Project Administration Manual

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Sri Lanka: Health System Enhancement Project

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
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
HSEP	Health System Enhancement Project
IEC	information, education and communication
IHR	International Health Regulations
MIS	management information system
MOFMM	Ministry of Finance and Mass Media
MOH	medical officer of health
MOHNIM	Ministry of Health, Nutrition and Indigenous Medicine
MOMCH	medical officer maternal and child health
NCD	noncommunicable disease
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 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, Nutrition and Indigenous Medicine (MOHNIM) as executing agency and four provincial councils of Central, North Central, Sabaragamuwa, and Uva provinces as implementing agencies 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. ADB staff is responsible for supporting implementation including compliance by MOHNIM and Provincial Councils of the four provinces (Central, North Central, Sabaragamuwa, and Uva provinces) of their obligations and responsibilities for 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 and grant agreements. 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 and grant agreements, the provisions of the loan and grant agreements 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 (HSEP) will be the first ADB-financed health operation in Sri Lanka after a gap of 20 years. This reentry project will be 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). It will be delivered through a project investment modality and is expected to be effective from 1 December 2018 and will complete on 30 November 2023.

2. The proposed project will 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 quality essential health services.

3. 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).

4. 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 within the four provinces, is estimated to be approximately 2.4 million.

5. **Impact and Outcome.** The expected project impact is to contribute to the Government development objective[1] of ensuring a healthier nation with a more comprehensive PHC system. The project outcome is to improve efficiency, equity, and responsiveness of the PHC system.

6. **Key indicators for monitoring**. 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; and (iv) cluster system reform implemented and evaluated in all nine clusters.

7. **Outputs.** The project outputs are (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.

1. Output 1: Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces.

8. This output intends to strengthen PHC services in the targeted 4 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

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

services that are provided via curative facilities (Primary Medical Care Units and the Divisional Hospitals), and via the preventive health network led by the Medical Officers of Health.

9. Output 1 will support four sets of activities: (i) development of primary medical care services; (ii) development of primary preventive care services; (iii) public awareness and behavior change communication for increasing PHC utilization; and (iv) strengthening PHC management for continuity of care.

(i) **Development of primary medical care services.** Under this output, the project supports the development of curative PHC facilities (this includes DHs and PMCUs). Approximately, 29% (135/469) of all PMCUs and DHs in the four provinces will be developed under this output. The infrastructure designs will be based on a MOHNIM approved physical space norm for PHCs. This output will also support to purchase the immediate medical equipment needs which were identified by carrying out a stocktaking of gaps against current guidelines. The additional equipment that would be needed to address the essential service package (ESP) at the PHC level will be procured from the second year of project implementation. The additional services may include services for elderly care, services for mental health, and more comprehensive non-communicable diseases and risk factor prevention related care at the PHC level, rehabilitation and disability care services and additional laboratory services.

(ii) **Development of primary preventive care services.** Under this output, the project intends to renovate and refurbish at least one field health center per medical officer of health area (approximately 127 field health centers in the four provinces). The project will enhance the mobility levels of the field health staff, especially the medical officers to expand and further improve and better supervise the preventive health services. Approximately 40 vehicles will be provided to medical officers of health and to regional level medical officers for maternal and child health services for supporting improved preventive and promotive health services in the four provinces. In addition, this output will support the within district drug distribution system with the purchase of 9 covered trucks for each of the regional medical supplies divisions under the districts. This output also supports 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.

(iii) **Public awareness and behavior change communication for increasing PHC utilization.** The objective of this output is to create demand and support a behavior change of health seekers who regularly bypass PHC services. This output will also support to encourage utilization of nutrition services and wellness and healthy living promotion in the community. Moreover, the campaign will also promote the nine selected clusters and the related MOH areas for (i) wellness and healthy lifestyle; (ii) integrated services such as nutrition, NCDs, and elderly care; and (iii) for convergence with other vertical programs (malaria, HIV, tuberculosis, leprosy, sexually transmitted diseases, etc.).

(iv) **Strengthen PHC management for continuity of care.** This output will support to strengthen mechanisms to establish continuity of care and provide a higher quality, more comprehensive, package of care primarily to PHC level health seekers in the target provinces. As part of this effort, on a pilot basis, each of the 9 districts

identified a cluster of PHC level hospitals that will be functionally linked to one apex secondary care level facility. This sub-output will support the provincial and regional health staff to propose and implement strategies to improve continuity of care in these clusters via district specific proposals submitted to each of the PIUs. In addition, to activities related to clusters, province and district health staff are encouraged to develop proposals (which will include detailed activity plans) to further support better delivery of PHC services under five broad areas: (i) improving PHC management; (ii) human resources development; (iii) information technology for better patient management and disease control; (iv) scaling up curative and preventive services; and (v) rehabilitation of facilities.

2. Output 2: Health information system and disease surveillance capacity strengthened

10. Output 2 will support two sets of activities: (i) adopt health information technology (HIT) for better continuity of care and disease surveillance; and (ii) implement IHR recommendations.

(i) **Adopt health information technology (HIT) for better continuity of care and disease surveillance.** This output 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. This will help enhance the referral system, patient quality of care, and disease surveillance capacity of the system and will establish a system for continuity of care for health seekers. The total number of facilities that will establish the system would be approximately 111 facilities grouped across the 9 clusters in each of the 9 districts and approximately 40 medical officer of health areas connected or falling within the clusters. The cluster HIT will also be used to strengthen disease surveillance, including for the timely reporting of the 28 notifiable diseases of Sri Lanka. The project will support the MOHNIM Epidemiology unit with servers and consulting services for software to link the cluster health information system with disease surveillance. 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 MOHNIM.

(ii) **Implement IHR recommendations.** This output intends to support the equipment gaps to meet the core capacity levels at all eight ports of entry (POEs) in Sri Lanka. Mobility is enhanced at the two designated ports (two vehicles). In addition, to further strengthening the disease surveillance related tasks carried out by the quarantine unit, the currently ongoing web-based surveillance system for notifiable diseases is further strengthened. This output supports developing of soft skills such as training of health personnel on IHR and quarantine, and other training related to use of quarantine manual, surveillance, and vector control. This sub-output will also seek the services of a local consultant to review and develop the legal regulatory framework for better implementation of IHR in Sri Lanka. In addition, as part of national security, this sub-output will support to carry out assessments related to establishing an inbound migrant health assessment system in Sri Lanka. Further, this output will support infection prevention and control activities and support to introduce better health care waste management practices in the cluster facilities.

3. Output 3: Policy development, capacity building, and project management supported

11. Output 3 will support (i) policy development; (ii) capacity building; and (iii) project management and results monitoring.

(i) **Policy development support.** This sub-output will 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. A package of essential health services is being developed by MOHNIM including for NCDs and emergency services. Facility and equipment standards are also being developed. MOHNIM is also developing a national policy for human resources for health. The project will provide selective support in the form of consulting services and workshops for various policy initiatives of MOHNIM. This 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.

(ii) **Capacity development.** This sub-output will support MOHNIM with capacity building and training resources for workshops for nutrition and health promotion, emergency management, cluster planning and management, infection prevention and control, distance learning for GIS. In addition, this sub-output, will provide resources for training for relevant staff in the target provinces to expand knowledge on family health, gender, infection prevention and control, health care waste management, monitoring and evaluation methodologies, counselling. This sub-output will also support the implementing of the gender action plan and environmental and social safeguards, and support training in procurement and financial management. This output will also support the development of a distance learning center at the National Institute of Health Sciences for introducing distance learning training programs in the health sector for PHC level staff.

(iii) **Project management and results monitoring.** The project will also support the operating costs (both fixed and variable) related to central and provincial project management and coordination, operating project management unit (PMU) and the 4 project implementation units (PIUs). In addition, this sub-output will support the conduction of a baseline and an end line survey including case studies and impact evaluations. In addition, this sub-output will support the consultancy firm to carry out design and supervision of civil works assignments identified under the project.

12. Detailed project description is in **Annex 1**.

II. IMPLEMENTATION PLANS

A. Project Readiness Activities

13. The project readiness activities, responsibilities, and estimated time frames are as follows:

Table 1: Project Readiness Activities

Indicative Activities	Month (2018)								Responsibility
	May	June	July	Aug	Sep	Oct	Nov	Dec	
Retroactive financing actions	X	X	X	X					MOHNIM
Establish project steering and implementation committees		X							MOHNIM
Establishment of PMU at MOHNIM		X							MOHNIM
Establishment of PIUs at the Provinces		X							MOHNIM
PMU and PIU staff recruited		X	X						MOHNIM
Prepare RRP and loan agreements			X	X					ADB
Loan negotiations				X					GOSL, ADB
Advance contracting actions		X	X	X	X	X			PMU
ADB Board approval						X			ADB
Loan signing							X		GOSL, ADB
Loan effectiveness								X	ADB, GOSL

ADB = Asian Development Bank; GOSL = Government of Sri Lanka; MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine; PIU = project implementation unit; PMU = project management unit; RRP = Report and Recommendation of the President.

