range of behaviors.

(iv) **Use of persuasive communication.** Advocacy material and strategies used to initiate a change of behavior should be 'persuasive'. This can be achieved by using a few simple techniques such as being credible, knowledgeable, relevant and culturally sensitive. Persuasive messaging works best when delivered one-to-one. In this context addressing a gathering first and then disseminating communication material creates a better impact.

D. Monitoring Results of the Impact of the Campaign

14. The following outcome indicators are expected to be monitored: (i) 10% increase of by-passers and non-users from the current footfall per PMCU/DH one year after the campaign launch; (ii) 10% increase of households utilizing preventive health services among the catchment population households in each medical officer of health area; and (iii) 20% increase in male participation for preventive health services and PHC utilization.

E. Proposed Implementation of the Communications Strategy under the Additional Financing

15. To implement the proposed strategies, services of external specialists are proposed. These service providers will be an integrated marketing communications firm who will conceptualize and produce all the integrated marketing communications material. They would provide the following services to enhance the demand to PHC utilization. The selected company will carry out a knowledge, attitude, practices (KAP) study that will help understand the base line status for future measurement and evaluation processes, handle all relaunch communications, including branding, all collaterals for the relaunch phase and public relations and advocacy for the project, support the social media and digital marketing communications component of the campaign, take the message to the community in the most engaging and interactive manner and produce the branding related material and manage visibility.

16. Based on the recommendation, the below Terms of Reference (TOR) that will be used by the Project Management Unit for hiring a firm to develop and carryout the strategy is given below. The additional financing will be funding this task and it is expected to award this contract by mid-2022, with a contract period of 24 months.

TERMS OF REFERENCE FOR A CONSULTANCY FIRM FOR BEHAVIOUR CHANGE AND COMMUNITY MOBILIZATION FOR INCREASING PRIMARY HEALTH CARE UTILIZATION

A. BACKGROUND

17. The Health System Enhancement Project (the original project), a US$60 million (comprising $37.5 million in concessionary loan and $12.5 million grant, and $10 million equivalent from the Government of Sri Lanka in counterpart funds), and the Additionally financed $123 million (comprising of $110 million loan funds, $3 million JFPR financed Grant funds and $ 10 million from the Government of Sri Lanka) delivered through a project investment modality is effective from February 2019 and will close in November 2025. The project will improve efficiency, equity, and responsiveness of the primary healthcare (PHC) system based on the concept of providing universal access and continuum of care to quality essential health services. The project is targeting PHC development and supporting to establish 9 population demarcated clusters, in all nine districts in the four provinces of Central, North Central, Sabaragamuwa, and Uva with a special focus on the geographically, socially, and economically- deprived populations. The beneficiary population of the project is approximately 7 million which is 33% of the Sri Lanka population (21 million) while the target population, identified using a vulnerability index, within the four provinces, is estimated to be approximately 2.4 million.

18. The project pursues an equity perspective in planning and delivering of essential primary health services. It expects to further inform and operationalize government PHC reform initiatives to reduce bypassing of PHC facilities by providing more comprehensive services, including for NCDs, develop a referral system, and functionally integrating preventive and curative services. Furthermore, the project will target underserved communities' access to PHC, and address selected gaps in core public health surveillance in line with the international health regulations (IHR).

19. The expected project impact is to contribute to the Government development objective[1] of ensuring a healthier nation with a more comprehensive primary health care (PHC) system. The project outcome is to improve efficiency, equity, and responsiveness of the PHC system. The project outcomes are assessed by observing a:

(i) 20% increase in outpatient utilization at PHC;
(ii) 20% increase in patient satisfaction, knowledge and attitudes on utilization;
(iii) 90% of notified notifiable diseases investigated within the stipulated time in the medical officer of health areas in the target provinces;
(iv) cluster system reform implemented and evaluated in all nine clusters.

20. The project outputs are:
(i) Output 1: PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces;
(ii) Output II: health information and disease surveillance capacity strengthened; and
(iii) Output III: policy development, capacity building, and project management supported.

BCCM and PHC Utilization - Current situation

21. Health Promotion Bureau (HPB) is the main unit in the MOH that is responsible for conducting activities related to health promotion and education of the population on health related issues and activities. The key focus areas include: (i) developing policies, plans and technical

guidelines pertaining to health promotion, advocacy and communication (ii) communication for public awareness and behavioral changes leading to health promotion (iii) development of health education, promotion, advocacy and communication materials (iv) capacity building of health care personnel and others involved or interested in health promotion and (v) monitoring and evaluation of health promotion programs.

22. In addition to HPB, other departments such as the FHB, NCD unit, and Dengue control unit, national program for tuberculosis control and prevention of chest diseases, cancer control unit, and leprosy prevention and control unit also carry out their own communications campaigns to achieve individual campaign objectives set out in the health master plan. In addition, at the provincial level, the regional directors of health services (RDHSs) led teams carry out effective outreach campaigns that mobilize communities towards national health outcomes.

23. The curative services are provided to the population via a network of over 150 tertiary and secondary level hospitals and nearly 1000 primary level health facilities, being Primary Medical Care Units (PMCUs) and District Hospitals (DHs). The preventive services are provided via a well laid out network of geographically demarcated, around 350 Medical Officer of Health (MOH) areas, and more than 1500 field health centers, for catchment populations ranging from 60,000 to 100,000.

24. The curative health care structure with primary, secondary, and tertiary services was planned in the early 1930s, to address acute health problems and maternal and child health related issues. However, with the changing demographic profile and the disease transition leading to changes in the disease burden from communicable to non-communicable diseases, and the change in patient health demands, the focus of the health system moved to the secondary and tertiary care levels. This gradual underinvestment at the primary medical care level led to inadequate facilities and generally poor utilization of primary medical care institutions. Bypassing of these facilities also led to increased burden on higher level secondary and tertiary health care facilities. As secondary and tertiary hospital care is cost intensive, overuse of higher level hospital services also creates an inefficiency in the use of government health expenditures.

25. The primary preventive care services, were also in place since 1920s to address disease surveillance, investigation, prevention and control of communicable diseases and antenatal care, child health and nutrition issues. The primary preventive care network, continues to provide a comprehensive package of services for communicable disease prevention and control, immunization, maternal and child health and nutrition services to the populations served within each of the Medical Officer of Health areas. But the changing disease pattern with a higher burden of non-communicable diseases which affect the working age population of adults, and the elderly are not comprehensively included in the primary level preventive health structure. Underinvestment in the preventive health sector has contributed to maintaining the status quo in terms of human resources, financing, equipment, and the organization structure.

26. The increasing cost and changing client demands are instrumental in catalyzing reforms towards changing the health service delivery system from a supply side system to a more people centered health system which is able to deliver a comprehensive package of preventive and curative health services of high quality at an affordable cost to the health seeker nearest to their homes. The government reforms to meet this demand includes efforts towards re-orienting the health system and increasing PHC utilization of the population.

27. The project intends to support improving PHC demand and utilization with the implementation of targeted behavior change communication and community mobilization

initiatives. This is expected to complement the investments on the supply side to improve PHC infrastructure and service package in the target provinces.

Proposed BCCM intervention for increasing PHC utilization

28. During project preparation, a draft strategy was developed to detail out the behavior change communication strategies that could be adopted to increase primary health care utilization in the project provinces. As described above, the original project intends to improve the PHC infrastructure and services in both curative and preventive sectors with the implementation of physical infrastructure, equipment support and development of 135 PHC curative facilities (PMCUs and DHs), and 127 Field Health Centers, mobility support to 38 MOH areas, 4 Medical Officers Maternal and Child Health and Regional Epidemiologists and 9 vehicles to each of the 9 district health education officers and enhanced nutrition services and supports the provinces to pilot a 'cluster linked network of facilities' for better PHC curative services that includes continuity of care.

29. The project intends to finance the behavior change communication strategy via a consultancy firm. It is proposed that the BCCM strategies can be effective only once the facilities that are to be developed are totally improved and enhanced to the quality standards that have been identified as the norm for PHCs.

30. This campaign is expected to be carried out in only the 4 provinces of North Central, Uva, Central and Sabaragamuwa with minimal mass media inclusion, but with regional media such as regional radio and other locally acceptable channels.

31. With the implementation of the BCCM program, the following outcome indicators are expected to be monitored:

(i) 10% increase of by-passers and non-users from the current footfall per PMCU/DH one year after the campaign launch;
(ii) 50% increase of cluster catchment population footfall in each of the 9 newly established clusters
(iii) 10% increase of households utilizing preventive health services among the catchment population households in each medical officer of health area; and
(iv) 20% increase in male participation for preventive health services and PHC utilization.

32. **Target audiences.**

a. The primary audience to be engaged will include:

i. **Current users of the PMCUs/DHs and MOHs.** This is a very important group that can help with positive word of mouth in the villages if they experience the changes to the services offered.
ii. **By-passers of the government health services**: They need to be lured back into the PHC facility at least once, in order to help them make the change in their health seeking behavior.
iii. **Non-users of preventive health services.** This group comprises both young and old males, who need to be made aware of the importance of 'prevention' vs 'cure' and about 'early detection and screening', especially with the rising rate of NCDs in the country and the rapid demographic transition.

iv. **Health service providers:** This group comprises the RDHS and health staff in each of the districts who focus on the curative care service delivery and on the preventive care service delivery of the population.

b. The secondary audience to be engaged will include:

i. **Key opinion leaders and influencers.** Politicians, bureaucrats, technocrats, religious and other community leaders and media fall into this important category who have to be approached using specialized communications methods such as advocacy and experiential marketing communications.

ii. **General public in the target provinces.** The 7 million population that lives in the targeted provinces, who can be reached via mass media such as newspapers, regional radio, social media and also via effective outdoor media.

33. The following strategies are recommended to be adopted to achieve the overall objective:

a. **Integrated marketing communications.** Branding, advocacy, use of IEC and outreach methods, location-based communications, strong outdoor visibility and information, communication, and technology (ICT) tools are proposed. These will need to be adapted from the Communication for Behavioural Impact (COMBI) Framework.
b. **Internal communications and capacity enhancement.** Technology to be used as a key strategy to achieve this objective.
c. **Social mobilization and community engagement.** These are two effective strategies to engage a wide range of traditional, community, civil society and opinion leaders around a common cause or issue. While community engagement empowers communities and their social networks to reflect on and address a range of behaviors.
d. **Use of persuasive communication.** Advocacy material and strategies used to initiate a change of behavior should be ‘persuasive’. This can be achieved by using a few simple techniques such as being credible, knowledgeable, relevant, and culturally sensitive. Persuasive messaging works best when delivered one-to-one. In this context addressing a gathering first and then disseminating communication material creates a better impact.

B. OBJECTIVES OF THE ASSIGNMENT

34. The PMU intends to recruit an integrated marketing communications consultancy firm to carry out the following tasks:

B.1 To create widespread awareness on the upgraded PMCUs and DHs and the PHCs and DHs linked to the cluster networks as the first choice for curative care for the health care seekers, by repositioning them as the ‘best government health institution closest to you’
B.2 To reinforce the preventive health services provision via the Medical Officer of Health areas (MOHs), as the ‘first point of contact for health prevention and promotion’.
B.3 To inculcate a stronger ‘preventive health seeking behavior’ mind-set amongst adult males and other non-user categories in the community.

C. SCOPE OF SERVICES

C.1 Preparation Phase

35. The tasks need to be carried out in collaboration and coordination with the Health Promotion Bureau (HPB) of the MOH, PMU and the 4 provincial and PIU counterparts, ADB, on the timing of the BCCM campaign as branding of the PHCs are linked to refurbishment of health facilities and to the establishment of pilot clusters.

- Review available information from qualitative and quantitative survey results, draft strategy document for increasing PHC utilization to best understand the baseline knowledge, behavior, and practices with regards to PHC utilization.
- Carry out qualitative assessments (if and where necessary) to best understand the potential consumers (current users and current by-passers (non-users) / health seeker and service provider perspectives on underutilization of PHCs.
- Identify the communications related gaps and issues that need to be addressed, develop the final strategy, and obtain clearance from the HPB and the District Health Offices before initiating the development phase.

