Report and Recommendation of the President to the Board of Directors

Project Number: 51107-003
September 2021

Proposed Loan and Administration of Grant for Additional Financing
Democratic Socialist Republic of Sri Lanka: Health System Enhancement Project

Asian Development Bank

CURRENCY EQUIVALENTS
(As of 17 August 2021)

Currency unit	–	Sri Lanka rupee/s (SLRe/SLRs)
SLRe1.00	=	$0.00501
$1.00	=	SLRs199.50

ABBREVIATIONS

ADB	–	Asian Development Bank
COVID-19	–	coronavirus disease
HIT	–	health information technology
MOH	–	Ministry of Health
NCD	–	noncommunicable disease
OP	–	operational priority
PAM	–	project administration manual
PHC	–	primary health care
PIU	–	project implementation unit
PMU	–	project management unit

NOTE

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

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CONTENTS

PROJECT AT A GLANCE

1. Basic Data

Project Number: 51107-003

Project Name	Health System Enhancement Project - Additional Financing
Country	Sri Lanka
Borrower	Sri Lanka
Country Economic Indicators	https://www.adb.org/Documents/LinkedDocs/?id=51107-003-CEI
Portfolio at a Glance	https://www.adb.org/Documents/LinkedDocs/?id=51107-003-PortAtaGlance
Department/Division	SARD/SAHS
Executing Agency	Ministry of Health

2. Sector

	Subsector(s)	ADB Financing ($ million)
✓ **Health**	Disease control of communicable disease	68.10
	Health sector development and reform	41.90
	Total	**110.00**

3. Operational Priorities

- ✓ Addressing remaining poverty and reducing inequalities
- ✓ Accelerating progress in gender equality
- ✓ Tackling climate change, building climate and disaster resilience, and enhancing environmental sustainability
- ✓ Promoting rural development and food security
- ✓ Strengthening governance and institutional capacity
- ✓ Fostering regional cooperation and integration

Climate Change Information

GHG reductions (tons per annum)	4,282.020
Climate Change impact on the Project	Medium

ADB Financing

Adaptation ($ million)	6.28
Mitigation ($ million)	3.05

Cofinancing

Adaptation ($ million)	0.00
Mitigation ($ million)	0.63

Sustainable Development Goals

SDG 3.3, 3.4
SDG 13.a

Gender Equity and Mainstreaming

Effective gender mainstreaming (EGM) ✓

Poverty Targeting

Geographic Targeting ✓

4. Risk Categorization: Low

5. Safeguard Categorization

Environment: B **Involuntary Resettlement:** C **Indigenous Peoples:** C

6. Financing

Modality and Sources	Amount ($ million)
ADB	**110.00**
Sovereign Project (Regular Loan): Ordinary capital resources	110.00
Cofinancing	**3.00**
Japan Fund for Poverty Reduction - Project grant (Full ADB Administration)	3.00
Counterpart	**10.00**
Government	10.00
Total	**123.00**

Currency of ADB Financing: US Dollar

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed loan to the Democratic Socialist Republic of Sri Lanka for the additional financing of the Health System Enhancement Project. The report also describes the proposed administration of a grant to be provided by the Japan Fund for Poverty Reduction for the additional financing of the Health System Enhancement Project, and if the Board approves the proposed loan, I, acting under the authority delegated to me by the Board, approve the administration of the grant.

2. The Asian Development Bank (ADB) approved the ongoing Health System Enhancement Project (original project) for $50.0 million, comprising a $37.5 million loan from ADB's ordinary capital resources and a $12.5 million grant from ADB's Special Funds resources on 23 October 2018. The original project aims to ensure that efficiency, equity, and responsiveness of the primary health care (PHC) system is improved. The proposed additional financing will bridge the financing gap created by the reallocations of funds for emergency COVID-19 pandemic response and support additional interventions such as (i) scaling up primary and secondary health care through the shared care cluster approach in Central, North Central, Sabaragamuwa, and Uva provinces, (ii) improving the government's response capacity to better address the ongoing devastation of coronavirus disease (COVID-19) pandemic, and (iii) supporting the e-learning in the health sector.

II. THE PROJECT

A. Rationale

3. **Health status**. Sri Lanka, an island with a population of 21.9 million, has made significant progress in the last few decades on socioeconomic and human development indicators in ensuring access to health services for all.[1] The vaccine-preventable disease burden has been well controlled, with immunization coverage at more than 99%.[2] Maternal and child care services coverage is nearly 100%, the maternal mortality ratio is very low at 32.0 per 100,000 live births, the infant mortality rate is 8.9 per 1,000 live births, and the under age 5 mortality rate is 9.5 per 1,000 live births.[3] Some vector-borne diseases like malaria and filaria have been eliminated, while diseases like dengue and leptospirosis are endemic. Sri Lanka's population is rapidly aging, and as much as 16% of the population is over the age of 60.[4] The noncommunicable disease (NCD) and risk factor burdens are significant, accounting for as many as 83% of all deaths, and 17% of these are people less than 70 years old.[5]