B. Overall Project Implementation Plan

Table 2: Overall Project Implementation Plan

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Output 1. Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva Provinces																								
1.1	**Development of primary medical care services**																								
1.1.1	**Physical infrastructure development of PMCUs and DHs (Round 1: 45 facilities across 9 districts)**																								
	Agree on the physical infrastructure requirements at the PMCUs and DH OPD units																								
	Agree on norm / standard space allocations for different levels of PHC																								
	Complete visits by Structural engineer to 35% (45) of facilities																								
	Prepare cost estimates for each of the 45 PHCs visited																								
	Finalize the designs, BOQs for the 45 first round facilities (with PPTA team assistance)																								
	Finalize the bid documents for the first-round civil works tenders																								
	Advertise tender for the for 45 facilities to be covered in first round																								
	Award the first-round tender for the 45 facilities (9 tenders)																								
	Initiate construction supervision of the first-round facilities by D&S firm																								
	Complete the first-round construction of 45 facilities																								
1.1.2	**Physical infrastructure development of PMCUs and DHs (Round 2: 90 facilities across 9 districts)**																								
	Initiate designs for the second round 90 facilities by D &S firm																								
	Complete designs, BOQs for 90 facilities by D&S firm																								
	Advertise the tender for construction of 90 facilities																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Award tender for construction of 90 facilities																								
	Provide construction supervision (by D&S firm)																								
	Complete second round of construction of PMCUs and DHs																								
1.1.3	**Provide medical equipment to PMCUs and DHs in the target provinces**																								
	Finalize medical equipment items and quantities and distribution (agreed list in PAM)																								
	Prepare/consolidate specifications for each item of medical equipment																								
	Develop the draft bid document for goods (equipment)																								
	Advertise 2 tenders for Lab, Physiotherapy, X-ray, RH, and nutrition equipment																								
	Award tender for Laboratory, Physiotherapy, X-ray, RH, and nutrition equipment																								
	Advertise 2 tenders for Dental and NCDs equipment																								
	Award tender for Dental and NCDs equipment (by PMU)																								
	Advertise the tender for ETU equipment																								
	Award the tender for ETU equipment																								
1.1.4	**Provide medical and general furniture to refurbish PMCUs and DHs (2 rounds)**																								
	Discuss/ develop norms for medical and general furniture by level of facility																								
	Finalize medical / general furniture needs, distribution plan (round 1 and 2 separately)																								
	Prepare/consolidate specifications for medical furniture (round 1 and 2 separately)																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Develop the draft Bid documents for goods (furniture) for Round 1 (45 facilities)																								
	Advertise the 2 tenders for medical and general furniture for round 1 (45 facilities)																								
	Award tenders for furniture (medical and general) with staggered delivery (45 facilities)																								
	Advertise and award 2 tenders for medical and general furniture (90 facilities)																								
1.1.5	**Provide additional medical equipment for Essential Service Package**																								
	Finalize additional medical equipment needs and quantities for implementation of ESP																								
	Finalize the medical equipment distribution plan by facility																								
	Prepare/consolidate specifications for each item of medical equipment																								
	Prepare bid documents																								
	Advertise and Award tenders for additional medical equipment for ESP																								
1.2	**Development of primary preventive care services**																								
1.2.1	**Development of Field Health Centers (FHCs)**																								
	Finalize the field health center list from all 9 districts (127 FHCs)																								
	Finalize designs and cost estimates by D&S firm																								
	Develop bid documents and award field health center civil works tenders																								
	Construction supervision of 127 field health centers by D &S firm																								
1.2.2	**Provision of vehicles for PHC services (all 67 vehicles)**																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Develop a province level vehicles fleet analysis and justification																								
	Finalize the specifications, distribution plan by name of facility, and Bid documents																								
	Finalize the Bid documents																								
	Advertise the tender for Vehicles																								
	Award tender for vehicles																								
1.2.3	**Consultancy firm for local level nutrition services and training in nutrition counselling for PHC staff**																								
	Develop draft TOR for consultancy firm																								
	Develop RFP for consultancy firm																								
	Advertise and award the tender																								
	Implement the tasks and complete the consultancy																								
1.3	**Public awareness and BCCM for increasing PHC utilization**																								
	Finalize strategy for BCCM for encouraging PHC utilization																								
	Develop and Finalize the TOR for hiring a communications firm																								
	Develop the RFP for firm																								
	Advertise tender for consultancy firm for BCCM																								
	Develop KAP material and roll out of the BCCM campaign																								
1.4	**PHC Innovation fund**																								
	Develop draft guideline for use of resources																								
	Inform the availability eligible activities for accessing PHC innovation fund																								
	Establish review committees for PHC innovation fund management at PIU levels																								
	Entertain proposals for review and award																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Output 2 - Health information system and disease surveillance capacity strengthened																								
2.1	**Health information technology for continuity of care and disease surveillance**																								
2.1.1	**Consulting firm to develop HIT system for PHC and Clusters**																								
	Develop TOR for software consulting firm for establishing HIT at PHC/ cluster level																								
	Develop the RFP for the consultancy																								
	Advertise and engage a consultant firm for establishing HIT in PHC / clusters																								
	Discuss and develop/ adapt software for the rollout of the EMR/PBS system																								
	Roll out the HIT system in the 9 clusters																								
2.1.2	**Computers and Peripherals for HIT and GIS units**																								
	Finalize the computers and peripherals for the HIT system in clusters and GIS units																								
	Develop the specifications of all required IT system related computers and peripherals																								
	Advertise tender for HIT and GIS related computers and peripherals																								
	Award tender for HIT system and GIS computers and peripherals																								
2.1.3	**Connectivity to PHCs**																								
	Develop Bid document for establishing IT connectivity to all PHCs in the provinces																								
	Advertise tender for connectivity and maintenance																								
	Award tender for connectivity and maintenance																								
2.1.4	**Training for HIT system**																								
	Develop training program to introduce HIT in clusters to staff																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Roll out the training for HIT (details in training plan)																								
	Pilot roll out of the HIT system in 9 clusters																								
2.1.5	**Establish GIS units in provinces and districts**																								
	Develop TOR for GIS consultant to support MOHNIM and the provinces on GIS																								
	Advertise to hire the GIS consultant																								
	Contract the services of a GIS consultant																								
2.2	**Support to implementation of IHR related to ports of entry (POE)**																								
2.2.1	**Support to Quarantine Unit**																								
	Finalize specifications and distribution plan for quarantine unit and POEs																								
	Develop Bid documents (3 tenders) for quarantine unit computers, furniture and QRMIS																								
	Advertise and award tenders (3 tenders)																								
	Carry out training of quarantine staff (details in training plan)																								
	Develop TOR for Legal consultant																								
	Advertise, award and engage a consultant (legal)																								
2.2.2	**Support to Epidemiology Unit**																								
	Develop and finalize specifications for the servers and develop shopping document																								
	Advertise tender for servers																								
	Award tender for servers																								
	Develop and finalize the TORs for the IT specialist for the Epidemiology Unit																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Advertise for IT specialist for epidemiology unit				■																				
	Engage the services of an IT specialist for the epidemiology unit					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.2.3	**Improving infection control and prevention**																								
	Training on development of PHC level IPC module and exposure visit						■																		
	Develop a training module on Infection control with College of Microbiologists and NIHS						■																		
	Roll out training program of PHC staff from the 4 target provinces							■	■	■	■	■	■	■	■	■	■	■	■	■	■				
2.2.4	**Support to Health care waste Management**																								
	Develop a standard design for waste storage at different levels of facilities				■																				
	Develop relevant bidding document for HCW storage space in all cluster facilities				■																				
	Advertise and award tender at PIU level for construction of storage space							■																	
	Develop bid documents for purchase of HCWM equipment, furniture to clusters					■																			
	Advertise and award tenders for HCWM equip and furniture to clusters						■																		
	Carry out workshops/ discussions to develop HCWM plans for each cluster					■	■																		
	Roll out training on HCWM (details in training plan)							■	■	■	■														
2.2.5	**Support to implementation of inbound health assessment services**																								
	Develop TOR for consultancy for developing guidelines for inbound assessment facility							■																	
	Advertise and engage the services of an individual consultant								■																
3	**Output 3 - Policy development, capacity building, and project management supported**																								
3.1	**Policy development support**																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Develop TORs (6) for consultants (ESP, Cluster, HRH, FMS, Env, Gen/ Social)																								
	Advertise (6) for consultants (ESP, Cluster, HRH, FMS, Env, Gen/ Social)																								
3.1.1	Award consultancies for ESP, Cluster, HRH, FMS, Env, Gen/ Social																								
3.2	**Capacity Building**																								
3.2.1	Roll out training for PHC staff and others (training plan in Cost sheet and PAM)																								
3.2.2	Support to establishment of a Distance Learning Facility at NIHS																								
	Develop bid documents, advertise, award tender (2) for computers, furniture, equip.																								
	Develop bid documents, advertise and award tenders for civil works renovations																								
	Engage the services of 3 consultants to develop portal, external evaluation, course content																								
	Develop training plans and carry out training programs via distance learning																								
3.3	**Project management and results monitoring**																								
3.3.1	**Project results monitoring baseline and endline surveys**																								
	Develop TOR to carry out two surveys for results monitoring at baseline and endline																								
	Advertise the tender for consultancy																								
	Award the tender for completion of baseline surveys and endline surveys																								
3.3.2	**Design and supervision consultancy for civil works**																								
	Finalize the TOR for the D&S consulting firm																								
	Develop RFP for D&S firm																								
	Advertise tender for D&S consulting firm																								

	Activities	Advance Actions 2018				Year 1 2019				Year 2 2020				Year 3 2021				Year 4 2022				Year 5 2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Award the tender to consulting firm to design and supervise construction of PHCs																								
3.3.3	**PMU/PIU Operations**																								
	Advertise for renting of project office space (PMUs and PIUs)																								
	Develop the bid documents for furniture and equipment for PMU/PIU (2 tenders)																								
	Advertise and award the tenders for furniture and equipment for PMU/PIU																								
3.3.4	Inception mission																								
3.3.5	Review of environmental management plan and other safeguard documents																								
3.3.6	Review and finalize gender action plan key activities																								
3.3.7	Implementation of gender action plan																								
3.3.8	Project completion report																								

BCCM = behavior change communication and community mobilization, D&S = design and supervision, DH = divisional hospital, DMF = design and monitoring framework, EMR = electronic medical record, ESP = essential service package, FHC = field health center, GIS = geographic information system, HCWM = health care waste management, HIT = health information technology, HRH = human resources for health, MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine, NCD = noncommunicable disease, NIHS = National Institute of Health Sciences, PBS = patient based system, PHC = primary health care, PIU = project implementation unit, PMCU = primary medical care unit, PMU = project management unit, POE = port of entry, PPTA = project preparatory technical assistance, RFP = request for proposal, TOR = terms of reference.