C.2. Development Phase

- Conceptualize and Develop a 'brand' for the campaign and an integrated communications campaign (consider new sign boards (reflective / illuminated), directions, access pathways to and within the facilities, applying a color code by type of service and type of facility and the communications campaign to include all relevant local level media and communications channels)
- Conceptualize, design and produce all the integrated marketing communications material.
  (Consider media options (regional campaign, more like a location-based communication) and IEC products, AV products, documentaries, outdoor awareness, PR, advocacy, digital marketing, Apps, social media, outreach activities to create a change of behavior amongst current users of PHC, by-passers, males, plantation (estate) sector workers, and other vulnerable population groups) and to enhance the image of PHC service providers amongst the community and the morale of PHC service providers.
- Obtain clearance of all material / collaterals from the HPB and /or the District Health Offices before launching the campaign.

C.3 Launch Phase

- Upgrade the infrastructure / physical appearance related to branding of the PHCs *(including the Cluster linked PHCs and all ADB supported PHCs).*
- Launch a communications campaign for at least 1-year duration utilizing the material developed.
- will handle public relations and advocacy for the project.
- will support the social media and digital marketing communications component of the campaign
- Train and handover the materials and methodology to the Health Education Officers at each of the districts to continue to support BCCM for PHC utilization.
- Support to monitor the footprint at the PHCs and to assess the quality of care during and following the launch of the BCC campaign.

D. DURATION OF THE ASSIGNMENT

36. The duration of the assignment is for 2 years from 1 July 2022 to 30 June 2024.

E. TEAM COMPOSITION AND QUALIFICATION REQUIREMENTS FOR KEY EXPERTS

Table 1: Team Composition and Qualification Requirements of Key Staff

Position	National / International Expert	Terms of Reference	Preferred Qualification	Person Months
Overall Project Implementation				
Team Leader	National	The Team Leader will manage all tasks described in the Terms of Reference and will ensure that the project is completed as planned and on time. The team Leader will lead the literature review and carry out the required qualitative analysis and field visits to best understand the tasks, help direct the design and development phase and facilitate to launch the programme and review the progress.	A Communications expert with at least 10 years experience. The Team Leader should have experience in carrying out branding in the health or in the social sectors and in managing health or social sector related regional level communication campaigns.	150 days (intermittent)
Communications Strategist	National	The Communications Strategist will review the available communications strategies developed for increasing primary health care utilization and update and agree with relevant stakeholders on the final strategy to increase PHC use in 4 selected provinces in Sri Lanka. The communications strategist will also work with the branding and communications team and with the material development and messaging teams to ensure a smooth implementation of the communications campaign.	A Communications expert with at least 8 years of experience. The Communications Strategist should have experience in drafting, implementing and monitoring communications strategies in the health or in the social sectors. He/She should also have at least 3 years experience in working with the branding, material development and implementation and monitoring team members.	100 days (intermittent)

Development and Design Phase -				
For Branding and Communications				
Creative Director	National	The Creative Director will oversee the entire task related to Design, Preparation and Launch phases and be responsible to deliver the agreed outputs.	At least 5 years of experience in developing successfully implemented 'Brands' and a communications campaign at regional level in the health and social sectors.	100days (Intermittent)
Art Director	National	The Art Director will work closely with the Creative Director on the designing of the branding of the PHCs and on Art design for all material related to Branding and Communications campaign.	At least 5 years of experience in managing the visual effects of well designed communications packages in the health and /or social sectors.	100 days (intermittent)
For Development and Implementation stage: Audio / visual Communications material for use via Social media / mobile phone communications and community based local level messaging				
Writer	National	The Communications writer will work closely with the Communications Strategist and the team to draft all necessary material content for the campaign based on the Communications strategy.	The Communications writer should have at least 5 years of experience in the social and / or health sectors.	
Designer	National	The designer will work closely with the Communications Strategist and the team to design all necessary material for the campaign based on the Communications strategy.	The Communications Designer should have at least 5 years of experience in the social and / or health sectors.	
Producer	National	The Producer will work closely with the Communications Strategist and the team to produce all necessary material for the campaign based on the Communications strategy.	The Communications Producer should have at least 5 years of experience in the social and / or health sectors.	

F. OUTPUTS AND TIMELINES

Table 2: Outputs and Timeline for BCCM firm

Output	Time Line
Inception report The inception report will be submitted to PMU.	Within 30 days of signing of contract.
The submission of the final agreed communications strategy and the Draft Action Plan for the roll out of the campaign (all media types and	90 days (end of Q1 Year 1) for signing the contract
Submission and approval of all draft designs and material (all media types)	180 days (end of Quarter 2, Year 1) from signing of contract
Submission and approval of the plan proposed for the physical outlook changes for Branding	180 days (end of Quarter 2, Year 1) from signing the contract
Quarterly progress reports on the implementation progress of the communications campaign activities based on the action plan.	End of Q 4 of Year 1; End of Q 1 of Year 2; End of Q 2 of Year 2; End of Q 3 of Year 2
Final report giving details of the campaign, with all material, updated results indicators submitted at completion of project.	End of Q4 of Year 2 (around June 2022)

G. PAYMENT SCHEDULE

Table 3: Payment Schedule for the BCCM Firm

Deliverable	Time	% of Payment
Submission and approval of the Inception report for the project	End of one month	10%
The submission and approval of the final agreed communications strategy, Draft Action Plan	End of Quarter 1, Year 1	10%
Submission and approval of all draft designs and material (all media types) and the Physical Outlook changes to be carried out	End of Quarter 2, Year 1	20%
Quarterly Interim reports	From Q 4 of year 1 to Quarter 3 of Year 2	7.5% at end of each Quarter (30% by end of Quarter 3, year 2)
Final Report	End of Quarter 4 of Year 2	30%

H. CLIENT INPUTS AND COUNTERPART PERSONNEL

37. The firm will work closely with the PMU, a team from the MOH (to be appointed) and with the ADB.

38. The focal point identified for this assignment (Communications Officer) from the PMU will facilitate the clearances and access to health offices, health facilities for the purpose of carrying out the communications campaign.

39. The following documents will be provided, during Request for proposal stage, to the selected firm by the client:

- The ADB supported BCCM Strategy Document

ANNEX 12: JAPAN FUND FOR POVERTY REDUCTION'S GUIDANCE NOTES ON JAPANESE VISIBILITY AND ON COORDINATION WITH THE EMBASSY OF JAPAN AND JICA

GUIDANCE NOTE ON JAPANESE VISIBILITY

I. Introduction

1. The Revised Operating Framework for the Japan Fund for Poverty Reduction (JFPR) was approved on 6 October 2009, combining Japan's project grant and technical assistance support under one umbrella, and paving the way for a more comprehensive approach to the use of these funds towards addressing poverty, building up human resources, and empowering institutions and communities in the region. Japan has been making generous contributions for technical assistance activities through the Japan Special Fund, and for poverty reduction projects through JFPR, since they were established in 1988 and 2000, respectively. It is but fitting and proper that said contributions are acknowledged and the recipients and general public are informed of the source of the funding assistance both at the Fund level and at the level of the individual TA and project grants. The purpose of this note is to provide guidance on measures to ensure that the contribution of Japan in supporting JFPR is widely recognized.[1]

II. Statement on Japanese Visibility

2. Project teams are required to help promote the visibility and local awareness of JFPR in recipient countries through the following:

(a) All press releases issued by ADB with respect to JFPR should refer to the financial contribution from the Government of Japan (GOJ)[2];

(b) Signing ceremonies and other publicity events should be encouraged, inviting Japan embassy officials, JICA staff, local and international press[3];

(c) Civil works, project billboards/signages, vehicles, and equipment must carry the JFPR and Japan ODA logos (see below). Likewise, all publications and training programs must bear the said logos, including all collaterals used (i.e. training materials, banners, posters, flyers, etc.) that are financed by JFPR; these logos are available in the SDPF-JFPR website; [4]

ADB | Japan Fund for Poverty Reduction | From the People of Japan

[1] A copy of the Guidance Note on Japanese Visibility is appended to the Project Administration Manual as guide to the project team and the government, during project implementation.
[2] Staff may coordinate with the Department of Communications.
[3] Coordination with resident missions are necessary.
[4] https://lnadbg1.adb.org/oco0006p.nsf/0/EEE594E105EAC26A482576C7002240AB/?OpenDocument

(d) Publications, reports, training programs, seminars and workshops financed by JFPR should acknowledge receipt of funding from GOJ;

(e) Recipients should be encouraged to ensure that JFPR financed activities are well covered by local print and electronic media, and that all related publicity materials, and official notices explicitly acknowledge funding from GOJ. Below is the suggested standard text to be used by those who prepare publicity materials: *"The grant fund for (project name/activity) was received from the Japan Fund for Poverty Reduction financed by the Government of Japan through the Asian Development Bank."*

III. Participation of Japanese Entities in Implementation

3. It is also important to generate visibility of the project within Japan. Involvement or cooperation with Japanese experts, financial resources and technologies are encouraged; occasional information sessions on JFPR for Japanese organizations may also be conducted. It is also highly recommended that ADB involve and cooperate with Japanese organizations including NGOs, civil society organizations, aid agencies in particular JICA and JBIC, the private sector enterprises or academic institutions.

IV. Reporting

4. At the end of the project, the completion report submitted by the project team should include evidence of Japanese visibility such as photos (preferably high resolution), press releases, articles or write-ups, and testimonials from project recipients and/or implementers. Sample products generated from the project grant are requested to be made available to SDPF for inclusion in future exhibits. Copies of publications[5] that are outputs of the project should also be provided to SDPF.

V. Visibility Support by ADB

5. SDPF promotes visibility of JFPR by: (i) informing Office and Department Heads of the importance of achieving high visibility in order to garner support for JFPR from Japanese officials and taxpayers; (ii) informing Country Directors of the importance of signing ceremonies to Japanese officials and the public to ensure recognition and support for JFPR funding; and (iii) continuing widespread distribution of the JFPR Annual Report, inclusion of JFPR information in relevant ADB documents, and occasional information sessions for Japanese organizations.

6. Resident Mission staff are requested to forward copies of all visibility materials, such as press releases, newspaper and magazine articles, and photographs (including descriptive captions) to SDPF's assigned focal staff for JFPR or e-mail to (jfpr@adb.org).

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[5] This particularly applies to knowledge and support TAs. Links to publication available online may be provided in lieu of print copy.

GUIDANCE NOTE ON COORDINATION WITH THE EMBASSY OF JAPAN AND JICA

I. Introduction

1. The Final Report on the Review of Japanese Official Development Assistance[1] (ODA) underscores the need for strategic and effective aid. One way to ensure alignment of Japan Fund for Poverty Reduction (JFPR) projects and technical assistance (TA) with Government of Japan's (GOJ) bilateral assistance strategy for a particular developing member country (DMC) is by bringing on board the comments and suggestions of the Embassy of Japan (EOJ) and the Japan International Cooperation Agency (JICA).[2] Thus, the summary of consultations with EOJ and JICA (to include, date of consultation, name and position of staff met, and EOJ and JICA's response) should be included in the proposal submitted to SDPF.[3] This Guidance Note provides detailed instructions regarding coordination activities with EOJ and JICA.[4]

II. EOJ and JICA Contact Persons

2. As soon as project officer informs SDPF of the intent to apply for JFPR funding,[5] SDPF will identify the appropriate contact persons in EOJ and JICA. The contact persons' information[6] will be provided by SDPF to the project officer to start consultation.

III. Consultation with EOJ and JICA – PROPOSAL PREPARATION

3. At concept stage, project officer should consult with EOJ and JICA[7] through e-mail the proposed project to, (i) seek if it is in line with Japan ODA priorities, (ii) ensure no duplication, and (iii) present the concept itself, with copy to SDPF.

4. Upon SDPF's confirmation to proceed with proposal preparation, the project officer may arrange the project design meeting with EOJ and JICA. This meeting intends to explain and discuss the actual project design. This is ideally conducted during the fact-finding mission.[8] The proposal,[9] should be provided to EOJ and JICA with copy to SDPF at least 5 working days before the meeting to give ample time for review and consideration. After the meeting, if needed, SDPF in coordination with the project officer, may follow-up with EOJ and JICA, and respond to requests for clarification.