4. **Health care delivery system.** Health services are provided mostly by the public sector with limited private sector contribution. The public sector provides 90% of inpatient care (more than 7 million hospitalizations in 2019), about 55% of outpatient care (more than 58 million outpatient visits in 2019), and nearly 100% of preventive care which includes childhood immunization, antenatal care, and family planning services. The government recognized the importance of free preventive care and therefore established a field-based preventive care service system, with a dedicated preventive health staff. The country is divided geographically into 356

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[1] Central Bank of Sri Lanka. 2021. *Annual Report 2020 (Special Statistical Appendix)*. Colombo.
[2] Government of Sri Lanka, Ministry of Health (MOH), Medical Statistics Unit. 2020. *Annual Health Bulletin 2019.* Colombo.
[3] Government of Sri Lanka, MOH, Family Health Bureau. National Statistics Bulletin (accessed 20 July 2021).
[4] ADB. 2019. *Growing Old Before Becoming Rich. Challenges of an Aging Population in Sri Lanka*. Manila.
[5] World Health Organization. 2018. *Noncommunicable Diseases (NCD) Country Profiles: Sri Lanka*. Geneva.

health areas, managed by a medical officer of health, each with a defined catchment area that coincides with the local administrative unit.

5. In parallel with the preventive care network, a geographically wide network of curative services in three tiers (primary, secondary, and tertiary) is provided via 1,165 health facilities spread across the country. This includes 643 hospitals with 86,589 beds (four beds per 1,000 people) and 522 facilities providing primary outpatient care services. About 74% of beds are in the 116 secondary and tertiary care hospitals and 38 special hospitals (e.g., mental health, prison, cancer, and dental hospitals), while 26% are in the 489 divisional hospitals which provide primary care.[6] However, the availability of intensive care facilities is limited to about 600 beds (three intensive care unit beds per 100,000 people).[7] People can access any level of curative facility (primary, secondary, or tertiary care hospitals) for first-contact care. A tier-wise referral system—starting from primary care facilities to higher facilities—is not in place. The Ministry of Health (MOH) is responsible for the health system policy, planning, human resource training, stewardship functions, and tertiary hospitals while nine provincial councils manage primary and most secondary health care services.

6. **COVID-19 pandemic.** COVID-19 cases were first reported in Sri Lanka in January 2020. The first wave of COVID-19 was during March–June 2020, the second wave was during October 2020–March 2021, and an ongoing third wave has affected the country since 25 April 2021. As of 23 August 2021, Sri Lanka had reported 390,000 confirmed cases and 7,366 deaths because of COVID-19.[8] The third wave continues to result in an unprecedented number of COVID-19 patients attending health facilities, and the effective reproduction rate during the third wave is markedly higher than that during the first and second waves. Since April 2021, the number of daily new confirmed cases has increased more than 350-fold, from 0.3 cases per million people to 106.0 cases per million people.[9] The reported spread of new, more infectious variants has contributed to this significant increase. The speed of transmission of the virus and its virulence requires the country to ramp up testing, quickly identify and isolate cases, and effectively care for people with COVID-19.

7. **Constraints.** Since 1990, evolving health challenges, including population aging, have led to prioritization of investments in secondary and tertiary health care at the expense of PHC services. The COVID-19 pandemic has exacerbated the lopsided investment. Deterioration of PHC facilities has led to the bypassing of primary curative care services for secondary and tertiary care for most health problems faced by the population. For example, secondary and tertiary health care levels manage as much as 93% of childbirths, 75% of NCD patients, and 40% of outpatient services. Preventive services (e.g., immunization) are well-managed at the PHC level, but for some preventive care (e.g., nutrition services), demand-side intervention gaps exist (footnote 7).

8. **Shared care clusters reform.** In 2018, to improve PHC utilization, address overcrowding of secondary and tertiary care facilities, and ensure universal health coverage, the government approved a new health care delivery policy.[10] The policy provides the implementation framework to transform the health care delivery model into a network of shared care clusters across the country to enable services that are more responsive, and patient centered. “Shared care” in the government’s definition means (i) an individual's health care will be shared and form a continuum

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[6] Government of Sri Lanka, MOH, Medical Statistics Unit. 2019. *Annual Health Statistics 2019*. Colombo.
[7] V. Pinto et al. 2019. *Critical Care in Sri Lanka*. Colombo.
[8] Government of Sri Lanka, MOH. *COVID-19 Situation Reports*. Colombo.
[9] Our World in Data. Effective reproduction rate (average number of new infections caused by a single infected person, 7-day rolling average) and daily new confirmed cases per million population (7-day rolling average).
[10] Government of Sri Lanka, MOH. 2018. *Policy on Health care Delivery for Universal Health Coverage*. Colombo.

between primary care and specialized services, and (ii) resources will be shared among health care facilities within a cluster so that there is optimum availability and utilization (footnote 10). Each shared care cluster is structured around a secondary care facility (apex hospital) linking the PHC facilities (divisional hospitals and primary medical care units as feeder hospitals that will serve a defined catchment population). The apex hospitals will serve as the secondary curative care facility for patients referred from PHC facilities within the cluster and provide a more comprehensive service package to accommodate transfers and referrals from the smaller feeder hospitals in the cluster. The cluster approach ensures the continuum of care between primary and specialist services for an individual patient over time and across an episode of care.