III. PROJECT MANAGEMENT ARRANGEMENTS

A. Project Implementation Organizations: Roles and Responsibilities

Table 3: Project Implementation: Roles and Responsibilities

Project Implementation Organizations	Management Roles and Responsibilities
MOHNIM Minister/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
MOFMM	• Recipient of funds from ADB • Release of funds to MOHNIM/PMU/PIU • 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 MOHNIM 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 • 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

Project Implementation Organizations	Management Roles and Responsibilities
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; MOFMM = Ministry of Finance and Mass Media; MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine; PCC = project coordination committee; PMU = project management unit; PIU = project implementation unit; PSC = project steering committee; SPS = Safeguard Policy Statement.

B. Key Persons Involved in Implementation

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C. Project Organization Structure

14. MOHNIM as the executing agency will establish a project management unit (PMU) for the project. The project implementation unit (PIU) under their provincial council will be the implementing agencies in their respective project areas. The national project steering committee (PSC) chaired by secretary, MOHNIM via the PMU will provide strategic guidance, review the performance and take timely strategic measures required to achieve the project outputs.

15. PMU will work under the direction of PSC and manage the overall project. MOHNIM will provide the overall guidance to the PMU and the deputy director general (planning) of the management development and planning unit (MDPU) will work as a Coordinator to link the PMU to the MOHNIM. In addition, the DDG (Planning) will be the secretary to the PSC.

16. MOHNIM will formulate all necessary guidelines and provide policy support to the PHC reforms related to the introduction of clusters, provide all other necessary support required to establish PIUs at the provinces, and ensure their effective functioning.

17. PIUs established at provincial level will be supervised by the project coordination committee (PCC) in each of the four provinces and will be headed by the chief secretary of the respective province. PIUs will be responsible for implementation of the project at provincial level.

18. The PMU will be led by a project director supported by a deputy project director, project coordinator, procurement and finance specialists 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**.

Figure 1: Project Management Structure

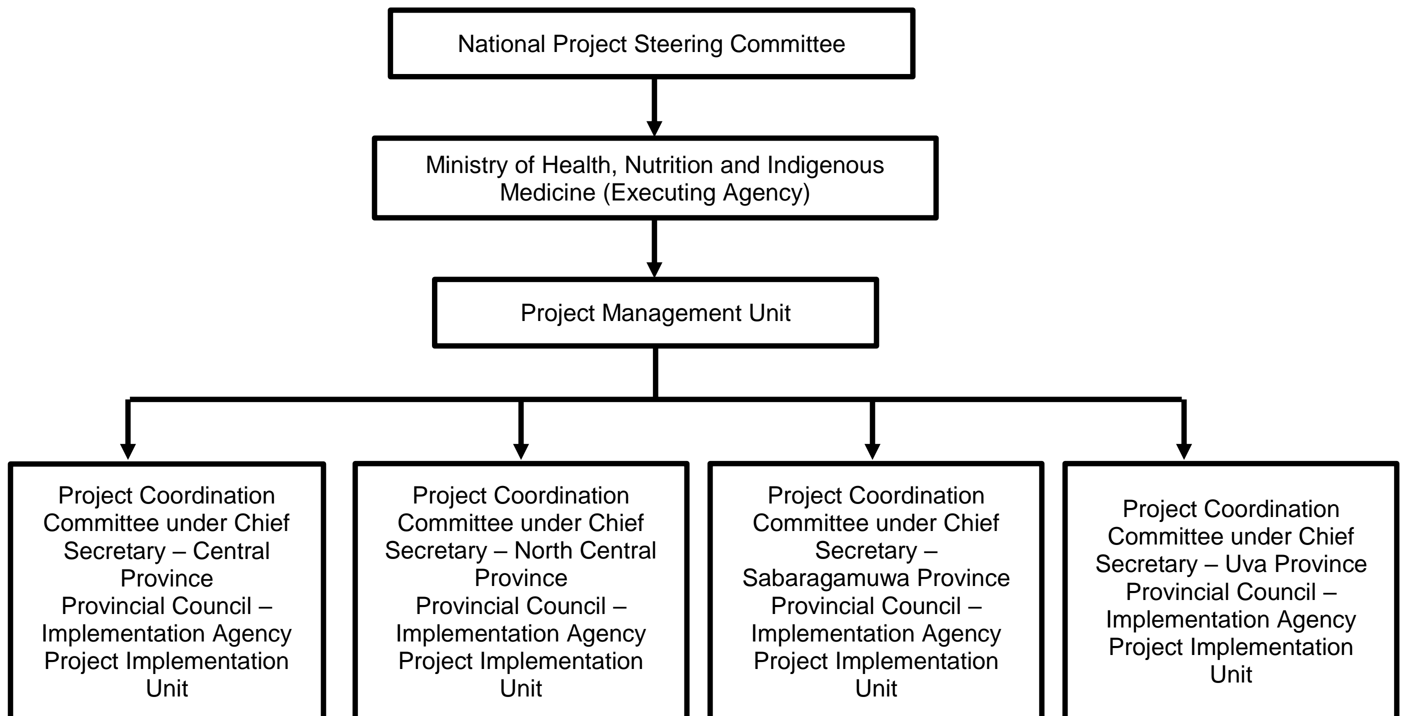
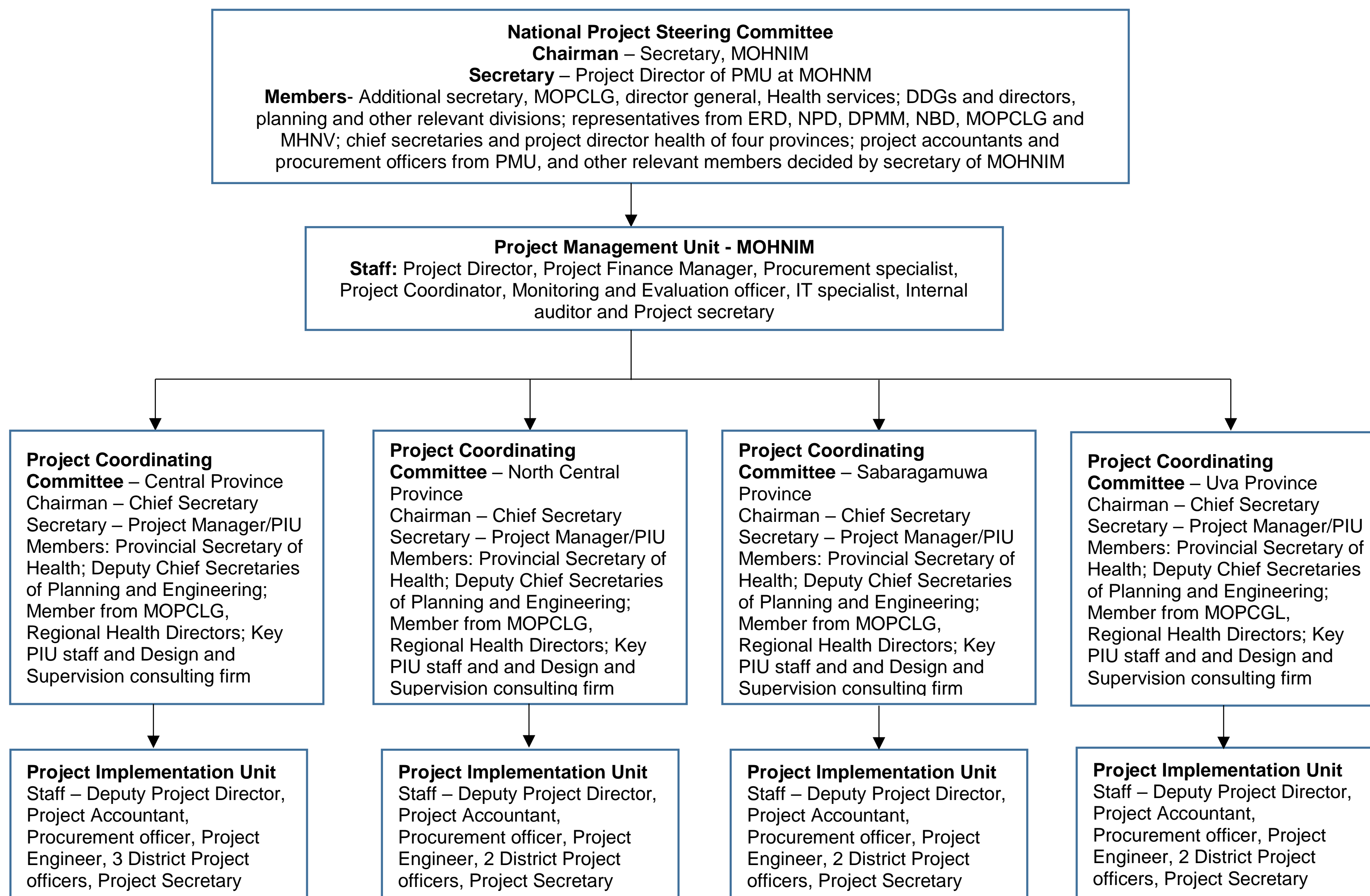


Figure 2: Project Management Committees and their Composition



DDG = deputy director general; DPMM = Department of Project Management and Monitoring; ERD = Department of External Resources; IT = information technology; MHNV = Ministry of Hill Country New Villages, Infrastructure and Community Development; MOHNIM = Ministry of Health, Nutrition, and Indigenous Medicine; MOPCLG = Ministry of Provincial Councils and Local Government; NBD = National Budget Department; NPD = National Planning Department; PIU = project implementation unit; PMU = project management unit.

IV. COSTS AND FINANCING

19. The project investment cost is estimated at $60 million including taxes and duties of $4.98 million. The total cost includes physical and price contingencies as well as interest charges during implementation.