5. In the case of regional TAs, the draft TA Summary and Report should be sent by email to EOJ and JICA contact persons on no-objection basis.

IV. Role of the Resident Mission and SDPF

6. Project officer's communications with EOJ and JICA should be done in coordination with

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[1] Ministry of Foreign Affairs of Japan. 2010. ODA Review - Summary of the Final Report. Tokyo.
[2] Incorporated administrative agency in charge of administering Japan's ODA.
[3] GOJ gives importance on the inputs provided EOJ and JICA during the internal approval process.
[4] A copy of the Guidance Note on Coordination with Embassy of Japan and JICA is appended to the Project Administration Manual as guide to the project team and the government, during project implementation.
[5] Project name and brief outline of proposal should be provided to SDPF.
[6] Name, status, telephone number and email address.
[7] Please refer to the contact persons provided by SDPF.
[8] If a meeting with EO and/or JICA is not possible, email exchange, telephone discussion or any other form of communication may be used.
[9] Draft Grant assistance report (for project grants) and draft TA Summary and Report (for TAs).

the resident mission[10] with copy to SDPF. If needed, SDPF supports to identify the appropriate staff to be consulted.

7. Resident mission also arranges the Grant Agreement/TA letter signing event (section V) and in the overall coordination/relationship management with EOJ and JICA.

8. SDPF's role are as follows: (i) provide contact details of relevant staff from EOJ and JICA for project consultation; (ii) liaise any need for clarification by EOJ and JICA in coordination with the project officer, during project consultation; (iii) inform EOJ and JICA when there is withdrawal or cancellation of a project; and (iv) forward all completion reports to both agencies.

V. Coordination with EOJ and JICA – Upon Approval of the Proposal

9. Project officer should inform EOJ and JICA about ADB's approval. Project officers are strongly encouraged to conduct signing or launching ceremonies with the attendance of EOJ officials.[11]

10. In coordination with the resident mission, the project officer should inform EOJ and SDPF of the signing ceremony– at least 10 working days in advance. SDPF then informs GOJ of this activity. The project officer should also draft news release in consultation with the Department of communications and coordinate arrangements with the resident mission. Local and international press are invited to these ceremonies.

VI. Coordination with EOJ and JICA – during Project Implementation and upon Project Completion

11. Throughout implementation, the project officer should inform EOJ about project progress, milestones, and outcomes, and discuss when major changes in scope and objectives are required. Progress and outcomes of JFPR projects are also requested to be shared with JICA. From time to time, EOJ and JICA may also wish to join completion review missions in order to see project results and to interact first-hand with project recipients. Lessons from the JFPR projects are also requested to be shared to enable both sides to explore and seek potential collaboration. Completion reports are required to be submitted by the project officer to SDPF for forwarding to EOJ and JICA.[12]

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22 April 2019

[10] Please inquire respective resident missions on their protocols or coordination arrangements with EoJ and JICA.
[11] Please refer to the Guidance Note on Japanese Visibility for details on visibility requirements under JFPR.
[12] Links to the completion reports will suffice.

ANNEX 13: SUMMARY OF HEALTH INFORMATION TECHNOLOGY SYSTEMS AND SUPPORT TO ESTABLISHING AN INTERCONNECTED CLUSTER IT SYSTEM

1. Health information systems that are currently in use in the public health sector in Sri Lanka include systems that support (i) patient management via electronic patient records (curative care systems), (ii) disease surveillance and immunization, maternal and child health related prevention program management (disease specific and preventive care systems), (iii) health administrative systems for human resource management, drug estimation, laboratory, digital X-ray management, etc. There are more than 30 such systems working as standalone systems. As part of the health information system review for the ADB-financed Health System Enhancement Project (the original project), 20 such systems were reviewed[13]. These systems were assessed and analyzed with respect to their potential for scaling, sustaining, and building interoperability to support the development, implementation and utilization of a national integrated e-health architecture which will consist of various pieces of software, hardware, standards, infrastructure, and institutional processes that can be linked to each other to share the required data in a seamless manner. An interoperable system is expected to be developed to strengthen person centric and longitudinal continuity of care, enhance efficiency of disease surveillance system, and minimize the data redundancies to increase its use for providing better, timely, patient and system related decision making.

2. It was observed that all the hospitals are not fully computerized and electronic data availability from hospitals is not shared across hospitals and are incomplete. The patient and hospital based, curative care systems were custom-built, including two hospital information systems, with overlapping functionalities and limited scale. Further, there are multiple smaller electronic medical record and patient registry systems initiated by various consultants, limited to hospitals, hospital wards or selected diseases. The proliferation of such systems limits development of a common platform and means for interoperability. While the e-indoor morbidity and mortality register (IMMR) system had reached national scale, it was constrained in functional scaling due to limited development resources. Two other systems for intensive care unit surveillance and for the National Hospital are in their initial stages of operation but with limited scale. Four of the five preventive care systems were based on the open source DHIS2 platform had scaled well but had evolved as independent instances without data sharing between them. The fifth system was for immunization, and limited in scale, and in process of being redeveloped on the DHIS2 platform. The core of the disease specific systems was the surveillance systems run by the Epidemiology unit, which also ran several other small-scale systems which are not integrated. This too was in the process of being redeveloped on DHIS2. There were other programmatic systems for HIV, TB, Malaria, Quarantine, NCDs and Disaster Management, all on the DHIS2 platform and in relatively early stages of implementation. Amongst the health systems strengthening systems, one system (facility survey system on DHIS2) had discontinued use. Another (the Master Patient Index) was still in the proof of concept stage being developed by ICTA, and the drug supply system was based on a proprietary platform with significant licensing costs but scaled up to link all secondary care hospitals with limited capability of linking with PHCs and Medical Officer of Health offices.

3. The review noted that the epidemiology unit of the MOH as the nodal agency in the country is responsible for the prevention and control of communicable diseases have adopted various information systems (e.g., e-Surveillance, sentinel site surveillance system, DenSys (Dengue),

[13] The detailed HIT system Assessment Report, was prepared during the preparation of the original project in 2018 by the ADB supported consultants in close collaboration with the Health Information unit of the MOH and is accessible from the www.original project.lk site.

FluSys (Influenza). Furthermore, the quarantine unit of the MOH also manages a surveillance system to support international health regulations. The surveillance related data comes from multiple systems, such as hospitals, medical officer of health areas, seaports, airports etc. There is also the need for different data sources to share data with each other, such as cases identified in the hospital should be automatically notified to the medical officer of health for response action, and the disaster management system to communicate with the surveillance systems to build early preparedness on response. The current landscape of systems is fragmented and are developed on different obsolete platforms, requiring urgently their consolidation and modernization. On the positive side, the e-Surveillance system has achieved national scale, and is in operational use. Furthermore, as the epidemiological unit seeks to move fully into a case-based and integrated surveillance system, there is the need for the testing of applications based on android devices and cloud hosting, to speed up, and reduce the time lag between identification, notification and response.

A. Establishment of a high-level coordination body within the MOH

4. There is the need for different data sources being able to share data with each other, such as cases identified in the hospital should be automatically notified to the medical officer of health for response action and linkage to the epidemiology unit, quarantine unit and the disaster management system to communicate with the surveillance systems to build early preparedness etc. The response interoperability relates to the potential of a system to share data with each other. Typically, in building interoperability when multiple systems are involved, one of them serves as the reference, or the “data warehouse” which acts as a repository to which other systems would share data with. A key requirement for such interoperability to take place is the country wide implementation of patient healthcare number (PHN) and master patient index (MPI). Many of the systems working in the country are now using the PHN, and this need to become mandatory for all to use. While many systems have the PHN, they are still not able to share data with other systems (e.g., HHIMS and HIMS).

5. The review recommends that a coordination body for health information technology should be established within the MOH to (i) make national level decision regarding the e-health architecture for the public health sector in Sri Lanka; (ii) to manage and coordinate the e-health systems that are being developed by independent (iii) consolidation of server hosting resources; (iv) creating one core technical group to support the suite of applications, and build new ones; (v) create a core data analytics group responsible for data analysis, dissemination and monitoring and evaluation; (vi) to ensure compliance to standards, coordination of procurement decisions and outsourcing functions; (vii) maintaining and updating central databases such as (MPI, shape files, facility and provider registries); and, (viii) developing and accrediting training curriculum for health professionals, (ix) establish institutional links with centers of excellence both globally and nationally to keep abreast with technology changes, and (x) development of best practices, and research and education.

6. As of July 2021, it is noted that the MOH has an active e-health committee which is chaired by the Secretary of Health and its members include both health and IT sector specialists and units including the ICTA. The secretary of the committee is the Director Health Information of the MOH.

B. Designing, development and rollout of a pilot cluster patient-based information system with linkage to the preventive health system

7. Currently, the primary patient-based systems (PBS) are through the two hospital systems (HHIMS and HIMS), and the e-IMMR system. However, the need now is to think of a system not

only for hospitals but PBS more broadly suitable for different facility types ranging from primary to secondary and tertiary care and preventive services. For example, primary care may need a PBS for tracking of beneficiaries under different health programs, a surveillance system needs line lists (anonymized or with names) for case notification, and hospital systems need full-fledged electronic medical record (EMR) systems to inter-link different services in a hospital which a patient experiences during their multiple visits to that facility.

8. There are multiple DHIS2-based applications currently operational, which while being largely successful in their isolated domains, have also created severe redundancy of resources and development capacity. For example, there are multiple server instances running different applications, which could be consolidated into one instance, hosted and managed on one server, and supported by one specialist technical team. This also makes system support less person dependent and more institution based.

9. As Sri Lanka moves towards achieving its universal health coverage goals, there is a growing need to strengthen continuity of care, improve mutual referral linkages between primary and secondary/tertiary care levels. Further, the need is to provide more effective care at the primary level, closer to the homes of patients and in a cost-effective manner, which can reduce the caseloads at higher levels and the cost of care.

10. It is proposed that a “cluster-based patient information system (CBPIS)” system is developed and piloted in the selected nine clusters supported via the original project in the target provinces. This system is expected to (i) maintain patient-based databases and their care parameters, based on the PHN; (ii) track and link individual encounters of the patient with the health system with linkages to the preventive health system for disease surveillance; (iii) help schedule shared services (specialist consultation, diagnostic and laboratory services and drugs) for patients within the cluster; (iv) establish to and back referral linkages for patients; and (v) be capable of generating all required facility reports.

11. It is recommended that the MOH seeks the services of a software systems team to design the appropriate e-health information technology architecture, operating processes and procedures, the framework for interoperability across such systems and to support implementation of such a system across selected groups of hospitals and preventive health providers (clusters). The software firm is selected via a competitive hiring process and has initiated its tasks since July 2021 and will carryout its tasks in two phases – development / adaptation and rollout of the system.

12. ADB agreed with the MOH, during the preparation period of the additional financing from May to July 2021, that the proposed Cluster HIT system will be developed in two phases, with the Phase two implementation of the cluster HIT system in 7 clusters made conditional on the performance of the Phase 1 rollout of the HIT system in 2 clusters. The performance of the HIT system needs to be approved by the e-health Steering Committee and the Project Steering Committee in consultation with the ADB. It was agreed with the ADB team that the Phase 1 cluster rollout will be at the Dambulla Base Hospital linked cluster (20 facilities) in Matale District, Central Province and the Thambuthegama Base Hospital linked cluster (11 facilities) at Anuradhapura, North Central Province.