9. **Original project.** The original project became effective on 5 February 2019 and has three outputs: (i) PHC enhanced in Central, North Central, Sabaragamuwa, and Uva provinces; (ii) health information system and disease surveillance capacity strengthened; and (iii) policy development, capacity building, and project management supported. The four provinces that the original project is supporting were selected based on high poverty levels, health disparities, as well as percentage of rural and estate sector populations.

10. As an immediate response to the COVID-19 pandemic, ADB approved a reallocation of $15 million from the loan and grant proceeds of the original project following a request by the government in March–April 2020.[11] This financing has already been used or committed to immediately procure essential medical and laboratory equipment and consumables, personal protective equipment, and civil works for establishing laboratories for testing which are in line with output 2 (health information system and disease surveillance capacity strengthened). The changes did not materially alter or fundamentally affect the overall impact, outcome, or scope of the original project. The design and monitoring framework was revised accordingly to reflect the changes of expanding the project scope and the geographic areas.

11. The original project is evaluated as a well-performing project as (i) it is rated *on track* on ADB's project performance rating system, (ii) safeguard covenants are fully complied with or are being complied with, (iii) the progress of outputs is on track, and (iv) management of risks is rated *successful*. As of 18 August 2021, cumulative contract awards were $21.1 million (42.2%) and disbursements, including advance financing, were $21.2 million (42.5%) against the net project amount of $50.0 million and 44.8% of the elapsed time. The original project's closing date is 31 May 2024.

12. **Additional financing.** Additional financing is the most appropriate and efficient modality to (i) provide the replenishment of reallocated funds for COVID-19 response approved in 2020 (footnote 11) to complete the originally planned activities related to PHC development, health information strengthening, and disease surveillance under the original project; (ii) scale up primary and secondary health care through the shared care cluster approach and support e-learning in the health sector with additional activities; and (iii) address the government's urgent financing requirements to support managing the ongoing third wave of the COVID-19 pandemic. The ongoing implementation arrangements of the original project will be continued, which ensures a high degree of readiness for the implementation of the additional financing. The

[11] Funding for activities under the original project was reallocated to support Sri Lanka's COVID-19 response as per the government's request in 2020. The reallocations were to support the development of 42 out of 135 identified PHC facilities, provision of nutrition services to mothers and children in the estate and rural areas, renovation of 127 field health centers, conduct of a behavior change communications campaign for encouraging PHC utilization, procurement of required hardware for enabling a shared care cluster information technology system, and strengthening the core capacity of selected ports of entry and the development of a quarantine information management system.

additional financing complies with the eligibility criteria for additional financing by ADB. With the additional financing, the project continues to be technically feasible, economically viable, and financially sound.

13. The additional financing is classified *low* risk given that (i) the loan amount does not exceed $200 million; (ii) ADB has a positive track record of health sector interventions in the country; (iii) the executing agency has considerable capacity in externally financed project administration; (iv) there are no known integrity concerns in the project; and (v) the proposed safeguards categorizations continue to be B for environment, C for involuntary resettlement, and C for indigenous peoples.

14. Activities and outputs under the additional financing are accorded high priority by the government and are aligned closely with the priorities identified in the government's development strategy, the National Policy Framework Vistas of Prosperity and Splendour 2019. The framework intends to (i) ensure that the existing free health care system is 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 United Nations Sustainable Development Goal 3. The additional financing is in line with ADB's country partnership strategy for Sri Lanka, 2018–2022 and country operations business plan for Sri Lanka, 2021–2023.[12] 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.[13]

B. Project Description

15. The project is aligned with the following impact: a healthier nation is ensured with a more comprehensive PHC system. The project is aligned with the following outcome: efficiency, equity, and responsiveness of the PHC system improved. The impact, outcome and outputs are aligned with the original project. The title of outputs 1 and 2 are adjusted to reflect the expanded scope.

16. **Output 1: Primary and secondary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces**. There are two sets of activities under the additional financing for this output. 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 reallocations of funds in 2020 for emergency COVID-19 pandemic response which will now resume with the additional financing. These activities include (i) developing 42 PHC facilities, (ii) expanding the package of nutrition services to mothers and children with a special focus on the most vulnerable population in the estate and rural areas in the four provinces, (iii) renovating 127 field health centers, and (iv) supporting a behavior change communications campaign for encouraging PHC utilization.