20. The Government of Sri Lanka has requested (i) a concessional loan of $37.5 million from ADB's ordinary capital resources and (ii) a grant of $12.50 million from ADB's Special Funds resources (Asian Development Fund) to help finance the project. The ADB loan will have a 25-year term including a grace period of 5 years, an interest rate of 2% per annum throughout the grace period and thereafter; and such other terms and conditions as set forth in the draft loan agreement. ADB will finance the expenditures in relation to civil works, vehicles, consulting services, training, equipment, interest charges, and the PHC innovation fund.

A. Cost Estimates Preparation and Revisions

21. The cost estimates have been prepared by the project preparatory technical assistance consultants based on inputs received from MOHNIM and the four selected provinces.

B. Key Assumptions

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

(i) Exchange rate: SLRs155 = $1.00 (as of April 2018)
(ii) Physical contingencies are calculated at 5% of base costs on civil works, equipment, furniture, and administrative costs; and 3% on training and consulting services costs.
(iii) Price contingencies are calculated based on Table 4 below:

Table 4: Escalation Rates for Price Contingency

Item	2019	2020	2021	2022	2023
Domestic rate of price inflation	4.9%	4.9%	4.9%	4.9%	4.9%
Adjusted Inflation rate	4.40%	9.52%	14.88%	20.51%	26.42%
Foreign rate of price inflation	1.5%	1.5%	1.6%	1.6%	1.6%
Adjusted Inflation rate	1.50%	3.02%	4.65%	6.32%	8.02%

Source: Asian Development Bank.

C. Detailed Cost Estimates by Expenditure Category

Table 5: Detailed Cost Estimates by Expenditure Category

Item		Foreign Exchange ($ million)	Local Cost ($ million)	Total Cost ($ million)	% of Total Base Cost
A.	**Investment Costs**				
1	Civil Works	0.00	24.93	24.93	47.4%
2	Equipment and furniture	0.00	9.13	9.13	17.4%
3	Vehicles	0.00	4.63	4.63	8.8%
4	Training	0.51	1.49	2.00	3.8%
5	Consulting services	0.00	4.03	4.03	7.7%
6	Project management costs	0.00	3.86	3.86	7.3%
7	PHC Innovation Fund	0.00	2.00	2.00	3.8%
	Subtotal (A)	**0.51**	**50.07**	**50.58**	**96.2%**
B.	**Recurrent Costs**				
1	Incremental administrative costs	0.00	1.99	1.99	3.8%
	Subtotal (B)	**0.00**	**1.99**	**1.99**	**3.8%**
	Total Base Cost	**0.51**	**52.06**	**52.57**	**100%**
C.	**Contingencies**				
1	Physical contingencies	0.01	1.33	1.34	2.5%
2	Price contingencies	0.02	4.08	4.10	7.8%
	Subtotal (C)	**0.03**	**5.41**	**5.44**	**10.3%**
D.	**Financing Charges During Implementation**				
1	Interest during construction	0.00	1.99	1.99	3.8%
	Subtotal (D)	**0.00**	**1.99**	**1.99**	**3.8%**
	Total Project Cost (A+B+C+D)	**0.54**	**59.46**	**60.00**	**114.1%**

PHC = primary health care.
Source: Asian Development Bank.

D. Allocation and Withdrawal of Loan Proceeds

Table 6: Allocation and Withdrawal of Loan Proceeds

Number	Item	Total Amount Allocated for ADB Loan Financing ($ million)	Basis for withdrawal from the loan account[a]	
A.	**Investment Costs**			
1	Civil works	21.67	100.0%	of expenditure claimed*
2	Medical equipment	4.89	88.3%	of expenditure claimed*
3	Vehicles	4.02	100.0%	of expenditure claimed**
4	Consulting services	3.43	100.0%	of expenditure claimed*
5	Interest charge	1.99	100.0%	of amounts due
6	Unallocated	1.50		
	TOTAL	**37.50**		

ADB = Asian Development Bank.
* Exclusive of taxes and duties imposed within the territory of the Borrower.
** ADB will finance cost of vehicles including applicable duties and excluding local indirect taxes (value-added tax and national building tax as applicable).

Table 7: Allocation and Withdrawal of Grant Proceeds

Number	Item	Total Amount Allocated for ADB Grant Financing ($ million)	Basis for Withdrawal from the Grant Account[a]	
A.	**Investment Costs**			
1	Computer Equipment	1.55	100%	of expenditure claimed*
2	Training	2.00	100%	of expenditure claimed*
3	Project Management Costs	3.84	100%	of expenditure claimed*
4	PHC Innovation Fund	2.00	100%	of expenditure claimed*
5	Incremental Administrative Costs	1.99	100%	of expenditure claimed*
6	Unallocated	1.12		
	TOTAL	**12.50**		

ADB = Asian Development Bank.
* Exclusive of taxes and duties imposed within the territory of the Recipient.

E. Detailed Cost Estimates by Financier

Table 8: Detailed Cost Estimates by Financier

	Item	ADB Grant ($ million)	Taxes ($ million)	% of cost category	ADB Loan ($ million)	Duty ($ million)	% of cost category	GOSL ($ million)	Taxes ($ million)	% of cost category	Total Gross Cost ($ million)
A.	**Investment Costs**										
1	Civil Works	0.00	0.00	0.0%	21.67	0.00	86.9%	0.00	3.26	13.1%	24.93
2	Equipment and furniture	1.55	0.00	17.0%	4.89	0.00	53.6%	2.19	0.50	29.5%	9.13
	Medical Equipment	0.00	0.00	0.0%	4.89	0.00	86.4%	0.65	0.12	13.6%	5.66
	Furniture	0.00	0.00	0.0%	0.00	0.00	0.0%	1.54	0.23	100.0%	1.77
	Computer & Electronic Items	1.55	0.00	91.2%	0.00	0.00	0.0%	0.00	0.15	8.8%	1.70
3	Vehicles	0.00	0.00	0.0%	1.34	2.68	86.8%	0.00	0.61	13.2%	4.63
4	Training	2.00	0.00	100.0%	0.00	0.00	0.0%	0.00	0.00	0.0%	2.00
5	Consulting Services	0.00	0.00	0.0%	3.43	0.00	85.0%	0.00	0.61	15.0%	4.03
6	Project Management Costs	3.84	0.00	99.5%	0.00	0.00	0.0%	0.00	0.02	0.5%	3.86
7	PHC Innovation Fund	2.00	0.00	100.0%	0.00	0.00	0.0%	0.00	0.00	0.0%	2.00
	Subtotal (A)	**9.39**	**0.00**	**18.6%**	**31.33**	**2.68**	**67.2%**	**2.19**	**4.99**	**14.2%**	**50.58**
B.	**Recurrent Costs**										
1	Incremental Administrative Costs	1.99	0.00	100.0%	0.00	0.00	0.0%	0.00	0.00	0.0%	1.99
	Subtotal (B)	**1.99**	**0.00**	100.0%	**0.00**	**0.00**	0.0%	**0.00**	**0.00**	0.0%	**1.99**
	Total Base Cost	**11.38**	**0.00**	**21.6%**	**31.33**	**2.68**	**64.7%**	**2.19**	**4.99**	**13.7%**	**52.57**
C.	**Contingencies**										
1	Physical Contingencies	0.43	0.00	32.1%	0.61	0.00	45.5%	0.30	0.00	22.4%	1.34
2	Price Contingencies	0.69	0.00	16.8%	0.89	0.00	21.7%	2.52	0.00	61.5%	4.10
	Subtotal (C)	**1.12**	**0.00**	**20.6%**	**1.50**	**0.00**	**27.6%**	**2.82**	**0.00**	**51.8%**	**5.44**
D.	**Financing Charges During Implementation**										
1	Interest during construction	0.00	0.00	0.0%	1.99	0.00	100.0%	0.00	0.00	0.0%	1.99
	Subtotal (D)	**0.00**	**0.00**	0.0%	**1.99**	**0.00**	100.0%	**0.00**	**0.00**	0.0%	**1.99**
	Total Project Cost (A+B+C+D)	**12.50**	**0.00**	**20.8%**	**34.82**	**2.68**	**62.5%**	**5.01**	**4.99**	**16.7%**	**60.00**
	Total Project Cost	**60.00**									

ADB = Asian Development Bank, GOSL = Government of Sri Lanka.
Note: ADB will finance cost of vehicles including applicable duties and excluding local indirect taxes (value added tax and nation building tax as applicable).
Source: Asian Development Bank.

F. Detailed Cost Estimates by Outputs and/or Components

Table 9: 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**								
	1	Civil Works	24.93	24.39	98%	0.40	2%	0.14	1%
	2	Equipment and furniture	9.13	7.17	79%	1.71	19%	0.25	3%
	3	Vehicles	4.63	3.97	86%	0.45	10%	0.21	5%
	4	Training	2.00	0.00	0%	0.61	31%	1.39	69%
	5	Consulting services	4.03	1.47	36%	0.53	13%	2.03	50%
	6	Project management costs	3.86	0.00	0%	0.00	0%	3.86	100%
	7	Primary health care Innovation Fund	2.00	2.00	100%	0.00	0%	0.00	0%
		Subtotal (A)	**50.58**	**39.00**	**77.1%**	**3.70**	**7.3%**	**7.88**	**15.6%**
B.	**Recurrent Costs**								
	1	Incremental Administrative Costs	1.99	0.0	0%	0.00	0.0%	1.99	0.0%
		Subtotal (B)	**1.99**	**0.0**	**0%**	**0.00**	**0.0%**	**1.99**	**0.0%**
		Total Base Cost	**52.57**	**39.00**	**74.2%**	**3.70**	**7.0%**	**9.87**	**18.8%**
C.	**Contingencies**								
	1	Physical Contingencies	1.34	1.00	74.6%	0.09	6.7%	0.25	18.7%
	2	Price Contingencies	4.10	3.04	74.1%	0.29	7.1%	0.77	18.8%
		Subtotal (D)	**5.44**	**4.04**	**74.3%**	**0.38**	**7.0%**	**1.02**	**18.8%**
D.	**Financing Charges During Implementation**								
	1	Interest during construction	1.99	1.48	74.4%	0.14	7.0%	0.37	18.6%
		Subtotal (D)	**1.99**	**1.48**	**74.4%**	**0.14**	**7.0%**	**0.37**	**18.6%**
		Total Project Cost (A+B+C+D)	**60.00**	**44.52**	**74.2%**	**4.22**	**7.0%**	**11.26**	**18.6%**

Source: Asian Development Bank.