13. The investments related to the development of the cluster-based HIT system is made available from the original project and the additional financing as given below:

- Development of the Cluster HIT System: will continue to be carried out by the selected firm, hired since July 2021 by the PMU) and it will continue to be funded via the original project. But as the implementation rollout of the system will be in two phases, the firm will develop the Cluster IT system and will initially introduce the cluster IT system to the selected two pilot clusters (Phase 1). The firm, in close collaboration with the Health Information unit of the MOH is expected to provide the IT equipment required to rollout the Phase 1 system (only for 2 of the 9 clusters).
- While the software firm develops the Cluster IT system (July to Dec 2021), the PMU will ensure that the hired firm for Internet connectivity will complete the internet accessibility to all 152 health institutions (Annex 3 provides the list of cluster linked facilities) before Phase 1 rollout of the Cluster IT system (before December 2021) and funding for this will be from the original project.
- The PMU will need to hire an expert (firm) to design the LAN for each of the 152 health facilities that are cluster linked (Annex 3) in two Phases. The Phase 1 assignment for designing the LAN will be for the 2 clusters (31 facilities in Dambulla and Thambuthegama clusters) and the LAN designs for the balance 7 cluster facilities will be developed by the LAN design firm as Phase 2 following submission and installing of the LAN in the Phase 1 clusters. The LAN design costs (for both phases, one firm) will be allocated via the additional financing.
- The PMU will also hire a firm to lay out the LAN designed by the LAN Design team, in each of the 152 health facilities that are cluster linked (Annex 3) in two Phases. The Phase 1 assignment for laying out the LAN design will be for the 2 clusters (31 facilities in Dambulla and Thambuthegama clusters) and the LAN laying out for the balance 7 cluster facilities will be by the LAN laying out firm as Phase 2 following acceptance of the LAN in the Phase 1 clusters. The LAN laying out costs (for both phases, one firm) will be allocated via the additional financing.
- The IT equipment needed for rolling out the Cluster HIT system will be determined by the Health Information unit of the MOH with technical inputs from the HIT firm hired to develop the Cluster HIT software. The PAM of the original project gives the equipment requirement, which was estimated in 2018, but this will be updated by the Health Information Unit in close collaboration with the HIT firm and after consultations with all relevant authorities. The technical specifications for the agreed IT equipment will be developed and finalized by the Health Information Unit of the MOH, considering the sustainability of this investment beyond the implementation period of the original project. The procurement of the IT equipment for the HIT system will be carried out in two phases. The items that are required to run the Phase 1 (2 clusters) will be procured initially. The IT equipment requirement for the other 7 clusters, (which can be amended based on the experience of running 2 clusters) will be procured thereafter. The Phase 1 equipment is expected to be available before end December 2021. Both Phase 1 and Phase 2 IT equipment needs for the HIT system will be funded via the additional financing.

14. Monitoring of the Cluster HIT Solution:

- The software firm will be responsible for developing and rolling out the software initially in 2 clusters, but the firm will need to work closely throughout this process with and via them with the cluster hospitals when planning the equipment requirement, decisions regarding the data entry points, data security measures, data access points etc.

- The Health information unit will identify a focal point for coordinating all tasks with the firm and the PMU.
- The deliverables (as specified in the firm TOR) will be received by the PMU but will be approved by the Health Information unit of the MOH before payments can be approved to the firm.
- Implementation will be reviewed by the Director Health information fortnightly and the meeting will be chaired by the DDG (Planning) every month.
- The decision to scale up to Phase 2 of the project will be made at the Project Steering Committee with the recommendation of the Director Health Information Unit and n consultation with the ADB.

Attachment 1 to Annex 13: The TOR of the HIT firm (awarded in July 2021 by the PMU)

TERMS OF REFERENCE

DESIGNING AND IMPLEMENTING A HEALTH INFORMATION SYSTEM SOLUTION IN 9 DISTRICT HEALTH FACILITY CLUSTERS IN SRI LANKA

A. BACKGROUND

1. The Health System Enhancement Project (the original project), a US $ 60 million (comprising $37.5 million in concessionary loan and $12.5 million grant, and $10 million equivalent from the Government of Sri Lanka in counterpart funds), delivered through a project investment modality is effective from February 2019 and will close in November 2023.

2. The project pursues an equity perspective in planning and delivering of essential primary health services. It expects to further inform and operationalize government PHC reform initiatives to reduce bypassing of PHC facilities by providing more comprehensive services, including for NCDs, develop a referral system, and functionally integrate preventive and curative services. Furthermore, the project will target underserved communities' access to PHC, and address selected gaps in core public health surveillance in line with the international health regulations (IHR).

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3. The project is targeting all nine districts in four provinces of Central, North Central, Sabaragamuwa, and Uva and the expected project impact is to contribute to the Government development objective of ensuring a healthier nation with a more comprehensive primary health care (PHC) system. The project outcome is to improve efficiency, equity, and responsiveness of the PHC system. based on the concept of providing universal access and continuum of care to quality essential health services.

4. The project outcomes are assessed by observing a:
   (i) 20% increase in outpatient utilization at PHC;
   (ii) 20% increase in patient satisfaction, knowledge and attitudes on utilization;
   (iii) 90% of notified notifiable diseases investigated within the stipulated time in the medical officer of health areas in the target provinces;
   (iv) cluster system reform implemented and evaluated in all nine clusters.

5. The project outputs are,
   Output 1: PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces;
   Output II: health information and disease surveillance capacity strengthened; and

Output III: policy development, capacity building, and project management supported.

6. Project intends to support the establishment of 9 shared care clusters in the 9 districts of Moneragala, Badulla, Anuradhapura, Polonnaruwa, Nuwera Eliya, Matale, Kandy, Rathnapura and Kegalle on a pilot basis to support the implementation of the recently approved 'Essential Service Package' and the policy on 'reorganizing health care delivery for universal health coverage'. The hospital clusters that would be piloted under the original project are currently identified by name of institution in each of the 9 districts, where the project is implemented (list of cluster facilities provided in Annexure A). Each cluster will have one secondary care facility (called Apex hospital which is a Base Hospital or a District General Hospital) and will be linked with the identified primary health care service providers to form a cluster group of facilities. The services that will be shared across each of the clusters will be identified and finalized prior to the establishment of the shared care clusters.

7. The services that may be initially provided via cluster care include the following and are expected to be managed across the cluster via an integrated health information system solution:

- Elderly care
- Family planning service
- Disease surveillance and infection control measures
- Stroke care including cerebrovascular diseases
- Rehabilitation and disability care
- Palliative care
- Care for selected NCDs: diabetes, cardiovascular diseases, chronic respiratory diseases and asthma, mental illnesses, and care for selected cancers
- Laboratory services related to chemical pathology, haematology, histopathology, microbiology and biochemistry.
- Imaging services – Ultrasound (US) scanning and radiology services
- Health care waste management services
- Emergency care services

8. An independent firm is expected to design/develop and implement a functioning Cluster Information System Solution and provide related services, as mentioned in Section C. The proposed Cluster Information System Solution is comprised of 3 major (mandatory) components. Namely, they are,

- Cluster and Apex Information System (Cluster/Apex IS)
- Cluster Master Patient Index (MPI)
- Cluster Enterprise Service Bus (ESB)

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9. In consultation with ADB and MOHIMS, the selected software firm is expected to expand this high-level architecture to detailed architectural diagrams and software requirement specification. There may be other minor aspects MOHIMS would like to bring in under this TOR and shall be negotiated with the firm prior to commencing the developments.

B. OBJECTIVES OF THE ASSIGNMENT

10. The PMU of the original project intends to recruit the consultancy firm to meet the following objectives:

B.1 To support the MOHIMS to refine the national e-Health architecture to design and develop the proposed Primary Care Information System within the provisions of the National e-

Health Standards and Guidelines and National Health Information Policy[14]. This shall be subjected to the scrutiny of a panel of experts, to be decided by the e-Health Steering Committee of MOHIMS, prior to the commencement of the work.

11. Following tasks will be entrusted under this objective.

I. The firm will extensively observe the health information systems which are functional by the date the contract is awarded in each cluster prior to design and develop Cluster Information System Solution. This review shall include the data capturing and reporting of the existing health information /electronic medical record systems, preventive health information systems, laboratory information systems, drug distribution systems, surveillance systems, inventory management systems, PAC and Radiology Information System, human resource management systems and appointment systems (including channeling and queue management systems) etc. to best understand the current practices related to the IT connectivity status in the health sector in Sri Lanka. The selected firm shall have the access to the recent HIT assessment carried out by the original project in Sri Lanka and the service of the consultants recruited under ADB for this purpose.

II. The firm (shall nominate a Team Leader) who will provide technical input and represent the ADB technical team at consultations that are ongoing to develop the blueprint using an Open MRS[15] platform for Cluster Information System Solution architecture.

B.2 To design, develop, implement and provide maintenance of the proposed Cluster Information System Solution at the cluster level in these 9 clusters for the contract period. This include linking one secondary care facility (known as Cluster Head/Apex, see Figure 1, below) with a group of primary care hospitals and units) to provide continuity of care for patients seeking services at any of the cluster linked hospitals in each of the 9 clusters in the 9 districts in Uva, Central, North Central and Sabaragamuwa Provinces.

12. Following tasks will be entrusted under this objective.

I. The firm will develop a report on the technical approach that shall be provided on the Cluster Information System Solution, which shall be approved by the MOHIMS prior to commissioning the system development.

II. The firm shall develop a detailed Software Requirement Specification (SRS) for cluster/apex IS and additional software modules based on the high-level architecture proposed by ADB and MOHIMS and seek approval from the ADB and MOHIMS prior to embark on development of the software components.

III. The software firm shall expand the system architecture proposed by, MOHIMS and facilitated by ADB to a working solution to establish a cluster managed health record and disease surveillance system with an MPI and ESB components to support intra and inter-cluster interoperability. This should permit patient-based systems to be used across various providers across levels (primary/ secondary/ tertiary) of facilities and in various separate departments / units at the same level of facility.

IV. The firm shall adopt Master Patient Index (MPI) architecture to facilitate continued care within and outside the cluster. This should support the unique Personal Health Number to be utilized by all providers in Sri Lanka's across health sector for continued care.

[14] http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/publishpolicy/policy-08-05-2018.pdf
[15] https://openmrs.org/

V. The firm shall provide an Enterprise Service Bus (ESB) architecture to share data between Cluster Information System Solution and the existing preventive, curative, HRM and supply chain information systems.

VI. The firm shall propose the modules and features to the Cluster Information System Solution and suitable mechanisms to make it interoperable with existing key curative and preventive sector data flows to provide continuity of care at cluster level and above.

VII. The firm shall design and develop additional software modules (APIs, MPI and ESB) those are essential to integrate the Cluster Information System Solution with existing and upcoming information systems within the purview of MOHIMS (please refer to figure 1).

VIII. The firm shall provide a generic API for future integrations/inter-links purposes (possible upcoming HIS initiatives). Facility (dashboard) should be provided to the MOHIMS to centrally monitor the data exchange through the APIs to assess the use and possible misuse of APIs.

IX. All software tools/modules (application & database) shall be developed on open source platforms and must be based on open standards, conforming to national guidelines for access to source codes. The cluster/Apex information system shall be based on Open MRS.

X. The firm will provide technical input as necessary for defining the privacy and security measures of the health data and will also support to determine the levels of accessibility within and across health facilities and clusters. The firm will provide other technical support as required/requested by the MOHIMS in completing this assignment of Cluster Information System Solution.

XI. The source code shall be the property of the MOHIMS. All versions shall be managed in a version control system and full access shall be granted to the MOHIMS. A copy of the source code shall be maintained under the Project Director during the contract period.

XII. The firm shall define the networking and connectivity requirements in implementing Cluster Information System Solution in the 9 clusters supported under the additional financing (a total of approximately 125 institutions and approximately 40 Medical Officer of Health Offices across the 9 clusters which represent around 25% of all PHC institutions in the 4 provinces).

XIII. The firm shall define the hardware requirement and provide the specifications for the servers and client computers in consultation with ADB and MOHIMS.

XIV. The firm shall support assembling hardware in health institutions and attend troubleshooting hardware and networking with the support of the computer hardware/network/internet suppliers during the contract period.

XV. The firm shall address the processes required for hosting the integrated software system on national cloud/IT infrastructure in consultation with the ADB and MOHIMS

XVI. The firm shall submit the system for a Security Audit (preferably by SL CERT[16]) and a User Acceptance Testing of developed software package. Firm shall correct the deficiencies highlighted by the security audit without no additional cost.

XVII. The firm shall provide technical support/troubleshooting to address the issues in the system at the 9 cluster districts locations during the implementation and maintenance phases.

[16] https://www.cert.gov.lk/

XVIII. The firm shall set up a centralized help desk to coordinate providing technical support to end users during the implementation and maintenance phases in the 9 clusters employing 9 ICT Assistants cum Cluster Help Desk coordinators.

XIX. The firm shall be equipped with on-site trouble shooting within 4 hours of a complaint during the initial implementation phase.