17. Considering the significant gaps in health care services of the four provinces at the secondary care level, the second set of activities under the additional financing for output 1 will

[12] ADB. 2017. *Country Partnership Strategy: Sri Lanka, 2018–2022—Transition to Upper Middle-Income Country Status*. Manila; and ADB. 2020. *Country Operations Business Plan: Sri Lanka, 2021–2023*. Manila.

[13] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific.* Manila.

develop selected secondary care cluster apex hospitals to ensure the continuity of health care service from primary to secondary care. These activities include (i) upgrading nine base hospitals (one in each of the nine districts in the four provinces) through expanding the physical space, repairing hospital facilities, and providing needed medical equipment to enable better secondary curative care services to patients referred from PHC facilities within the respective cluster; and (ii) expanding the existing PHC innovation fund to improve continuity of care, quality of care, and comprehensiveness of the service package provided through the shared care cluster approach.

18. **Output 2: Health information system, disease surveillance capacity, and COVID-19 response strengthened.** There are also two sets of activities under the additional financing for this output. The first set are the planned activities under output 2 of the original project which were placed on hold because of the reallocations of funds in 2020 for emergency COVID-19 pandemic response which will now resume and be expanded with the additional financing. These activities are (i) procuring required hardware and establishing local area networks that interconnect computers within health facilities to pilot the adoption of health information technology (HIT) for better continuity of health care and disease surveillance within nine shared care clusters in the four target provinces; and (ii) supporting the quarantine unit by further strengthening components under the core international health regulation capacity for selected ports of entry and developing a quarantine information management system. The adoption of HIT in the shared care clusters will be implemented with a phased approach. The first phase will roll out the HIT solution in two selected shared care clusters; and the second phase will be implemented in the remaining seven shared care clusters subject to successful integration and implementation of the first phase.

19. With the third wave of COVID-19 reported since April 2021, the government requested that ADB provides further support to strengthen its COVID-19 response island-wide. This constitutes the second set of activities under the additional financing for output 2, which include (i) scaling up the capacity of at least 25% of secondary and tertiary care hospitals across the country to better manage COVID-19 patients by providing emergency medical equipment and supplies; increasing intensive care, high dependency, and emergency treatment units; expanding access to oxygen; and supporting transportation for home care, quarantine, and intermediate care services; (ii) improving the quality of and access to laboratory testing services by supporting state-owned laboratories to carry out tests for COVID-19 detection, surveillance, and management, and conducting a feasibility study on increasing access to testing in rural and hard-to-reach areas through deployment of mobile laboratories; and (iii) enhancing the efficiency of the prehospital ambulance system (1990 Suwa Seriya ambulance system) to link COVID-19 patients to the designated hospitals for further treatment and management without compromising the non-COVID-19 emergency services. The last activity is financed by the Japan Fund for Poverty Reduction grant.[14]

20. The additional activities (ii) and (iii) under output 2 will reach beneficiaries living in all nine provinces of the country. The expansion of the geographic coverage will further complement the World Bank's ongoing COVID-19 Emergency Response and Health Systems Preparedness Project. The procurement of critical medical supplies and equipment to address the ongoing third wave of the pandemic under ADB additional financing is coordinated to ensure no duplication of effort with the support provided by the World Bank.

21. **Output 3: Policy development, capacity building, and project management supported.** On top of ongoing activities under the original project, the additional financing for

[14] $3 million project grant from the Japan Fund for Poverty Reduction was approved by the Government of Japan on 25 August 2021.

output 3 will support the following new activities: (i) scaling up infrastructure, information technology systems, and e-learning facilities in the National Institute of Health Sciences and nine selected regional training centers (one center per province) to enable facilitation of pre-service, in-service, and continuous medical education of health sector staff, (ii) developing a gender-responsive PHC service module, a hospital design module, and PHC training modules, and (iii) supporting policy development, capacity building, gender action plan implementation, and project management and administration for the proposed 24-month project extension**.**

C. Value Added by ADB

22. The additional financing brings value by (i) supporting the institutionalization of the shared care cluster approach for health service delivery, which improves the efficiency and equity of health care in most underserved provinces; (ii) addressing the devastating COVID-19 pandemic through the timely provision of the most-needed medical and laboratory equipment and supplies to rapidly scale up the government's capacity to detect, treat, and manage incremental COVID-19 cases and reduce morbidities and fatalities from COVID-19; (iii) improving the efficacy, timeliness, and safety of prehospital ambulance services for COVID-19-positive patients without compromising the needs of non-COVID-19 patients; and (iv) enabling e-learning in the health sector to provide a safe and efficient way to build the capacity of people working in the health sector to address emerging health issues including COVID-19. The additional financing will strengthen the health system through immediate as well as medium-term measures to address COVID-19, creating synergy with the newly approved Responsive COVID-19 Vaccines for Recovery Project under the Asia Pacific Vaccine Access Facility. The project management unit (PMU) under the original project will be augmented to support the vaccination activities.