G. Detailed Cost Estimates by Year

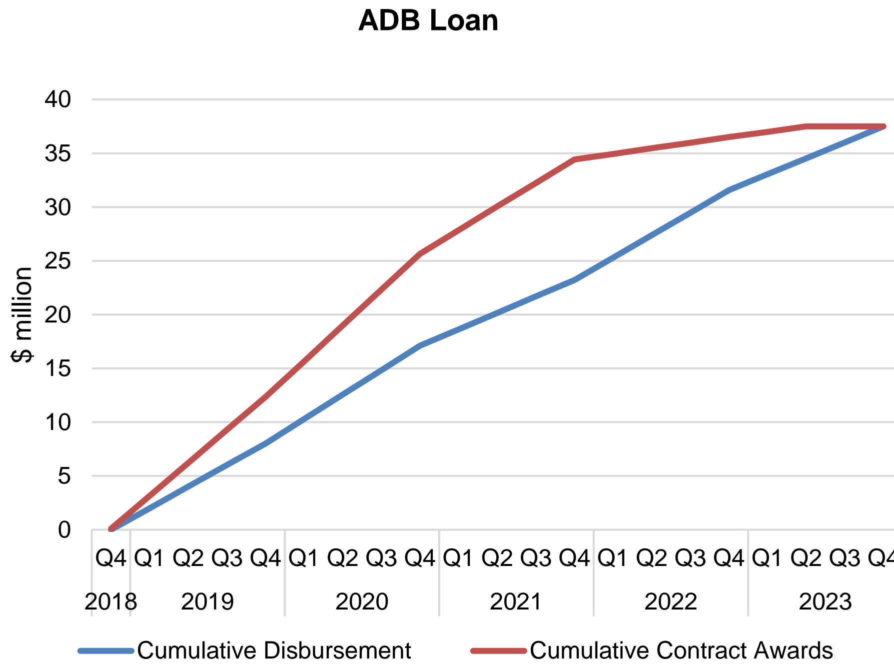
Table 10: Detailed Cost Estimates by Year ($ million)

	Item	Total Cost	2019	2020	2021	2022	2023
A.	**Investment Costs**						
1	Civil Works	24.93	0.81	5.48	5.11	8.36	5.16
2	Equipment and furniture	9.13	5.22	2.60	0.86	0.38	0.06
	Medical equipment	5.66	3.82	1.84	0.00	0.00	0.00
	Furniture	1.77	0.07	0.58	0.80	0.32	0.00
	Computers and electronic items	1.70	1.33	0.17	0.06	0.06	0.06
3	Vehicles	4.63	2.65	1.99	0.00	0.00	0.00
4	Training	2.00	0.51	0.54	0.41	0.30	0.24
5	Consulting services	4.03	1.21	1.21	0.54	0.47	0.61
6	Project management cost	3.86	0.82	0.66	0.72	0.79	0.87
8	Primary Health Care Innovation Fund	2.00	0.40	0.40	0.40	0.40	0.40
	Subtotal (A)	**50.58**	**11.62**	**12.87**	**8.04**	**10.71**	**7.35**
B.	**Recurrent Costs**						
1	Incremental administrative costs	1.99	0.40	0.40	0.40	0.40	0.40
	Subtotal (B)	**1.99**	**0.40**	**0.40**	**0.40**	**0.40**	**0.40**
	Total Base Cost	**52.57**	**12.01**	**13.27**	**8.44**	**11.10**	**7.75**
C.	**Contingencies**						
1	Physical contingencies	1.34	0.12	0.13	0.23	0.51	0.35
2	Price contingencies	4.10	0.23	0.70	0.67	1.19	1.31
	Subtotal (C)	**5.44**	**0.35**	**0.83**	**0.90**	**1.70**	**1.66**
D.	**Financial Charges During Implementation**						
1	Interest during construction	1.99	0.08	0.25	0.41	0.55	0.70
	Subtotal (D)	**1.99**	**0.08**	**0.25**	**0.41**	**0.55**	**0.70**
	Total Project Cost (A+B+C+D)	**60.00**	**12.84**	**14.55**	**9.75**	**13.35**	**9.51**
	% Total Project Cost (A+B+C+D)	**100%**	**21%**	**24%**	**16%**	**22%**	**16%**

Source: Asian Development Bank.

H. Contract and Disbursement S-Curve

Figure 3: Contract Award and Disbursement S-Curve



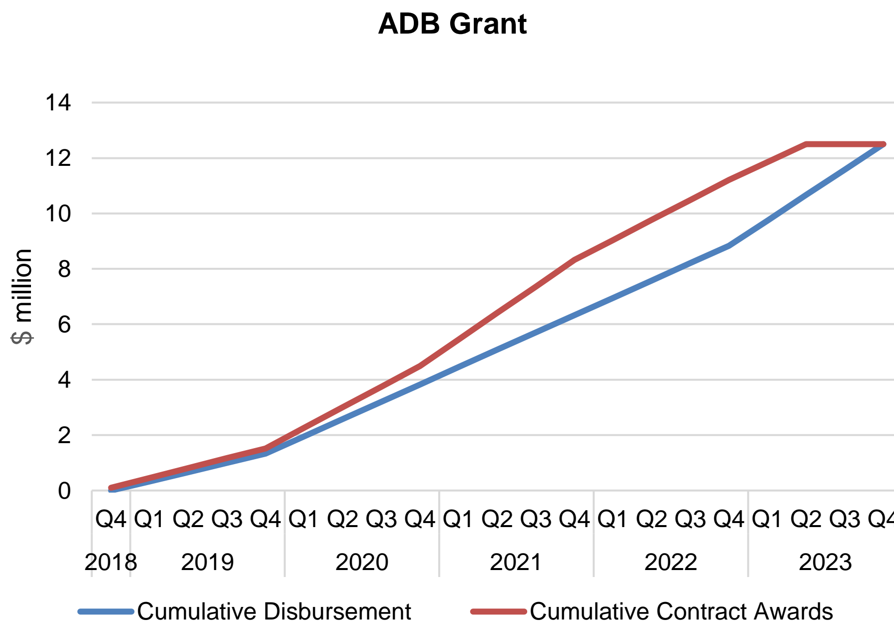


Table 11: Contract Awards and Disbursements

ADB Loan ($ million)

Year	Contract awards						Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.	Q1	Q2	Q3	Q4	Total	Cum.
2018	0.000	0.000	0.000	0.100	0.100	0.100	0.000	0.000	0.000	0.000	0.000	0.000
2019	3.060	3.060	3.060	3.060	12.240	12.340	2.005	2.005	2.005	2.005	8.020	8.020
2020	3.327	3.327	3.327	3.329	13.310	25.650	2.272	2.272	2.272	2.274	9.090	17.110
2021	2.195	2.195	2.195	2.195	8.780	34.430	1.525	1.525	1.525	1.525	6.100	23.210
2022	0.517	0.517	0.517	0.519	2.070	36.500	2.087	2.087	2.087	2.089	8.350	31.560
2023	0.500	0.500	0.000	0.000	1.000	37.500	1.485	1.485	1.485	1.485	5.940	37.500

ADB Grant ($ million)