XX. The firm shall propose a mechanism for provision of technical support/troubleshooting and maintenance during the system maintenance period (second half of the contract period).

B. 3 To design and carry out the training programs in 9 clusters to train end users of the proposed cluster/apex information system. This shall include preparing training programs and developing training/user manuals. The training manuals shall be drafted in English and translated to Sinhala and Tamil. The softcopies of all three versions (English, Sinhala and Tamil) of the training/user manual shall be handed over to the MOH at the end of the contract period.

13. Following tasks will be entrusted under this objective.

I. The firm shall develop the training guides and user manuals for training all users on the newly developed integrated software system in the cluster pilot locations (9 clusters). The firm may recruit additional staff for training, with the consultation of ADB, if required. This need to be negotiated by the pre-bid meeting and the training schedule needs to be submitted with the final proposal with the number of trainers and assistance for each training session.

II. The firm shall roll out the 18 training sessions (2 in each cluster) during the initial 6 months of system introduction. Each training session for each cluster will be for 2 attendees from a MOH office, 1 from a Primary Medical Care Unit (PMCU), 2 from a divisional hospital and 8 from the Apex hospital. Estimated number of participants for one training session representing cluster health facilities and apex would be 30.

- First round of the training (9 sessions, one session for each cluster) should complete within 2 months from the roll out of the system. One training session should be minimum of 2 working days and should be attended by minimum of 2 trainers.
- Second round of training (9 sessions, one session for each cluster as refresher training) within 5 months from the first round of training.
- One on-site training visit should be carried out between the first and second rounds of training sessions. During this training an IT Assistant cum Cluster Help Desk Coordinator shall visit the health facility. One full working day shall be allocated to a health facility and all system users shall be trained in such on-site training visit.

III. The firm shall support MOHIMS to conduct ongoing capacity building for the system end users throughout the implementation and utilization and maintenance stages (see section D for the Duration of the Assignment).

B.4 To facilitate the integration/inter-link of cluster-based Primary Care health Information System and selected clinical and public health information systems currently used by the MOHIMS. This shall essentially include the disease surveillance mechanism and also include proposing an interoperability mechanism for any upcoming clinical/public health information system initiative in future.

Following tasks will be entrusted under this objective.

I. The firm shall integrate existing EMR/HER, if such system is implemented in the cluster health facilities, and the drug distribution system of the Medical Supplies Division with the Cluster Information System.
II. The firm shall provide recommendations to scale up the system to other facilities/ clusters towards the end of project implementation period.

14. The scope of work under these objectives are discussed in detailed in the section C below.

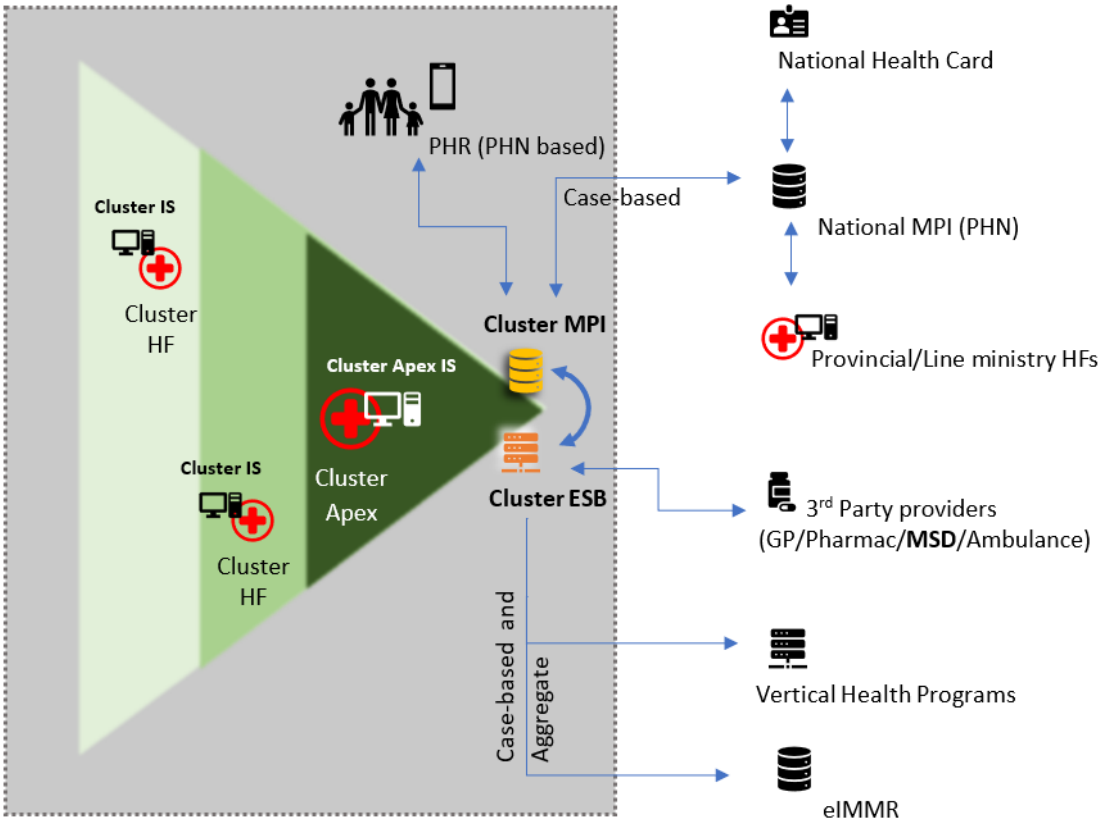
C. SCOPE OF SERVICES

15. The consultancy firm will work closely with the MOH, PMU and the ADB when carrying out the tasks associated with the consultancy.

2. C.1. Guidelines on design, establish and provide maintenance support to the 9 cluster-based patient information systems in the 9 clusters in the 9 selected districts

16. The following schematic diagram which defines the high-level architecture for the Cluster Information System Solution, shall guide the software firm in analyzing the existing solutions and providing the interoperability required at the cluster level and beyond (please refer to Annexure B also).

Figure 1: Proposed high-level system architecture for the Cluster Information System solution to facilitate the health information flow within and among clusters



3. C.2 The key functionalities expected from the Cluster Information System Solution and its additional software modules in order to provide the continuity of care within and across cluster linked facilities

17. Continuity of care is a key concern in the cluster linked facilities approach. Hence, it is expected that the proposed information system will provide an interoperability platform for linking existing electronic medical record systems and, to maintain a concise encounter-based health record for clients at the cluster/apex level.

18. The assignment shall be, at minimum, based on the features listed below. Hence, the selected software firm shall include and extend the functionalities listed below in the detailed Software Requirement Specification expected to be developed under the scope of this TOR.

1. Cluster/Apex Information System

I. To ensure the sustainability beyond the contract period, the Cluster/Apex Information System shall be developed on OpenMRS platform.

II. The system shall cater to and can be adopted to all three (03) levels of delivery points - PMCU, District Hospitals (DH) and Base Hospitals (BH) as discussed in the Essential Services Package (ESP) for Sri Lanka.

III. An encounter-based summary record shall be captured at each visit of a client at the cluster and apex health institutions (Please refer to Figure 1 above). During subsequent visits, the client's summary health record shall be available to the physician at any level of the cluster.

IV. The software solution provided shall be able to empanel the cluster/apex population.

V. The records shall be able to summarize all the medical and surgical conditions mentioned in the ESP.

VI. The system shall have an interconnected health record component optimized for the scope of cluster and apex institutions based on a unique patient identification number, known as the Personal Health Number (PHN).

VII. The cluster and apex IS shall maintain an encounter-based summary record (see 3, below) in a secure manner, that can link and track patient utilization across preventive and curative services and that provides back referral linkages and schedules for shared services described in the ESP.

VIII. Key components of the encounter-based summary record ('eDiagnosis Card') shall be,
- Demographics and Identifier, Allergies, Blood group
- Medications/procedures / follow-up actions
- Vaccines
- diagnoses- international classification of primary care, second edition (ICPC2) and/or International Classification of Diseases 10 (ICD 10)

IX. The system shall offer selective access to the cluster/apex IS dashboard with defined user levels (access control) relevant to each cluster/apex health facility. These user levels may include medical officer of health, physician/medical officer, consultants, head of the institution (director/medical superintendent), nursing staff, pharmacy, laboratory and radiology, etc.

X. The system shall be able to report disease surveillance information on the notifiable diseases to the Medical Officer of Health office area of the patient (reporting a notifiable disease).

XI. The system shall include laboratory reports and imaging services such as CT/X-ray/Ultrasound etc., in the encounter-based patient health record. In case of a sharable service, this information shall be available to service providers across cluster facilities in continuing medical care and follow-up.

XII. The record shall contain the patient identification, working diagnosis, management plan at discharge from the health facility, together with investigations carried out, prescription the patient is on, and any new allergies reported. This record shall be linked with the client record (profile) mentioned below in the MPI section, as appropriate.

XIII. The cluster/Apex IS shall have a mechanism to link itself with the EMR locally implemented in the cluster/apex health facility. Hence, a software socket or similar mechanism shall be implemented to connect the cluster/apex IS with HIMS/HHIMS and; a generic socket/API shall be designed with the possibility of emerging new EMR in future.

XIV. If the cluster/apex health facility possesses any EMR already implemented (e.g. HIMS/HHIMS), the software socket/API shall extract information related to encounter-based summary record from the said EMR.

XV. The software socket/API shall facilitate the EMR communicating with the Cluster MPI through the Cluster/Apex IS.

XVI. The Cluster Information System Solution shall be able to replicate in the other health facilities/clusters at later dates.

2. Cluster Master Patient Index (MPI)

I. System shall be developed with a client record (Personal Health Record) which carry basic identification and relevant clinical data, such as allergies at a central location with access to any cluster/apex IS. This client record shall be the core of the proposed cluster MPI aggregating the encounter-based records of an individual.

II. Difference of the encounter-based record (at cluster/apex level) and the personal health record component of MPI is summarized below. *Please note that this list is the minimum required and could be extended by the MOHIMS*.

Table A13. 1: Comparison of Local Health Record and Corresponding Record in MPI

	Encounter-Based Record (in Cluster/Apex IS)	**Client Record (in MPI)**
Demographics	Name, Age, Sex, Contact Details, Next of Kin, etc. Female – pregnancy record Child – Height/Weight	Current Height/Weight Pregnancy record linked (PHN) to the records of children
Identifier	PHN	PHN
Allergies	From this encounter	All
Blood group	(if changed)	Blood Group
Medications	From this encounter	Long term management
Vaccines	From this encounter	EPI and other vaccines given
Diagnoses	New - from this encounter (code)	Conditions long term managed (code)
Laboratory results	From this encounter	Relevant for long term management of the client
Radiology findings	Images from this encounter	Reported radiological findings and images relevant to long term management

III. HL7 (FHIR/CDA) shall be used to realize the interoperability as required.
IV. Shall be able to make ad-hoc connections with MPIs of other clusters (Please refer to Figure 1).
V. Shall be able to upgrade to the National MPI (which overrides cluster MPIs) at a later date
VI. The system shall provide access to the patient to view his/her laboratory reports, images and diagnosis information through this Personal Health Record using PHN. The firm shall demonstrate the possibility of retrieving such record by the patient using a mobile device (preferably an API compatible with mobile clients).

3. Cluster Enterprise Service Bus (ESB)

19. The cluster ESB shall provide a mechanism to connect relevant systems in the cluster digital health ecosystem. The interoperability shall be for all the health conditions (medical, surgical, imaging and laboratory) mentioned in the ESP.

I. The proposed Cluster Information System Solution shall be able to be linked with the existing national level GOSL systems such as drug distribution system and HRH system (please refer to Figure 1) through the proposed ESB.
II. Open standards shall be used to code the request between systems (APIs/Web Services etc) to facilitate interoperability.
III. The ESB shall have concept mapping and terminology Services to support all the conditions listed in ESP (see Figure 2 below).