D. Summary Cost Estimates and Financing Plan

23. The additional financing is estimated to cost $123 million (Table 1). The revised overall project cost, including the additional financing, is estimated at $185 million. Detailed cost estimates by expenditure category and by financier are included in the project administration manual (PAM).[15]

Table 1: 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, North Central, Sabaragamuwa, and Uva provinces	39.00	36.29	75.29
	2.	Health information system, 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]		**5.44**	**8.94**	**14.38**
C.	**Financial Charges During Implementation**[e]		**1.99**	**2.43**	**4.42**
		Total (A+B+C)	**60.00**	**123.00**	**183.00**

Note: Numbers may not sum precisely because of rounding.
[a] Refers to the original 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.

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

[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) plus a spread of 0.50%, funding cost margin of 0.01% (1 basis point for 1 July–31 December 2021) and a commitment charge of 0.15% of the undisbursed amount.
Source: Asian Development Bank estimates.

24. The government has requested a regular loan of $110 million from ADB's ordinary capital resources to help finance the project. The loan will have a 29-year term, including a grace period of 8 years, an annual interest rate determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility, a commitment charge of 0.15% per year, and such other terms and conditions set forth in the draft loan agreement.

25. The summary financing plan is in Table 2. ADB will finance $110 million, which is 89.43% of the additional financing cost of $123 million and includes expenditures in relation to civil works, vehicles, consulting services, training, equipment, interest charges, and the expansion of the PHC innovation fund. The Japan Fund for Poverty Reduction will provide a $3 million grant (2.44% of the additional financing), to be administered by ADB. This grant will be used for expenditures in relation to renovating ambulance stations, procuring ambulances, and delivering trainings to prehospital service personnel. The government will finance the remaining 8.13% ($10 million) for project implementation of the additional financing, covering value-added tax and customs' duties.

Table 2: Summary Financing Plan

	Current[a]		Additional Financing		Total	
Source	**Amount** ($ million)	**Share of Total** (%)	**Amount** ($ million)	**Share of Total** (%)	**Amount** ($ million)	**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[b]	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**	**100.00**	**183.00**	**100.00**

ADF = Asian Development Fund, JFPR = Japan Fund for Poverty Reduction, OCR = ordinary capital resources.
[a] Refers to the original amount.
[b] Administered by the Asian Development Bank.
Source: Asian Development Bank estimates.

26. For the proposed additional financing, climate adaptation is estimated to cost $6.28 million and climate mitigation is estimated to cost $3.675 million. ADB will finance 100% of the adaptation costs and 83% of the mitigation costs. JFPR will finance 17% of the mitigation costs. Details are in the PAM (footnote 15).

E. Implementation Arrangements

27. The implementation arrangements are summarized in Table 3 and described in detail in the PAM (footnote 15). The original project implementation arrangements will continue for the additional financing. The four established project implementation units (PIUs) under the provincial councils of Central, North Central, Sabaragamuwa, and Uva provinces will be the implementing agencies of activities under output 1 in their respective project areas. The implementation of activities under outputs 2 and 3 will be centralized and managed by the existing PMU under the

MOH. The MOH will provide strategic guidance to the PMU, review the performance, and take timely strategic measures required to achieve the project's outcome and outputs. The additional financing will be implemented over 4 years (2021–2025). The procurement (including consulting services) to be financed by ADB will follow the ADB Procurement Policy (2017, as amended from time to time) and the Procurement Regulations for ADB Borrowers (2017, as amended from time to time). The potential impact of the COVID-19 pandemic on implementation is reflected in the project implementation period and corresponding cost estimates.

Table 3: Implementation Arrangements

Aspects	Arrangements		
Implementation period	October 2021–November 2025		
Estimated completion date	30 November 2025		
Estimated loan and grant closing date	31 May 2026		
Management			
(i) Oversight body	National project steering committee chaired by the secretary, MOH		
(ii) Executing agency	MOH		
(iii) Key implementing agencies	Provincial councils of Central, North Central, Sabaragamuwa, and Uva provinces		
(iv) Implementation unit	Project management unit under MOH and project implementation units under the four provincial councils		
Procurement	Open competitive bidding (internationally advertised)	1 contract (loan); 1 contract (JFPR)	$3.76 million
	Open competitive bidding (nationally advertised)	21 contracts (loan)	$46.41 million
	Request for quotations	24 contracts	$46.47 million
Consulting services	Quality- and cost-based selection	360 person-months	$2.16 million
	Consultants' qualification selection	270 person-months	$0.66 million
	Individual consultant selection	246 person-months	$0.78 million
Retroactive financing and advance contracting	MOH requested retroactive financing of not more than 20% of the loan amount as well as advance contracting to recruit consultants and procure urgent medical and laboratory equipment, consumables, and vehicles to support the management and treatment of the coronavirus disease. In addition, civil work contracts ready to be awarded under the original scope may also require retroactive financing because of the reallocations of funds in 2020. Expenditures financed should be incurred no earlier than 12 months before signing the loan agreement.		
Disbursement	The loan and grant proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.		