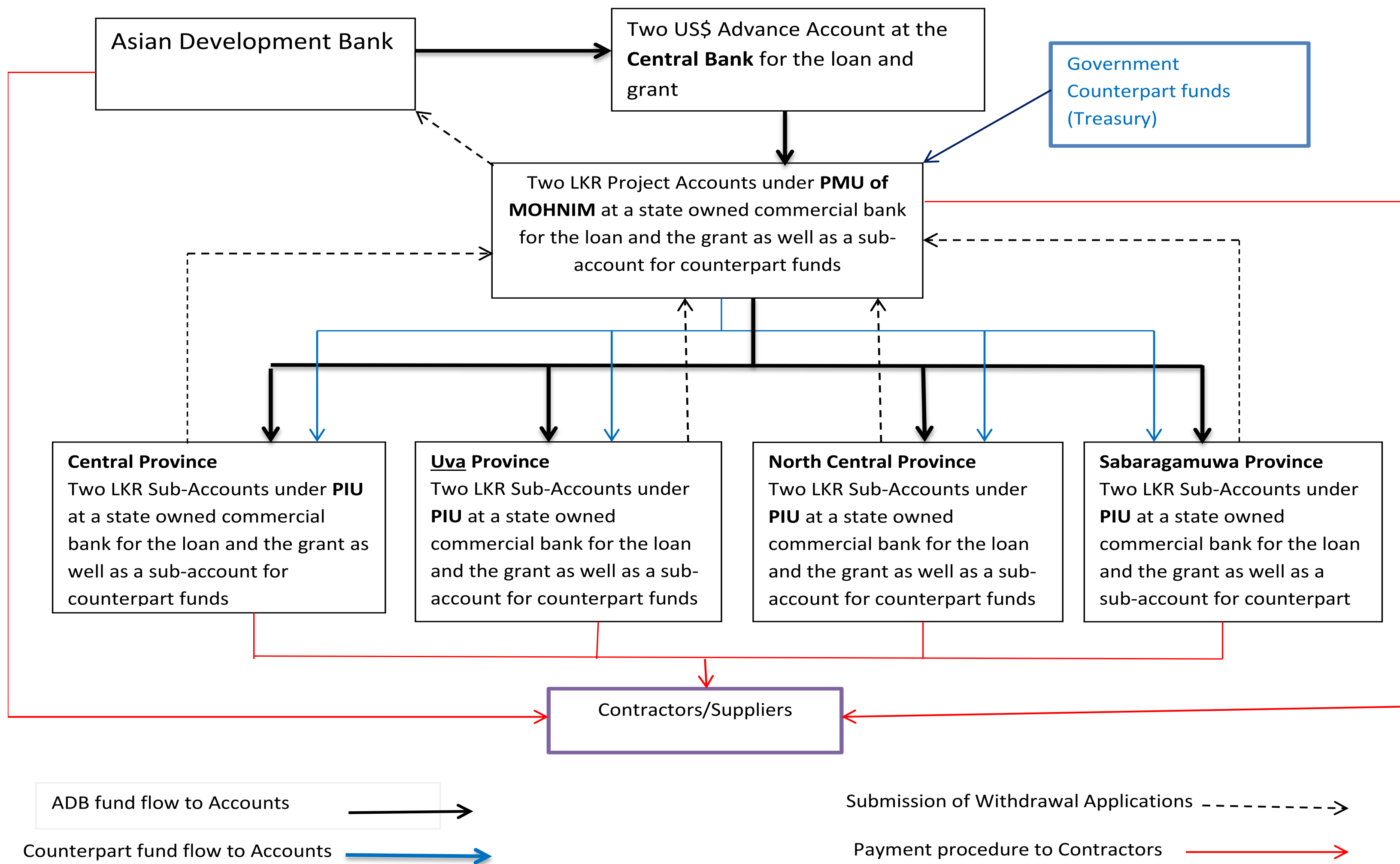
Year	Contract awards						Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.	Q1	Q2	Q3	Q4	Total	Cum.
2018	0.000	0.000	0.000	0.100	0.100	0.100	0.000	0.000	0.000	0.000	0.000	0.000
2019	0.355	0.355	0.355	0.355	1.420	1.520	0.331	0.333	0.333	0.333	1.330	1.330
2020	0.741	0.743	0.743	0.743	2.970	4.490	0.625	0.625	0.625	0.625	2.500	3.830
2021	0.957	0.957	0.957	0.959	3.830	8.320	0.625	0.625	0.625	0.625	2.500	6.330
2022	0.721	0.723	0.723	0.723	2.890	11.210	0.625	0.625	0.625	0.625	2.500	8.830
2023	0.645	0.645	0.000	0.000	1.290	12.500	0.916	0.918	0.918	0.918	3.670	12.500

I. Fund Flow Diagram

23. The advance US$ accounts will be established at the Central Bank of Sri Lanka (CBSL) under MOHNIM for the loan and the grant.

24. The advance account will be established at the CBSL only upon establishment of satisfactory accounting capacity at the PMU. Two Sri Lankan rupee project accounts will be established for the loan and the grant at state owned commercial banks acceptable to the Government and ADB for implementation of the project at PMU. The PMU will also establish an SLR account for the counterpart funds. Similarly, two SLR sub-project accounts will be established for the loan and the grant at state owned commercial banks acceptable to the government and ADB for PIUs at the provinces. Each PIU will also establish an SLR account for the counterpart funds. The PMU will transfer ADB funds as well as counterpart funds to sub-accounts at PIUs. The PMU will be responsible for monitoring advance accounts, monthly reconciliation of the accounts and monitoring of the sub-project accounts at PMU and the PUIs and for the preparation of withdrawal applications for replenishment of the advance accounts. The PMU will submit all withdrawal applications to ADB for replenishment.

Figure 4: Fund Flow Diagram



V. FINANCIAL MANAGEMENT

A. Financial Management Assessment

25. A financial management assessment (FMA) was conducted during January–May 2018 in accordance with ADB's Financial Management Assessment Technical Guidance Note[2] and ADB's Financial Due Diligence: A Methodology Note.[3] The FMA has considered the capacity of MOHNIM and the four provinces (Central, North Central, Sabaragamuwa, and Uva), including fund-flow arrangements, staffing, accounting and financial reporting systems, financial information systems, and internal and external auditing arrangements. The key risks identified are (i) potential delay in release of fund from different fund sources, (ii) MOHNIM is not familiar with ADB procedures, and (iii) limited resource in internal audit. The financial management and internal control risk assessment is summarized in the FMA. To mitigate these key risks, (i) cost sharing arrangement is simplified, (ii) capacity building support will be provided to PMU/PIU accounting staff, and (iii) internal auditor will be recruited for the project. It is concluded that the overall pre-mitigation financial management risk is substantial. The borrower, MOHNIM and the provinces have agreed to implement an action plan as key measures to address the deficiencies. With the implementation of the proposed risk mitigating measures, it is expected that the financial management risk of the project will be satisfactory. In addition, it is concluded that MOHNIM and the four provinces have sufficient capacity to administer advance fund and statement of expenditure (SOE) procedures.

26. Financial management and internal control risk assessment is in Table 12 and Financial Management Action Plan in Table 13.

Table 12: Financial Management and Internal Control Risk Assessment

Risk	Risk Rating (pre-mitigation)	Mitigation Measures
Inherent risks		
Country-specific An ADB report on the public financial management systems of Sri Lanka identified certain risks related to delays in fund transfers, weak audit arrangements, unclear segregation of duties, and concerns over timely availability of project funds, among others.[4] A USAID assessment also diagnosed a frail public financial management system without a fully established vision, operations, and checks and balances.[5]	Substantial	The Fiscal Management Report, 2018 of the Finance Department, Sri Lanka, has identified certain reforms that are under way to improve public financial management. The Public Finance Act will be enacted to provide the basis for sound budget formulation, public debt management, financial management, and financial reporting. ADB will continuously monitor progress of these reforms.

[2] ADB. 2015. *Financial Management Assessment: Financial Management Technical Guidance Note*. Manila.
[3] ADB. 2009. *Financial Due Diligence: A Methodology Note*. Manila.
[4] ADB. 2018. *Public Financial Management Systems—Sri Lanka; Key Elements from a Financial Management Perspective.* Manila.
[5] USAID. 2015. *Assessment Report Asia and the Middle East Economic Growth Best Practices (AMEG) Project. Chemonics International Inc.* Task Order No. AID-OAA-12-00008

Risk	Risk Rating (pre-mitigation)	Mitigation Measures
Entity-specific The involvement of multilayer (ministry and provinces) agencies complicates the overall project implementation process. The risk of one implementing agency not being able to meet project deadlines in any one aspect can drag the entire project toward noncompliance.	Moderate	A high-level national Project Steering Committee under the Chairmanship of the Secretary, MOHNIM will be formed. Similarly, a Project Coordination Committee under the Chairmanship of the Chief Secretary will be formed at the respective Province level.
Overall Inherent risks	**Substantial**	
Control risks		
Executing Agency MOHNIM is a government ministry, which follows the national financial rules and regulations. MOHNIM has significant experience in handling donor-funded projects and is familiar with donor-funded financial management and other fiduciary requirements. However, MOHNIM has not implemented an ADB project in the recent past; thus, they are not familiar with ADB procedures. The provinces have worked with donor-funded projects including with ADB financed projects. Therefore, the higher-level officers and some departments at the province level (e.g., education department), are familiar with ADB financial management, procurement, and other fiduciary requirements. However, the provincial health departments have not implemented an ADB project in the recent past; thus, they are not familiar with ADB procedures.	MOHNIM Substantial Provinces Moderate	PMU and PIU accountants to be trained on ADB's disbursement procedures by attending training organized by ADB. At the province level, some provincial level staff have past and ongoing experience working on ADB financed projects (especially education projects). It is expected that some of the PIU finance and procurement staff engaged under the project will have ADB project management experience. Furthermore, the higher authorities of each of the provinces who oversee the project (Chief Secretary, Deputy Chief Secretaries - Finance, Engineering and Planning) have ADB project management, financial management, and procurement experience.
Funds flow The project will be funded from three fund sources (grant, loan, government) and timely release of funds and proper management of each fund source is critical. Since Sri Lanka follows the system of actual transfer of funds for capital projects from the line ministry to the provinces and cheques are physically sent, there lies a risk of delay in transfer of funds to the provinces and further delay in payments.	Substantial	To simplify the payment process and avoid potential delays in payments to suppliers and contractors, the ADB loan and grant and government funds will finance different expenditures (no cost-sharing of same activities). The government will ensure that sufficient counterpart funds are allocated to the project and the timely release of funds. The government will ensure that fund transfer will be completed within 2 weeks of receipt of request. The PMU will monitor the timely release of funds at each level.
Staffing MOHNIM has a dedicated accounts department at the Ministry's office in Colombo headed by the Chief Financial Officer. A Provincial Chief Accountant heads the provinces and has a team of accountants to assist him in discharging his duty. There is, however, a risk that if dedicated responsibility of the project is not given to a person, there could be delays in making payments and in preparing reports for the project.	Moderate	MOHNIM and the provinces will recruit a full-time accounting staff at the Ministry PMU and the provincial PIU level. The accounting staff will work for the project on a full-time basis and preferably continue for the full term of the project. The staff will be trained in ADB's procedures. In addition, a financial management expert will be recruited under the PMU, on an intermittent basis, to support capacity building of PMU and PIU staff.