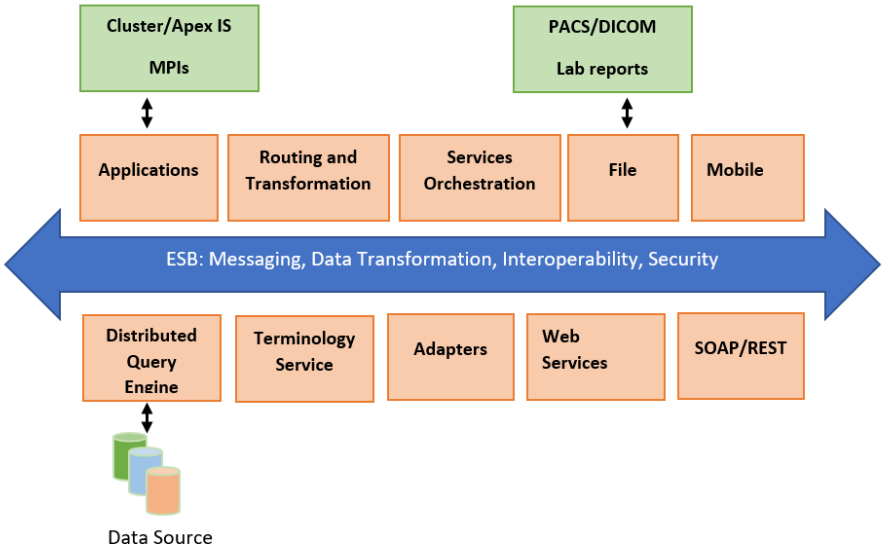


Figure A13. 2: High-level architecture for ESB

IV. Terminology services shall be based on following standards and ESP
- Medication - ATC/DDD
- Diagnosis - ICD, ICPC
- Vaccination – to be decided
- Blood Groups – to be decided
- Allergies – to be decided

V. Mandatory applications the proposed ESB shall support interoperability include,
- Cluster/Apex IS
- Cluster MPI
- eIMMR

- MSD drug distribution system
- Surveillance of notifiable diseases

20. Following are additional features listed under this TOR, which may be required to facilitate cluster health institution operations.

4. Human resource management

I. The system shall be able to monitor human resources within each of the clusters in cluster/apex dashboard using existing HRM system.
II. In order to achieve this the cluster/apex information system shall provide connection to existing HRM system through the proposed ESB.
III. The HR information shall be used as required in user authentication in cluster/apex IS.
IV. However, a comprehensive HRM system is out of the scope of this TOR.

5. Drug distribution

I. The ESB system provide interoperability between cluster/apex IS and existing drug distribution system used by the MOHIMS.
II. The cluster/apex IS shall provide the option to maintain the drug stock at the cluster/apex health facility and a mechanism to dispatch the drugs at pharmacies updating the local stocks.
III. Provision (API) shall be given for tele-prescription in designing the drug distribution component/module in a such a way that external pharmacies can access a prescription issues by a cluster/apex health facility if required.
IV. MSD/MOHIMS shall provide the list of essential drugs and their coding according to the ESP.

6. Queue Management

I. The system shall have queue management and patient appointment system for each cluster/apex health facility (as a part of or independent of cluster/apex IS). If it is independent of the cluster/apex IS, the system shall retrieve the referral note from MPI with relevant patient identification/PHN).
II. The system shall provide access to cluster health facility to request an appointment from apex health facility for scheduling shared services (referral management).
III. Queue management system shall add the referral note to PHR component.

7. Listing telecare/shared services and distance learning links in cluster/apex IS dashboard

I. The cluster/apex IS shall have options to list and link the existing teleconferencing/ teleconsultation system developed by the MOHIMS/ADB and other shared services available at apex health facilities in the cluster/apex IS dashboard for quick access.
II. Shared services are listed in ESP. Dashboard may list other services such as ambulance, that can be shared among cluster/apex health facilities.
III. The cluster/apex IS shall have options to list existing teaching/learning modules and distance learning resources developed by the MOHIMS (e.g. guidelines and manuals for sample collection procedures and instructions, infection control procedures, disease

surveillance mechanisms and protocols, health care waste disposal methods, etc.) which are relevant in providing high quality health services within the cluster, to be listed in the cluster/apex IS dashboard for quick access.

D. DURATION OF THE ASSIGNMENT

21. The duration of the design, development, training and implementation support is for 3 years from June 2021 to May 2024.

E. EXPERIENCE OF THE SOFTWARE FIRM

22. It would be an advantage if the software firm has prior experience in working on medium to large scale projects in health sector of Sri Lanka for at least for 10 years. Proven track records of working with the State health sector with the key medical record/public health information system solutions (specially, open source) would be essential in qualifying for this assignment. Also, prior experience on health information interoperability, MPI and Sri Lanka national e-Health standards and guidelines, and national health information policy would be useful for this assignment. Experience of working with OpenMRS would be an added advantage as use of OpenMRS is a key component of this assignment. The firm shall work in collaboration with MOHIMS and ADB.

F. TEAM COMPOSITION AND QUALIFICATION REQUIREMENTS FOR KEY EXPERTS OF THE SOFTWARE FIRM

Table 2: Software Firm – Team Composition

Key Position	National / International Expert	Preferred Qualification	Person Months
Key staff			
Project Manager (Team Leader) cum Senior Software Engineer (1)	National (The Project Manager will be responsible to meet all above tasks identified in the firm TOR and will manage his / her team to deliver the results.). He/she will lead the software development team	A masters in management/computer science/engineering or equivalent. At least 10 years of experience in managing projects related to the health sectors. This may include electronic health records, public health information/surveillance systems, Master Patient/Population Indexes, health sector Geographical Information Systems (GIS).	24 months (Intermittent) during the project period.
Systems Architect (1)	National. System Architect will lead the requirement gathering and preparation of software requirement specifications and ensure	A master's in IT/computer science/engineering or equivalent qualifications. At least 05 years of	12 months (full time) for the 1st year of the assignment

	implementing required health information system standards and adherence to the national e-Health and interoperability guidelines. She/he will support the integration of system components and oversee field implementations in the 9 districts and will provide technical assistance to address the issues that arise with implementation.	experience in designing technology solutions. Preferable to have exposure in networking and server management. Experience in working with OpenMRS would be an added advantage and willingness to learn OpenMRS is required.	
OpenMRS expert (1)	National/International. The OpenMRS expert shall do the initial customization of the open source platform OpenMRS for the cluster/apex health facility needs as per C.2 – 1. Parallel to this, the OpenMRS expert shall work with and the software engineers to initiate custom development on OpenMRS framework to complete the deliverable listed in C.2 – 1 and to integrate the same with the relevant other deliverables listed in this TOR.	A master's in IT/computer science/engineering or equivalent qualifications or higher with at least 05 years of experience in customization of OpenMRS and custom development on OpenMRS platform.	6 months (intermittent during the 1st year of the assignment)
Software Engineers (5)	National (The Software Engineers will develop the solution under the guidance of PM and SA. SEs are responsible for server administration and database management as well.) Further, they are responsible for the System QA and preparation of test cases and managing the system testing, security audits and software testing.	BS/ B Tech/ BE/ MCA/ MS or similar IT professional degree With minimum 05 years of experience in design, development and implementation of health information systems. Experience in working with OpenMRS would be an added advantage and willingness to learn OpenMRS is required.	4 Engineers for 12 months full time for the 1st year of the assignment and 1 Engineer for 36 months (total project period)
Other support staff			
ICT Assistants cum	National (Support	IT professional diploma	36 months

Cluster Help Desk coordinators (4)	Software Engineers during the development phase and coordinate user training and field implementations; and coordinating help desk operations during the implementation period). The ICT assistants shall be stationed in the 4 provinces where the solutions are implemented.	with minimum 02 years of experience in design, development and implementation of information (preferably health sector) systems and possess ability to troubleshoot networking and internet connectivity issues.	(full time)

G. OUTPUTS AND TIMELINES

23. Intended outputs of this assignment and the allocated time frame for each deliverable are listed below.

24. All the reports shall be submitted in English and both in printed and PDF format. The reports shall be submitted within the time frame stipulated in table 2 and table 3. The contents of reports, number of copies and persons to receive them shall be decided by the MOHIMS and ADB.

Table 3: Output and Timeline

	Timeline
Inception report This should include firm's approach to design, development and implementation of the proposed cluster/apex information system, its integration with the existing health information system of the State health sector, training plan and the possible mechanism of support after the assignment is over with the detailed implementation timeline (Gantt chart – weekly activities). Further, it should mention how the high-level system architecture proposed by the TOR can be expanded and how the firm acquire OpenMRS development skills. This report should also elaborate the network and hardware requirements to implement the proposed information system.	30 days (1 months) from signing the contract
OpenMRS based cluster/apex information system and cluster MPI. This version of the cluster/apex information system should be able to communicate with an institution within the same cluster through the cluster MPI enabling continued care within a cluster [as per Sections C.2 (item 1)]. Also, Section C.2 (item 6) - Queue management system While implementing the system in cluster servers a functional source code of this component shall be handed over to the Project Director, ORIGINAL PROJECT for security audit.	120 days (4 months) from signing the contract
Final version of MPI and ESB with the dashboard for MOHIMS to monitor activities in ESB and MPI [Section C.2 (item 2 and 3)].. During this phase, the security concerns raised by SL CERT shall be addressed by the firm.	210 days (7 months) from signing the contract
Interim Report 1 updated with all tasks carried out including on training to all	365 days (12

users in 9 clusters. Submitted with training guides and training/user manuals (in all 3 languages).	months) from signing the contract
Interim Report 2, which will include tasks carried out in relation to Section C.2, items 4, 5 and 7 and Integration. The time sheets of the Engineer and 4 ICT Assistants should be included.	540 days (18 months) from signing the contract
Interim Report 3, with an update on all tasks and will include the issues addressed during the implementation and initiation of the maintenance phase. The time sheets of the Engineer and 4 ICT Assistants should be included.	730 days (24 months) from signing the contract
Interim Report 4 with an update on all tasks and will include the issues addressed during the maintenance phase. The time sheets of the Engineer and 4 ICT Assistants should be included.	912 days (30 months) form signing the contract
Final report will include system (technical) documentation, server and data base configuration, software libraries, back-up/export and import scripts, software libraries. All temporary passwords used for development and implementation purposes and system access used during support has to be terminated before the end of contract period.	At the end of the contract (36 months) from signing the contract

H. PAYMENT SCHEDULE

Table 4: Payment Schedule for the Lump Sum of the IT Firm

Milestone Payment	Time	% of Payment
Inception report This should include firm's approach to design, development and implementation of the proposed cluster/apex information system, its integration with the existing health information system of the State health sector, training plan and the possible mechanism of support after the assignment is over with the detailed implementation timeline (Gantt chart – weekly activities). Further, it should mention how the high-level system architecture proposed by the TOR can be expanded and how the firm acquire OpenMRS development skills. This report should also elaborate the network and hardware requirements to implement the proposed information system.	30 days after signing the contract	10%
OpenMRS based cluster/apex information system and cluster MPI. This version of the cluster/apex information system should be able to communicate with an institution within the same cluster through the cluster MPI enabling continued care within a cluster [as per Sections C.2 (item 1)] and Section C.2 (item 6) - Queue management system	120 days (4 months) from signing the contract	20%

Final version of MPI and ESB with the dashboard for MOHIMS to monitor activities in ESB and MPI [Section C.2 (item 2 and 3)].	210 days (7 months) from signing the contract	20%
Interim Report 1 updated with report on training to all users in 9 clusters. Submitted with training guides and training/user manuals (in all 3 languages).	365 days (12 months) from signing the contract	10%
Interim Report 2, which will include Section C.2, item 4, 5 and 7 and Integration with the time sheet of the Engineer and 4 ICT Assistants)	540 days (18 months) from signing the contract	10%
Interim Report 3, which will include the issues addressed during the implementation and initiation of the maintenance phase and with the time sheets of the Engineer and 4 ICT Assistants)	730 days (24 months) from signing the contract	10%
Interim Report 4 which will include the issues addressed during the implementation and the maintenance phase and with the time sheets of the Engineer and 4 ICT Assistants.	912 days (30 months) form signing the contract	10%
Final report with should include system (technical) documentation, server and data base configuration, software libraries, back-up/export and import scripts, software libraries. All temporary passwords used for development and implementation purposes and system access used during support has to be terminated before the end of contract period. This should include source code, supportive software libraries, server and data base configuration scripts and technical documentation. Should also include the time sheets of the Engineer and 4 ICT Assistants.	At end contract (36 months from contract signing)	10%

I. CLIENT INPUTS AND COUNTERPART PERSONNEL AND LOCATION OF SERVICES

1. ICT Assistant/Training and Help Desk coordinator (4) shall be stationed at provincial level and may visit cluster health facilities as and when needed. Other key positions (Project Manager cum Senior Software Engineer, Systems Architect, Software Engineers) may operate from centrally. However, software firm shall use their own premises for software development and project management.