ADB = Asian Development Bank, JFPR = Japan Fund for Poverty Reduction, MOH = Ministry of Health.
Source: Asian Development Bank.

III. DUE DILIGENCE

A. Technical

28. The additional financing will further strengthen the country's response to infectious diseases, such as COVID-19, and other pandemics in the future by scaling up its disease surveillance and treatment capacity. Such capacity will significantly reduce the risk of the ongoing devastating pandemic by disrupting its local transmission chain and preventing further spread. It will also strengthen the health system's resilience to better and cost-effectively address the health care needs of vulnerable people through the shared care clusters and the improved functional link for disease surveillance between the curative and preventive services. Moreover, the HIT system will improve the quality, efficiency, and continuum of curative health care services at the primary and secondary levels of the health system. ADB is closely coordinating with the World

Health Organization and other development partners to ensure that its financing and technical support under the additional financing will be provided in a coordinated and unduplicated manner.

B. Economic and Financial Viability

29. An economic analysis was conducted in accordance with ADB's Guidelines on Economic Analysis.[16] The economic analysis considers direct benefits in both outputs 1 and 2 in terms of additional productivity gains from disability-adjusted life years averted by reducing the impact of COVID-19 and other communicable diseases.[17] The cost benefit analysis shows that the economic internal rate of return (EIRR) of additional financing is 28.9%. The economic analysis of the updated project as a whole (both the original project and the additional financing) was also conducted, yielding economic net present value of $158.9 million. Sensitivity analysis has also been carried out against the possible increase in updated project costs and decrease in benefits. In the least-favorable scenario, the EIRR is 16.0%, indicating robust economic viability. The project has no cost recovery component; hence, financial viability assessment is not required.

C. Sustainability

30. The additional financing is providing very much-needed financing to continue health care delivery model reform while the government is facing budgetary constraints. Adopting the shared care cluster approach will also improve the efficiency of public expenditures in the health system, as currently secondary and tertiary health care facilities are overcrowded and therefore overstretched. The financial sustainability of the project was assessed. The sustainability of the project investment depends on the country's fiscal resources, the government's commitment to the health sector, and the adequacy of the MOH's recurrent budget. Despite the tight fiscal resources, the health sector remains at the top of the government's priorities and budgetary support has been strong. Securing PHC for all, with medical services that are matched with international standards, is one of the government's top priorities. There is an increasing trend in the health sector budget allocations, with compound annual growth of 17.2% during 2015–2020, compared with the total government budget growth of 6.7% in the same period. An evaluation of the MOH's budget performance shows a compound annual growth rate of 20.7% for the recurrent budget and 4.6% for the capital budget. Also, overall budget utilization rate is 91%, which demonstrates that the MOH has the capacity and commitment to maintain its assets. The good health indicator outcomes reflect the effective and efficient use of resources in the health sector. The estimated project incremental recurrent expenditures as a percentage of the government's total health sector budget are 0.17%, which is a relatively small amount, and the recipient entities show capacity to sustain it. In addition, the government has provided assurances on (i) sufficient and timely counterpart funds in each fiscal year, and (ii) adequate funds to support the operation and maintenance of the project facilities through budget allocation to the executing agency during and after the project completion date.

D. Governance

31. **Financial management.** A financial management assessment has been conducted for the project. The additional financing will use the original project financial management systems and arrangements, for which the MOH and the implementing agencies have satisfactorily conformed with ADB's financial management requirements. All the actions outlined in the agreed original project financial management action plans, including establishing management and

[16] ADB. 2017. *Guidelines on Analysis of Health Projects*. Manila.
[17] Economic Analysis (accessible from the list of linked documents in Appendix 2).

implementing units, recruiting an internal auditor, procuring accounting software, and setting up a separate fixed asset register, have been satisfactorily complied with. The project's pre-mitigation financial management risk is rated *moderate,* mainly because of the budget allocation for the additional financing which has not yet been made. The delays in release of funds may cause possible delays in project implementation. This 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 on as part of the quarterly progress reports.

32. **Procurement.** An updated procurement assessment confirmed that the PMU and PIUs have sound procurement track records. The PMU and the PIUs have experience in procurement following ADB requirements. Procurement for major civil works, services, and equipment will be handled by the PMU, and the PIUs will procure small works within the PHC innovation fund under the oversight of the PMU. The procurement system is accountable and transparent but experiences significant delays, and the overall procurement risk is *moderate*. To mitigate this risk, the project will implement systematic procurement training to strengthen staff capacity in procurement and compliance monitoring and monitor the procurement process through an electronic platform and report the delays to the steering committee. The project will also (i) engage additional procurement staff, (ii) pursue the option to engage United Nations agencies to expedite processes, and (iii) improve procurement transparency by setting up a project-specific page on the MOH website. Value for money procurement will be achieved by selecting the most appropriate methods with careful packaging after consideration of, among others, the PMU's and PIUs' capacity, size, market, and location of the site.