Risk	Risk Rating (pre-mitigation)	Mitigation Measures
Accounting policies and procedures MOHNIM prepares its accounts based on the government's rules and regulations as defined in the Financial Regulations. The entity audit reports issued by the AGD identifies "accounting" as an area requiring special attention in respect of systems and control. Thus, there are certain inherent risks in the policies and procedures, which needs to be taken care of by the Accounts Departments both at Ministry and the province level.	Moderate	MOHNIM and the provinces will maintain project-related records on a cash basis sufficient to prepare consolidated project financial statements. The MOHNIM-PMU and Provinces-PIU along with the AGD, will ensure that an action taken report (ATR) be prepared to address the audit points raised in the AGD's report on a timely basis.
Internal Controls The entity audit reports issued by the AGD identifies "internal control" as an area requiring special attention in respect of systems and control. Following areas are identified as control weakness: (1) Per the paragraph 6 of the Management Audit Circular No. DMA/2009(1) dated 09 June 2009, Audit and Management Committee Meetings should be held at least once in a quarter. However, in some provinces, no meetings were held during the previous years. (2) Whereas fixed asses register module is available in CIGAS, fixed assets are in some cases maintained manually or not maintained.	MOHNIM Moderate Provinces Substantial	(1) The role of Audit and Management Committees needs to be further strengthened. Regular meetings, at least once in a quarter, as per the Government Circular need to be held. An indicative terms of reference for the Committee is in **Appendix 1** of the financial management assessment report. (2) PMU and PIUs will ensure to maintain fixed asset register for assets procured under the Project separately.
Internal audit The internal audit function has limited staff and the risk of noncoverage of all functions of the ministry and provinces is high. With limited staff, the quality of internal audit also suffers. Thus, there is a risk that no internal audit could be undertaken for the project, or if undertaken, quality may be an issue.	Substantial	An internal auditor will be recruited for the project at MOHNIM PMU. He or she will be undertaking internal audit of the project in consultation with the respective internal audit departments at MOHNIM and the provinces. An indicative terms of reference for internal audit, which include more of performance audits, increase in coverage and risk-based audit, is in **Appendix 2** in the financial management assessment report.
External Audit The Auditor General's Department (AGD) audits accounts of the Ministry and the provinces on an annual basis. A comparison of the date of submission of APFS of ongoing projects in Sri Lanka to ADB in the last 3 years shows that the average delay has been above 2 months. Thus, there is a risk that audited APFS may not be submitted to ADB within the stipulated period of 6 months after the end of FY.	Moderate	To ensure timely submission (6 months) of APFS to ADB, MOHNIM and the provinces will submit project financial statements to AGD within 2 months from the end of the financial year.
Reporting and monitoring Sri Lanka maintains its accounts on a cash basis in line with Financial Rules and Regulations, with annual financial statements prepared and regular progress reporting through the CIGAS system. CIGAS is not designed to enable project wise accounting, and there is physical data flow between districts	Moderate	MOHNIM and the provinces will introduce an off-the shelf accounting system that will be used both for accounting as well as reporting purposes. MOHNIM-PMU and Province-PIUs will ensure that reporting to ADB is duly reconciled with bank statements and books

Risk	Risk Rating (pre-mitigation)	Mitigation Measures
and provinces through pen drives, CDs or data file sent through emails.		of accounts. PMU and PIUs will compile their accounts on a monthly basis so that there are no delays at year-end.
Information systems Government of Sri Lanka's Ministries and Departments use a computerized accounting system CIGAS to record all transactions. Sri Lanka is in the process of adopting accrual basis of accounting in the Government system based on Sri Lanka Public Accounting Standards (SLPAS); however due to inherent issues, it has not been able to complete the pre-requisite tasks to adopt to the new system of accounting.	Moderate	PMU and PIUs to procure an accounting software, preferably an off-the-shelf to enable project accounting and reporting. Staff will be trained to operate the software during implementation.
Overall control risks	**Substantial**	

ADB = Asian Development Bank, APFS = audited project financial statements, CIGAS = computerized integrated government accounting system, MOHNIM = Ministry of Health, MOF = Ministry of Finance, AGD = Auditor General's Department, PIU = project implementation unit, PMU = Project Management Unit.

Table 13: Financial Management Action Plan

S. No.	Risk Area	Description	Timeline	Responsibility
1.	Staffing and capacity building	PMU will be staffed with a Finance Officer and each PIU will be staffed with a full time Accountant	By loan negotiations	MOHNIM (PMU) and Four Provinces (PIUs)
2.	Staffing and capacity building	Recruitment of FM Expert as Individual Consultant to build the capacity of PMU and PIUs on an intermittent basis	Before loan effectiveness	MOHNIM (PMU)
3.	Staffing and capacity building	PMU and PIU Accountants to be trained on ADB's disbursement procedures by attending training	Upon deployment and ongoing	MOHNIM (PMU) and Four Provinces (PIUs)
4.	Internal Audit	MOHNIM – PMU to advertise recruitment of Internal Auditor to conduct audit of PMU and PIUs on semi-annual basis (Sample scope of work attached in Appendix 2 of FMA)	Upon loan effectiveness	MOHNIM (PMU) and Four Provinces (PIU)
5.	Timely release of ADB fund	MOHNIM to open separate advance accounts for loan and grant at Central Bank of Sri Lanka for the proposed project MOHNIM to open sub-accounts for PMU (separate bank accounts for loan and grant) for receiving funds from Central Bank of Sri Lanka Respective Provincial Governments to open sub-accounts (separate bank accounts for loan and grant) at Provincial Government level	Upon loan effectiveness	MOF, MOHNIM and Provinces

S. No.	Risk Area	Description	Timeline	Responsibility
6.	Timely release of ADB fund	Release of funds from advance account to MOHNIM (PMU) sub-account and from MOHNIM (PMU) to four Provinces (PIUs) sub-account shall be within a maximum of two weeks of receipt of request.	Upon loan effectiveness	MOF and MOHNIM
7.	Timely release of counterpart fund	Counterpart funds to be released to PMU within two weeks of release of funds from ADB MOHNIM-PMU to open separate bank account for receiving counterpart funds from Treasury. Respective Provincial Governments to open bank account for receiving counterpart funds from MOHNIM-PMU.	Upon loan effectiveness	MOHNIM and Provinces
8.	Information systems	PMU and PIUs to procure an accounting software, preferably an off-the-shelf to enable project accounting and reporting	Upon loan effectiveness	MOHNIM (PMU) and Four Provinces (PIU)
9.	Internal control (fixed asset maintenance)	PMU and PIUs to maintain separate Fixed Asset Register for assets procured under the Project	On-going	MOHNIM (PMU) and Four Provinces (PIU)
10.	Timely submission of APFS	MOHNIM (PMU) and Provincial Governments (PIUs) to complete preparation of project financial statements within 2 months of the end of the FY and present to AGD for audit	Within 2 months of end of FY	MOHNIM (PMU) and Four Provinces (PIU)
11.	Timely submission of APFS	Submission of annual audited project financial statements (APFS)	Within 6 months from the end of every financial year	MOHNIM (PMU) in consultation with AGD
12.	Timely resolution of audit observations	MOHNIM PMU to address audit observations raised in the AGD's Audit report	Every year, before submission of next year's APFS	MOHNIM and four Provinces along with AGD's office
13.	Internal Control	Audit and Management Committees at Provinces to meet regularly based on the sample TOR in Appendix 1 of FMA	During project implementation	Four Provinces
14.	Reporting and monitoring	MOHNIM PMU to submit quarterly financial and disbursement reports to ADB including status of FM Action Plan	Ongoing on a quarterly basis	MOHNIM (PMU) and Four Provinces (PIU)

ADB = Asian Development Bank, APFS = audited project financial statements, FMA = financial management assessment, MOHNIM = Ministry of Health, Nutrition and Indigenous Medicine, PIU = project implementation unit, PMU = project management unit.

B. Disbursement

1. Disbursement Arrangements for ADB Funds

27. The loan and grant proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time)[6] and detailed arrangements agreed upon between the government and ADB.[7] Online training for project staff on disbursement policies and procedures is available.[8] Project staff is encouraged to avail of this training to help ensure efficient disbursement and fiduciary control.

28. **Advance fund procedure.** Separate advance accounts shall be established and maintained by the MOHNIM-PMU for each funding source. A separate account shall be maintained for counterpart funding. The currency of the advance accounts from ADB to Central Bank of Sri Lanka is US dollar. The advance accounts are to be used exclusively for ADB's share of eligible expenditures. The MOHNIM-PMU, which established the sub-advance account in its name, is accountable and responsible for proper use of advances to the advance account including advances to the sub-accounts at the MOHNIM-PMU/ Province-PIUs to be established and maintained by the PMU and PIU for each funding sources. The currency of the sub-accounts is Sri Lankan Rupees (SLR). The sub-accounts are to be used exclusively for ADB's share of eligible expenditures.

29. 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 MOHNIM-PMU may request for initial and additional advances to the advance accounts based on an Estimate of Expenditure Sheet[9] 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 MOHNIM-PMU and Province-PIUs in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) when liquidating or replenishing the advance accounts.

30. **Statement of expenditure procedure.**[10] The SOE procedure may be used for reimbursement of eligible expenditures or liquidation of advances to advance accounts. The ceiling of the SOE procedure is the equivalent of $100,000 per individual payment. 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. Reimbursement of individual payments in excess of the SOE ceiling should be supported by full documentation when submitting the withdrawal application to ADB.

31. 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

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6 The handbook is available electronically from the ADB website at http://www.adb.org/documents/loan-disbursement-handbook.

7 Online training for project staff on disbursement policies and procedures is available at http://wpqr4.adb.org/disbursement_elearning. Project staffs are encouraged to avail of this training to help ensure efficient disbursement and fiduciary control.

8 Disbursement eLearning. http://wpqr4.adb.org/disbursement_elearning

9 ADB. 2017. *Loan Disbursement Handbook*. Manila.

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

authorized person. The minimum value per withdrawal application is set $100,000. Individual payments below such amount should be paid (i) by the MOHNIM-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.

32. The PHC innovation fund will be managed, monitored and administered by PIU. Expenditures financed by the grant will be supported by adequate documents in accordance with ADB's Loan Disbursement Handbook (2017, as amended from time to time). Detailed guidelines on the PHC innovation fund are provided in **Annex 3**.

2. Disbursement Arrangements for Counterpart Fund

33. The Government of Sri Lanka has agreed to provide $10 million as counterpart funding for the project. MOHNIM-PMU and Province-PIUs shall open separate accounts for the use of counterpart funding.