2. The firm will work closely with the MOHIMS (a team appointed by the Project Director and the DDG (Planning)), PMU and ADB. The MOHIMS-appointed team will include representatives from the PMU, DDG Planning unit (including Directors Organization and Development and Health Information).

3. The authorized representative of the Client during the implementation of this Contract is the Dr. Anil Dissanayake, Project Director of the Health System Enhancement Project, 3/19, Kynsey Road, Colombo 0, tel., 0112697173.

4. The following documents will be provided to the selected firm by the client.

- The government, e-health architecture plans (Draft National HER Architecture)
  - The HIS report developed under the ADB-financed Health System Enhancement Project (See Annexure B)
  - The e-health strategy for Sri Lanka
  - e-Health Standards and Guidelines
  - Health Information Policy
  - Essential (Health) Services Package (ESP) for Sri Lanka.
  - Policy and Procedures for ICT Usage in Government (e-Government Policy)

ANNEX 14: SUMMARY OF COMMUNITY NUTRITION INTERVENTIONS TO REDUCE THE BURDEN OF MALNUTRITION IN ESTATE AND RURAL DISTRICTS

1. The Health System Enhancement Project (the original project) intended to support a community based nutrition intervention to enhance the nutrition related supply side nutrition interventions package provided by the MOH for defined period of 4 years. The objective of this support via the original project was to support the MOH to improve the nutrition related outcomes of mothers and children under 5 years in the 9 project districts.

2. Under Output 1(ii) the original project intended to support this task by hiring the services of a firm / NGO to work collaboratively with the MOH, namely the FHB, HPB and the 9 RDHS and the 4 provinces.

3. Due to reallocations, this assignment is moved to the Additional Financing to the Health Enhancement Project (the additional financing) and will be initiated from 2021 for a period of 4 years.

- The nutrition firm will be responsible for delivering all tasks defined in the TOR, but the firm will need to work closely throughout this process with the Family Health Bureau (FHB) and with the Health Promotion Bureau (HPB) and with the PDs, RDHSs and relevant staff, when planning the training modules, rollout, material and all activities defined and proposed in the assignment.
- The FHB will identify a focal point for coordinating all tasks with the firm and the PMU.
- The deliverables (as specified in the firm TOR) will be received by the PMU but will be approved by the FHB of the MOH before payments can be approved to the firm.
- Implementation will be reviewed by the Director of the FHB monthly, and the meeting will be chaired by the DDG (PHS 1) every 3 months.
- The nutrition project implemented by the selected firm will be discussed at the MCN subcommittee and at the National Nutrition Steering Committee, as a regular agenda item, and necessary support and clearance to the firm will be facilitated via this process.
- The agreed results of the nutrition project, as defined in the TOR of the nutrition firm, will be discussed and reviewed bi-annually at the MCN subcommittee and annually at the National Nutrition Steering Committee.

The TOR for hiring the services of a firm for this purpose is given below as the Attachment 1 of the Annex 14.

ATTACHMENT 1: TERMS OF REFERENCE FOR A CONSULTANCY ORGANIZATION / NON-GOVERNMENTAL ORGANIZATION FOR PROVISION OF SUPPORT FOR COMMUNITY EMPOWERMENT AND CAPACITY BUILDING FOR IMPROVING THE NUTRITION STATUS OF MOTHERS AND CHILDREN UNDER 5 YEARS IN 9 DISTRICTS COVERING THE ESTATE AND RURAL SECTORS UNDER THE ASIAN DEVELOPMENT BANK FINANCED HEALTH SYSTEM ENHANCEMENT PROJECT

A. BACKGROUND

1. The Health System Enhancement Project (the original project), a US$60 million (comprising $37.5 million in concessionary loan and $12.5 million grant, and $10 million equivalent from the Government of Sri Lanka in counterpart funds), delivered through a project investment modality is effective from February 2019 and will close in December 2023. The project will improve efficiency, equity, and responsiveness of the primary healthcare (PHC) system based on the concept of providing universal access and continuum of care to quality essential health services. The project is targeting all nine districts in four provinces of Central, North Central, Sabaragamuwa, and Uva with a special focus on the geographically, socially, and economically-deprived populations. The beneficiary population of the project is approximately 7 million which is 33% of the Sri Lanka population (21 million) while the target population, identified using a vulnerability index, within the four provinces, is estimated to be approximately 2.4 million.

2. The project pursues an equity perspective in planning and delivering of essential primary health services. It expects to further inform and operationalize government PHC reform initiatives to reduce bypassing of PHC facilities by providing more comprehensive services, including for NCDs, develop a referral system, and functionally integrating preventive and curative services. Furthermore, the project will target underserved communities' access to PHC, and address selected gaps in core public health surveillance in line with the international health regulations (IHR).

3. The expected project impact is to contribute to the Government development objective of ensuring a healthier nation with a more comprehensive primary health care (PHC) system. The project outcome is to improve efficiency, equity, and responsiveness of the PHC system. The project outcomes are assessed by observing a:

(v) 20% increase in outpatient utilization at PHC;
(vi) 20% increase in patient satisfaction, knowledge and attitudes on utilization;
(vii) 90% of notified notifiable diseases investigated within the stipulated time in the medical officer of health areas in the target provinces;
(viii) cluster system reform implemented and evaluated in all nine clusters.

4. The project outputs are (all details of the original project are accessible from www.original project.lk):

(i) Output 1: PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces; *This output, supports to expand the targeted nutrition related services available to the mothers and children in the 4 provinces with a special focus of more vulnerable populations in the estate and rural areas.*
(ii) Output II: health information and disease surveillance capacity strengthened; and
(iii) Output III: policy development, capacity building, and project management supported.

Nutrition status of mothers and children in the Estate and Rural sectors

5. Sri Lanka still faces unresolved health issues of malnutrition in mothers and children as a national level problem and more acutely seen in the estate sector. At the national level, 20.5% are underweight and 17.3% children under 5 years are stunted. In addition, as much as 15.7% of all children are of low birth weight (less than 2,500 grams). In the estate sector, 25.4% of children are low birth weight, 31.7% of the children below 5 years are stunted and 29.7% are underweight[1]. Among women in the reproductive age group, at the national level 9.1% have a low body mass index (less than 18.5) and as much as 22% of estate women have a low body mass index.

Existing Nutrition Services and Challenges

6. Nutrition is addressed in children under 5 years of age, in pregnant and lactating mothers and among the women in the reproductive age group (15 to 49 years) as a national program managed by the Family Health Bureau and delivered via the well laid out preventive health network. When needed, curative secondary care level intervenes for therapeutic management of malnutrition related issues and primary and secondary levels for life style guidance for all age groups.

7. The main human resource category at the local level (Divisional level) that overseas maternal and child nutrition issues are the Public Health Midwives, under the guidance of Supervising Public Health Midwives, Public Health Nursing Sisters and the Medical Officers of Health. The Medical Officer Maternal Child Health in each district is the focal point for the MCH program in the districts. The PHMs role related to nutrition includes both home visits and managing nutrition and maternal health related clinics. Due to various reasons, as of September 2018, as much as 15% (426) of the total 2871 PHM posts are vacant in the 9 districts covered by the original project. In these project districts, Badulla district has the lowest vacancy proportion at 5.6% (18 /319), Ratnapura has 12% (44/369); Kandy has 14% (69/492); Polonnaruwa has 14% (23/163); Matale has 16% (63/385); Nuwera Eliya has 16% (51/321), Anuradhapura has 18.5% (55/298); Kegalle has 19% (56/289 and Moneragala has 20% (47/235) PHM vacancies[2]. As each of these vacant areas are covered by another PHM who has to in addition to her area, carry out cover up duties in a vacant area, the services provided to as much as 30% of PHM areas in these 9 districts are compromised.

8. In terms of nutrition capacity development, the FHB delivers 3 standardized WHO recommended courses on nutrition at the national level. These full time 3 to 5 day, Training of Trainers (TOT) courses, are on Infant and Young Child Feeding program (IYCF), Growth Monitoring and Promotion (GMP) and the Lactation Management (LM) Course. The courses are offered by the FHB each year. These TOT program followers are expected to roll out these training programs in the respective districts. But due to various reasons like limitations in resources and resource persons, and time, the roll out of the TOT programs onthese crucial nutrition programs are not able to cover all PHC staff on an annual basis. Furthermore, these courses are yet available only via the face to face mode.

9. In terms of nutrition counselling, while the above mentioned 3 courses cover counselling skills, the Health Promotion Bureau (HPB) carries out a 3 day nutrition counselling skills development program in Colombo for nominated representatives from the districts as a TOT

[1] Government of Sri Lanka, Department of Census and Statistics and MOHNIM. 2017. *Demographic and Health Survey 2016.* Colombo.

[2] Data from the Monitoring and Evaluation Unit of the Family Health Bureau.

program. But, this course has not covered a majority of the PHMs in the 9 districts as yet.

10. It is also noted that large numbers of the new recruits as PHMs are SInhala language speakers and they are posted to estate areas where the language of communication is estate Tamil. This is creating gaps in knowledge and skills transfer to the mothers and children. Therefore, there is a need to review the language competency of the PHMs and other relevant cadres serving estate sector populations and provide language training opportunities to further improve the quality of care given to the mothers and children in the estate areas.

Nutrition Communication and Challenges

11. The MOH via the FHB and the HPB provide many communication materials to improve the knowledge and skills of mothers and care givers to improve maternal and child health related nutrition issues. This includes the following:

- Child Health Development Record given to each and every child at time of birth. This gives extensive information related to growth monitoring, immunization, development and management and is available in Tamil and Sinhala languages).
- The Complementary Feeding guide is a booklet that provides more detailed information on complimentary feeding, given to mother when the child is 4 months old (at the time of the 4th vaccination) and is available in Tamil and Sinhala languages
- Leaflets, video clips developed on specific messages of nutrients, calories intake, countering nutrition related myths are given to mothers and children at clinics etc. (usually available in Tamil and Sinhala languages).

12. Even though these documents are given the utilization of these knowledge products are not regularly reviewed for assessing nutrition related practices. Furthermore, nutrition related myths and practices are also widely practiced to varying extents in the estate and rural communities.

Monitoring of the Nutrition Program for Mothers and Children

13. The progress monitoring of the nutrition program of mothers and children is managed by the Family Health Bureau. In addition, the national nutrition program is reviewed during the nutrition month each year. The Demographic and Health Surveys that are carried out at 6–8-year intervals report on the nutrition status of mothers and children. A location-based nutrition status monitoring program is not in place.

14. Given the persisting nutrition related issues, the project intends to support the 9 project districts to utilize project resources to further strengthen and enhance the GOSL managed interventions that are routinely provided via the preventive health services. The services proposed to be provided for by the project will be provided as support services to the provinces, districts and the respective Medical Officer of Health areas via a consultancy organization / Non-Governmental Organization over a period of 3 years from July 2020 to July 2023. It is anticipated that the interventions supported via the selected organization will address system related, language related, capacity related, community empowerment related gaps in the existing system in the estate and some rural sector districts supported under the project.

15. The PMU intends to recruit an organization to address both supply (service providers) and demand (community) aspects related to nutrition interventions by carrying out the following tasks:

- Support to further enhance the capacity building of service providers (e.g. PHC level staff) on nutrition knowledge, and skills to improve the quality of the package of nutrition services delivered by the national program.
- Support to establish a nutrition community empowerment program incorporating the existing mother support groups, healthy village concepts to improve nutrition related outputs and outcomes of the communities / beneficiaries (especially of mothers and children under 5 years) in the 9 districts.