33. Sri Lanka ranked 94th of 180 countries on Transparency International's corruption perception index for 2020.[18] The government has been strengthening its anticorruption framework, including enforcing existing anticorruption laws, further empowering institutions to deal specifically with corruption, and implementing the 5-year Anti-Corruption Action Plan with the target of making Sri Lanka a corruption-free nation by 2023. Integrity risks associated with the project are mostly from procurement. The procurement activities under the project will be closely monitored for any systemic weaknesses by the internal auditors and will be strengthened with the measures discussed in para. 31. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and the MOH. The specific policy requirements and supplementary measures are described in the PAM (footnote 15).[19]

E. Poverty, Social, and Gender

34. Poverty in Sri Lanka is more relative than absolute; 4.1% of the country's population are deemed to be below the national poverty line while three of the four selected provinces show higher poverty rates—Central 5.4%, Sabaragamuwa 6.7%, and Uva 6.5%—with North Central being lower than the national average at 3.3%. Despite inclusive development efforts, regional disparities remain and are particularly evident in access, utilization, and service provision related to PHC. About 500,000 additional people are estimated to have fallen below the poverty line during the COVID-19 pandemic, with disproportionately large adverse impacts in Sabaragamuwa and Uva provinces where poverty rates are already higher than the national average.[20] The pandemic has also disproportionately affected women by exacerbating their care burden and

[18] Transparency International. Corruption Perception Index for 2020 (accessed 21 July 2021).
[19] ADB. 1998. *Anticorruption Policy*. Manila.
[20] World Bank. 2021. *Sri Lanka Development Update 2021: Economic and Poverty Impact of COVID-19*. Washington, DC.

vulnerability to poverty because of the loss or reduction in own and household incomes.[21] The country's changing epidemiological profile has presented a unique challenge to the existing system of free universal health care. Capitalizing on the country's extensive PHC network, the project will support poverty reduction and strengthen human capital.

35. The effective gender mainstreaming category of the original project remains. Out of 17 targets in the original gender action plan, one has been completed and six are ongoing. The gender action plan has been updated with a few changes in the gender mainstreaming activities and targets reflecting expanded and new activities under the additional financing. The project outputs are designed to advance the access of both women and men to health services and infrastructure, which in turn will help promote gender equality. Interventions include gender-responsive facilities (separate toilets and private examination and changing rooms); a gender-responsive and inclusive essential services package; sex-disaggregated data in health information systems; and training for medical officers and PHC staff on gender sensitivity, gender-related policies, and interventions.

F. Safeguards

36. In compliance with ADB's Safeguard Policy Statement (2009), the project's safeguard categories are as follows.

37. **Environment (category B)**. The environment safeguard category is the same as for the original project. The proposed civil works in the nine existing hospitals and ambulance facilities include physical expansion of up to about 22,500 square meters and refurbishment works. The environmental impacts are site specific and can be readily addressed through the adoption of mitigation measures. An initial environmental examination, including an environmental management plan for the proposed subprojects, has been prepared based on a preliminary design. Consultations have been conducted using adaptive mechanisms (i.e., telephone and virtual platforms) with project officials, health care staff, and health care facility users, and will continue during project implementation. The initial environmental examination will be updated based on detailed design incorporating additional information on audit findings from the existing hospitals, will form part of the bidding and contract documents, and will be submitted to ADB for review and disclosure. The environmental assessment and review framework prepared for the original project has been updated to reflect the additional scope and to enhance guidance in screening, categorizing, and assessing subproject impacts, and for impact mitigation planning in the event of unanticipated environmental impacts.

38. Compliance with environmental safeguard requirements in the original project has been satisfactory, and risks are well-managed. The project-specific grievance redress mechanism has been established and has been functional. The same mechanism will continue for the additional financing. The environment specialist at the PMU is working closely with the appointed environment specialists in the PIU in monitoring environment safeguards implementation. The PMU will continue to submit semiannual environment safeguard monitoring reports to ADB for review and disclosure.

39. **Involuntary resettlement (category C)**. The additional financing will not require land acquisition, and civil works for new building constructions, reconstruction, and refurbishment of existing building will be done within government health facilities, which will not result in any

[21] T. N. K. Meegaswatta. 2021. The Balancing Act: Employed Women Navigating the COVID-19 Lockdown in Sri Lanka. *South Asian Survey*. 28(1): pp. 157–171 (doi:10.1177/0971523121993342).

involuntary resettlement impacts. The ambulance stations that will be renovated are within the police stations and are on government-owned land, and there will also be no involuntary resettlement impacts. An involuntary resettlement screening checklist has been included in the environmental assessment and review framework to screen each subproject after completion of detailed designs.

40. **Indigenous peoples (category C)**. Physical parameters of the project are confined to existing health care facilities and are not located within or near indigenous people's domain. Project activities will not have any adverse impact on indigenous peoples and their communities. The interventions do not directly target indigenous peoples as a group but may benefit individual indigenous peoples who seek medical assistance from these hospitals.

G. Summary of Risk Assessment and Risk Management Plan

41. Significant risks and mitigating measures are summarized in Table 4 and described in detail in the risk assessment and risk management plan.[22]

Table 4: Summary of Risks and Mitigating Measures

Risks	Mitigation Measures
Risk related to timely availability of funds may lead to inadequate project financing and implementation delays.	ADB will closely monitor budgetary allocations, and project activities to reduce country-specific public financial management risk in the project. As per the loan agreement, the government will ensure that sufficient counterpart funds from its budget will be provided for each fiscal year, in a timely manner, for the efficient implementation of the project. The government will also ensure that adequate funds towards operations and maintenance of project facilities, through budgetary allocations or other means, will be provided to the project executing agency by the time of loan effectiveness and during and after project completion. The availability of counterpart financing will be monitored regularly through quarterly progress reports.

ADB = Asian Development Bank.
Source: Asian Development Bank.

IV. ASSURANCES

42. The government and MOH have assured ADB that project implementation shall conform to all applicable ADB requirements, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, financial management, and disbursement, as described in detail in the PAM (footnote 15) and loan documents.

V. RECOMMENDATION

43. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve the loan of $110,000,000 to the Democratic Socialist Republic of Sri Lanka for the additional financing of the Health System Enhancement Project, from ADB's ordinary capital resources, in regular terms, with interest to be determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; for a term of 29 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board.

Masatsugu Asakawa
President

8 September 2021

[22] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

REVISED DESIGN AND MONITORING FRAMEWORK

Impact the Project is Aligned With A healthier nation is ensured with a more comprehensive PHC system (National Health Policy, 2016–2025)[a]			
Results Chain	**Performance Indicators**	**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) 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) c. Notifiable diseases~~[b,c]~~ 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) d. Cluster system reform implemented and evaluated in all nine clusters~~[c]~~[d] (2018 baseline: 0) (OP 5.1.3 and OP 6.2) 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)	a. Annual health bulletins published by ~~MOHNIM~~ MOH (data for the target provinces and districts) and baseline and endline surveys (disaggregated data) b. Baseline and endline surveys c. Routine data from a 25% sample of cluster linked medical officers of health areas in the provinces d. Evaluation report at end of project e. MOH data	Changes in health-seeking behavior that lead to increased health utilization take time to effect beyond the project implementation period. (Risk)
Outputs 1. ~~PHC~~ Primary and secondary health care enhanced in Central,	1a. By ~~2023~~ 2025, 9 base hospitals and at least 40% of PMCUs and ~~district~~ divisional hospitals in target provinces upgraded and renovated with gender-responsive designs~~[d]~~[e] ~~reached at least~~ ~~30%~~ (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. (Risk)
	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	

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
	2e. By 2025, at least 25% of secondary and tertiary level hospitals' capacity to treat and manage COVID-19 patients upgraded[g] (2021 baseline: 0) (OP 6.2) 2f. By 2025, the 1990 Suwa Seriya ambulance system in all districts upgraded[h] (2021 baseline: Not upgraded) (OP 1.1.2)	2e. Routine data from MOH, Medical Supplies Division, Bio Medical Services Unit, and PMU progress reports 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) 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) 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) 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) 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)	3a.–b. ~~MOHNIM~~ MOH Planning Unit and Family Health Bureau administrative data 3c. ~~MOHNIM~~ MOH Education, Training, and Research Unit administrative data 3d. Provincial administrative data 3e. PMU progress reports	~~Delay in approval and implementation of national policy and management reforms~~ Changes in the administrative procedures because of COVID-19 restrictions limits participation in planned training or delays completion of some policies. (Risk)

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 and divisional hospitals (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) (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~~ Q3 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.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=51107-003-3

1. Loan Agreement
2. Grant Agreement
3. Sector Assessment (Summary): Health
4. Project Administration Manual
5. Summary of Project Performance
6. Financial Analysis
7. Economic Analysis
8. Summary Poverty Reduction and Social Strategy
9. Risk Assessment and Risk Management Plan
10. Japan Fund for Poverty Reduction Grant
11. Climate Change Assessment
12. Gender Action Plan
13. Initial Environmental Examination
14. Environmental Assessment and Review Framework
15. Contribution to Strategy 2030 Operational Priorities

Supplementary Document

16. Financial Management Assessment