16. The Organization will be assessed based on the achievement of the following progress indicators.

- At least 75% of MOH offices are facilitated to provide nutrition services which are gender sensitive and gender responsive (data to be provided by sex).
- At least 90% of the MOH staff (especially the PHMs) trained on Nutrition counselling skills.
- At least 90% of the MOH staff (especially PHMs) working in estate areas who require tamil language training are trained.
- At least 75% of the community in the 9 districts are engaged in the nutrition empowerment program via mothers clubs, healthy village concept and other community based initiatives.

SCOPE OF SERVICES

17. The contracted Organization will work closely with the PMU and the focal point from the Ministry would be the Health Promotion Bureau for this assignment. A technical team from the MOH (will include representatives from the Family Health Bureau (FHB), the Nutrition Division, the Health Promotion Bureau (HPB)) and the ADB when carrying out all tasks associated with the consultancy. At the district level, the organization will coordinate with the Regional Directors of Health Services, the respective Medical Officers of Maternal and Child Health (MO MCH), Medical Officers of Health (MOHs) and the Health Education Officers on all district specific tasks.

18. The Organization will carry out the following tasks and will be monitored against the progress indicators mentioned in paragraph 19.

B.1 Support to strengthen the existing processes and mechanisms to increase the capacity of the regional level nutrition service providers (e.g. PHC level staff)

B.1.1 Support the MOH and the Districts to expand the coverage of trained PHC staff on Nutrition Counselling and Nutrition Knowledge

- Engage in discussions with the FHB, Nutrition Division and the HPB to agree on the changes including the possibility of developing e-modules of the existing nutrition courses and incorporating any additional training content related to gender perspective, to the existing nutrition courses described in paragraphs 11-13 above.

- Support the HPB to further expand the resource persons teams (in Sinhala and Tamil) for nutrition counselling capacity development and facilitate the process to roll out the capacity building on nutrition counselling in the 4 provinces (9 districts) for various categories of PHC staff (SPHMs, PHNS, PHMs, Health volunteers, MOHs, MOs in PHCs, Nurses in PHCs etc.). It is expected that the regional level nutrition counselling course should be delivered in Sinhala and Tamil languages in the 9 districts for PHC staff who have not attended a refresher course on nutrition counselling in the prior year. The estimate number of PHC staff who may need to

undergo training is approximately 1750. Each regional level nutrition counselling training program should be approximately for 25 PHC staff and therefore approximately 70 programs need to be carried out in the 9 districts within the first 1.5 years of implementation of this project by the selected organization.

- Support the 9 districts to implement the roll out plan to train all relevant categories of Medical Officer of Health staff (especially PHMs) and the PHC hospital staff on the existing nutrition capacity development courses (IYCF, GMP and LM) and on gender responsiveness and inclusivity in nutrition programs. Similar to the nutrition counselling program given above, approximately 1750 PHC staff will need to be trained *in each* of the 3 courses. The selected Organization is expected to provide the logistics support to the 9 districts to carry out these programs within the first 1.5 years of the implementation of this project.

B.1.2 Tamil Language Competency

- Develop/ Identify a Tamil language module to improve the Tamil language knowledge and skills that are required to provide a comprehensive package of MCH and Nutrition services. The module should be atleast of 12 days of duration (24 half day sessions delivered over a 3 month period) and should be delivered in the respective 6 districts. It is estimated that approximately 500 PHC staff (mainly newly appointed PHMs) will require the Tamil language competency training to manage nutrition related issues as a PHC service provider in the estates sector.

- Develop a language training roll out program for the relevant 6 districts (Kegalle, Ratnapura, Badulla, Nuwera Eliya, Matale and Kandy) in close collaboration with the respective RDHSs.

B 2: Design and facilitate implementation of a nutrition community empowerment program to support the district teams to improve nutrition related outputs and outcomes of mothers and children under 5 years in the 9 districts.

B.2.1 Design Phase (6 months):

- The organization, in close collaboration with the HPB, the respective MO MCH and District Health Education Officers, will carry out a literature review, review available data, if necessary will also carry out small qualitative assessments to best understand the local level nutrition issues faced by mothers and children and the possible reasons for them and document to understand the coverage of the ongoing community empowerment activities in the 9 project districts. It is expected that the Organization will carry out 9 district level qualitative assessments and stakeholder consultations at each of the 132 MOH areas to best understand the knowledge, practices, believes and to identify nutritionally vulnerable small areas etc.

- The organization, in close collaboration with the HPB, the respective MO MCH and District Health Education Officers, will design a community empowerment program, incorporating the existing community empowerment activities carried out via mother support groups, healthy village concept etc. and in collaboration with the other non-health sectors at the local and regional levels for nutrition promotion and nutrition behavior change by mothers and children under 5 years.

- The Organization will get clearance for the proposed enhanced nutrition empowerment program activities from the HPB and MOH appointed technical committee and prior to facilitating the rolling out of the empowerment program in the 9 districts.

132.

B.2.2 Implementation Phase (2.5 years):

- The Organization will support and facilitate the roll out of the approved nutrition community empowerment program with the district and medical officer of health levels in the 9 districts.

- The Organization will support the District and MOH levels to utilize the existing data (and where necessary with additional data) to monitor, on a quarterly basis, the implementation progress of the outputs of the enhanced community empowerment program.

- The Organization, in close collaboration with the MOH appointed Technical Committee and the district and MOH level officials, will make appropriate and necessary adjustments to the program to meet the agreed nutrition related results and the progress indicators (mentioned in Paragraph 19) in the 9 districts.

J. DURATION OF THE ASSIGNMENT

18. The duration of the assignment is for 3 years (36 months) from July 2020 to July 2023.

K. TEAM COMPOSITION AND QUALIFICATION REQUIREMENTS FOR KEY EXPERTS

19. The Organization should propose a team comprising of the following team members and the Organization must have at least 5 years' experience in nutrition, health promotion and community empowerment in Sri Lanka to be eligible for consideration.

Table 1: Team Composition and Qualification Requirements of Key Staff

Position	National / International Expert	Terms of Reference	Preferred Qualification	Person days
Key Staff				
Lead Specialist in Health Promotion (Team Leader)	National (Part time)	The Team Leader will be responsible for all clearances that are required and for managing all the tasks identified in the organization TOR. The team leader will work closely with ADB, GOSL including the MOH and Province and District levels in the target provinces.	Post Graduate Qualifications in Medicine, Nutrition, Public Health, Psychiatry, Psychology, Sociology, Health Promotion or a related field. Past experience of at least 10 years in supporting, implementing, monitoring community empowerment porgrammes in the health sector is essential.	150 days (intermittent)
Specialist in Nutrition	National (Part time)	The Nutrition Specialist will coordinate the Nutrition knowledge and	Degree in Nutrition / MBBS/ Post graduate	100 days (intermittent)

		skills related capacity building programme and provide and technical expertise to the enhanced community enhancement program that needs to be delivered at the districts.	qualification (Masters Degree) in Public Health / Nutrition with extensive knowledge of qualitative assessments.	
Health Promotion Specialist	National (Part Time)	The Health Promotion Specialist will work closely with the Team Leader to plan, design and implement, in consultation with the MOH Technical review team and the district and local level health staff, the Nutrition Community Empowerment Program in the 9 districts. He / She will oversee the enhanced implementation of community empowerment activities in the 9 districts with the support of the district level officers and the local communities / clubs etc.	Degree in Nutrition / health promotion/ public health / sociology with atleast 10 year's experience in carrying out community empowerment programs and with exposure in working with underserved communities.	100 (intermittent)
Health Promotion Officers (5 officers dedicated for each province, total 20 officers)	National (Part Time)	The Health Promotion Officers will support implementation of the enhanced community empowerment activities (Activities under B 2). The Health Promotion Officers will also support the MOHs and the district level officials with enhancing the national nutrition monitoring mechanisms.	Degree in Nutrition / health promotion/ public health / Medicine with experience in carrying out community empowerment programs and have exposure in working in underserved communities.	100 days (intermittent)
Other Staff				
Project Coordinator (Nutrition Capacity Building)	National (Full time)	The Project Coordinator will be in charge of logistics, implementation, reporting progress, supporting and coordinating with all team members, etc. of	Degree in Public Health, Nutrition, Psychology, Sociology, Health Promotion	36 months

		all activities in the TOR relating to Capacity Building under the direct supervision and guidance of the Specialist in Nutrition.		
Project Coordinator (Community Empowerment programme)	National (Full time)	The Project Coordinator will be in charge of logistics, implementation, reporting progress, supporting and coordinating with all team members, etc. of all activities in the TOR related to community empowerment. She / He will be under the direct supervision of the Health Promotion Specialist.	Degree in Public Health, Nutrition, Psychology, Sociology, Health Promotion	36 months

L. OUTPUTS AND TIMELINES

20. All reports / outputs will be handed over to the Project Director in 3 hard copies and in soft copy format in a CD-ROM and a PEN DRIVE.

Table 2: Outputs and Timeline for Nutrition Organization

	Timeline
Inception report which should address the 2 (B1 and B2 above) tasks (Capacity Building and Empowerment) identified under the consultancy. The Inception report should include a **tentative** plan for facilitating the implementation of the capacity building program and a brief summary of the literature review and a description of the proposed community empowerment activities.	Within **30 days** of signing of contract.
A Technical Report giving details of the proposed program of support / facilitation that will be provided to the provinces and the districts to enhance the nutrition community empowerment program in the 9 districts.	Within **120 days (4 months)** of signing the contract.
E-Modules of the existing Nutrition Programs (IYCF, GMP and LM),	Within **180 days (6 months)** of signing of the contract.
First Interim Report with an update of all project related tasks, updated with the outputs identified for the project (in paragraph 19), based on the TOR (B.1 and B.2) should be submitted to the PMU.	Within **365 days** of signing (end of first year) of the contract (July 2021)
Second Interim Report with an update of all project related tasks, updated with the 3 outputs identified for the project (in paragraph 19), based on the TOR (B.1 and B.2) should be submitted to the PMU.	At the end of **2 years** from signing the

	contract (July 2022)
Final Report with an update of all project related tasks, progress results update using the 3 nutrition indicators (in paragraph 19) and based on the TOR hould be submitted to the PMU.	At the **end of contract** (July 2023)

M. PAYMENT SCHEDULE

21. Payment to the organization will be based on approval of the reports by the Technical Review Committee and on proportional achievement of the 3 progress indicators.

Table 3: Payment Schedule for the Nutrition Organization

Deliverable	**Time**	**% of Payment**
On approval of Inception report	30 days (1 month) from signing of the contract	10
On approval of the Technical Report on the Proposed program for enhancing the Community Empowerment Program	120 days (4 months) from signing of the contract	20
On approval of the E-Modules of the existing Nutrition Programs (IYCF, GMP and LM),	180 days (6 months) from signing of the contract	20
On approval of the First Interim Report updating on all tasks identified in the Scope of services and reporting achievement of at least 20% of the proposed 3 progress indicators mentioned in Paragraph 19 above.	July 31, 2021 or end of one year from signing of the contract.	15
On approval of the Second Interim Report updating on all tasks identified in the Scope of services and reporting achievement of at least 60% of the proposed 3 progress indicators mentioned in Paragraph 19 above.	July 31, 2022 or end of 2 years from signing of the contract	15
On approval of Final Report updating on all tasks identified in the Scope of services and reporting achievement of more than 90% of the proposed 3 progress indicators mentioned in Paragraph 19 above. The final report has to be submitted with all Final AV material/ reports/Course modules / training material in hard and soft copies.	July 31, 2023 or end of 3 years from signing of the contract.	20

N. CLIENT INPUTS AND COUNTERPART PERSONNEL

The Organization will work closely with the PMU, the HPB, a technical committee from the MOH and the Provinces (to be appointed) and with the ADB. The technical review committee, appointed by the Secretary Health, will be for reviewing project reports, implementation support and supervision of the project.

The Deputy Project Directors in the 4 Provinces (Provincial Directors of Health) , via the technical committee, Provincial Director of Health Services will facilitate the clearances and access to carrying out all tasks mentioned in the TOR.

The following documents will be provided, during Request for proposal stage, to the selected Organization by the client.

- The project design and implementation information from the project administration manual.
- The Sri Lanka Essential Service Package document

Regular project implementation updates especially with the timing related to the implementation of the cluster pilots in the 9 districts.