C. Accounting

34. MOHNIM-PMU and the Province-PIUs will maintain, or cause to be maintained, separate books and records by funding source for all expenditures incurred on the project following the Government of Sri Lanka's cash-based accounting standards. MOHNIM-PMU will prepare consolidated project financial statements in accordance with the government's accounting laws and regulations, which are consistent with international accounting principles and practices which are consistent with international accounting principles and practices.

D. Auditing and Public Disclosure

35. MOHNIM will cause the detailed consolidated project financial statements audited in accordance with International Standards on Auditing and in accordance with the government's audit regulations, by the Auditor General's Department (AGD). The audited project financial statements (APFS) together with the auditor's opinion will be presented in English language to ADB within 6 months from the end of the fiscal year by MOHNIM.

36. The audit report for the project financial statements will include a management letter and auditor's opinions. The letter should include information on (i) whether the project financial statements present an accurate 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 and grant were used only for the purpose(s) of the project; and (iii) whether MOHNIM was in compliance with the financial covenants contained in the legal agreements (where applicable).

37. 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.

38. The government, MOHNIM have been made aware of ADB's approach to delayed submission, and the requirements for satisfactory and acceptable quality of the APFS.[11] ADB

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[11] ADB's approach and procedures regarding 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

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.

39. Public disclosure of the APFS, including the auditor's opinion on the project financial statements, will be guided by ADB's Public Communications Policy 2011.[12] 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, additional auditor's opinions, and audited entity financial statements will not be disclosed.

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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 grant may be suspended if the audit documents are not received within the next 6 months.

(iii) When audited project financial statements are not received within 12 months after the due date, ADB may suspend the grant.

[12] ADB. 2011. *Public Communications Policy*. Manila.

VI. PROCUREMENT AND CONSULTING SERVICES

41. All procurement of goods, works, nonconsulting and consulting services for the proposed Project 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.

42. 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.

A. Advance Contracting

43. 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 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

44. 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

45. The major procurement items, estimated costs, and mode of procurement are shown in the tables below.

Table 14: Summary of Major Procurement Items

Item No	Description	No of lots/contracts	Estimated costs (million $)	Method of procurement
1	Procurement of Vehicles (Lot 1: 45 double cabs; Lot 2: 9 Lorries; Lot 3: 13 Vans)	3	4.02	OCB Nationally advertised
2	Laboratory, Physiotherapy, and X-Ray Equipment for Apex Hospitals	5	1.19	OCB Nationally advertised
3	Procurement of Dental Equipment	2	1.01	OCB Nationally advertised
4	Procurement of Medical Equipment			
	a) Reproductive Health and Nutrition	1	0.50	OCB Nationally advertised
	b) NCDs	1	0.05	RFQ
	c) ETU Equipment	1	0.75	OCB
	d) Essential package	1	1.96	Nationally advertised
4	Civil works			
	a) Round one – (45 health facilities)	9 packages for each district comprising 5 contracts for each district as multiple contracts	5.60	OCB Nationally Advertised
	b) Round two- (90 health facilities)	9 packages for each district comprising 10 contracts for each district as multiple contracts	11.23	OCB Nationally Advertised
	c) Renovation of field health centers	To be suitably packaged	4.42	"
	d) Improvements to buildings - Distance Learning Centers	To be suitably packaged	0.12	"
	e) Civil works related to healthcare waste management	To be suitably packaged	0.35	RFQ
5	a) Furniture for PMU and PIUs b) General and medical furniture	1 contract 8 contracts	0.05 1.64	RFQ OCB nationally advertised and RFQ
6	a) Office equipment for PMU and PIUs		0.15	RFQ
	b) Computers and peripherals* including GIS & HIT system for cluster facilities		0.73	OCB Nationally Advertised
	c) IT connectivity for DHs, PMCUs and epidemiology unit including monthly payment for 5 years		0.42	
	d) Computers and peripherals for QHRMS and other items for disease surveillance		0.11	RFQ
	e) Procurement of computers for Quarantine Unit		0.08	RFQ

Item No	Description	No of lots/contracts	Estimated costs (million $)	Method of procurement
	f) Procurement of 4 servers for Epidemiology Unit g) Procurement of computers and peripherals for DLC		0.02 0.19	RFQ OCB Nationally Advertised
7	Consultancy services (firms): a) Design and supervision consultancy b) Project result monitoring surveys (baseline and endline) c) Public awareness and communication campaign d) Design and develop health IT system for continuity of care e) Review nutrition service & assist training in nutrition counselling for PHC staff	 1 1 1 1 1	 0.97 0.49 0.77 0.34 0.50	 QCBS CQS QCBS CQS QCBS
8	Consultancy services (individual consultants): a) Support development of ESP b) Consultancy for PHC HRH plan for cluster work force plan c) Develop operation policies and guidelines for cluster management d) GIS based planning and monitoring e) IT specialist for epidemiology unit f) Financial Management Specialist g) Environment Specialist h) Gender and Social Safeguard Specialist i) Review and develop inbound assessment guidelines j) Development of Distance Education Portal k) External Evaluation of course content for DLC l) Legal expert for quarantine unit m) Health care waste management expert n) Health communications expert	 1 1 1 1 1 1 1 1 1 1 1 1 1 1	 0.02 0.02 0.02 0.03 0.06 0.05 0.04 0.06 0.02 0.02 0.01 0.01 0.023 0.038	 ICS for all
	Total		**38.081**	

*The peripherals include printers, bar code scanners, UPS, etc.

46. **Civil works.** All civil works contracts will be conducted through open competitive bidding (OCB) advertised nationally. 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. Single-stage one-envelope bidding procedure will be followed as these contracts are less complex and of smaller value. 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 4**. Few small contracts may be carried out through request for quotations (RFQ) method where required.

47. **Equipment and materials.** Vehicles, medical equipment, IT equipment, office equipment and furniture will be procured through the methods namely (i) OCB advertised nationally; (ii) RFQ

for contracts costing below USD 100,000; and (iii) Direct Contracting in accordance with ADB Procurement Policy and Regulations. Detailed equipment list for procurement is in **Annex 6**.

48. **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).

49. **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 security declaration may be accepted for smaller value works contracts.

50. **ADB policy clauses.** A provision shall be included in all OCB works and goods 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.

51. A provision shall be included in all bidding documents for works and goods contracts financed by ADB stating that the Borrower shall reject a proposal for award if it determines that the bidder recommended for award has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices in competing for the contract in question.

52. A provision shall be included in all bidding documents for OCB works and goods contracts financed by ADB stating that ADB will declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by ADB, if ADB at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices or any integrity violation in competing for, or in executing, ADB-financed contract.

53. **ADB review of procurement decisions.** First two procurement activities to be carried out by PMU and PIUs for each category and each method as identified in the procurement plan are subject to prior review by ADB as described in Appendix 6 of the Procurement Regulations.

54. All other contracts except consultancy services and except in case of direct contracting will be subject to post review on sample basis as described in Appendix 6 of the Procurement Regulations and agreed in the ADB Procurement Plan.

55. **Capacity building.** The 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 once the procurement staff of the Borrower is in place.

D. Procurement Plan

Basic Data	
Project Name: Health System Enhancement Project	
Project Number: 51107-002	Approval Number:
Country: Sri Lanka	Executing Agency: Ministry of Health, Nutrition and Indigenous Medicine

Basic Data		
Project Procurement Classification: A	Implementing Agency: Provincial Councils of Central, Sabragamuwa, Uva and North Central provinces	
Procurement Risk: Moderate		
Project Financing Amount: ADB Financing $50 million Ordinary Capital Resources (concessional loan): $37.5 million Special Funds Resources (ADF Grant): $12.5 million Government of Sri Lanka: $10 million	Project Closing Date: 30 November 2023	
Date of First Procurement Plan {loan/grant approval date}: 1 December 2018	Date of this Procurement Plan: 31 August 2018	
Procurement Plan Duration: 18 months	Advance contracting: Yes	eGP: No

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.

Table 15: Procurement of Goods, Works, and Nonconsulting Services

Method	Applicability	Comments
Open Competitive Bidding for Works	For contracts equivalent to ≤ US$15,000,000 and > US$100,00	Nationally advertised. First two procurement activities carried out by each PIU are subject to Prior Review.
Request for Quotations for Works	For contracts equivalent to < US$ 100,000	First two procurement activities carried out by each PIU are subject to Prior Review.
Open Competitive Bidding for Goods	For contracts equivalent to > US$ 2,000,000	Internationally advertised. All procurement activities carried out by PMU and/or PIU are subject to Prior Review.
Open Competitive Bidding for Goods	For contracts equivalent to ≤ US$ 2,000,000 and > US$ 100,000	Nationally advertised. First two procurement activities carried out by PMU and/or each PIU are subject to Prior Review.
Request for Quotations for Goods	For contracts costing < US$ 100,000	First two procurement activities carried out by PMU and/or each PIU are subject to Prior Review.
Direct Contracting for Goods		All procurement activities carried out by PMU and/or PIU are subject to Prior Review.
Procurement from Specialized Agencies		All procurement activities carried out by PMU and/or PIU are subject to Prior Review.

Table 16: 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.

Table 17: Goods, Works, and Nonconsulting Services

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
G-01	Procurement of Vehicles (Lot 1: 45 double cabs; Lot 2: 9 Lorries; Lot 3: 13 Vans)	4.02	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Advance contracting; (e) No e-GP Comments: Bidders from all eligible countries are permitted.
G-02	Procurement of Office Equipment for PMU and PIUs	0.15	RFQ	Post		Q3/2018	(a) No PQ and No domestic preference; (b) Goods RFQ Document; (c) Advance contracting; (d) No e-GP
G-03	Procurement of Furniture for PMU and PIUs	0.05	RFQ	Post		Q3/2018	(a) No PQ and No domestic preference; (b) Goods RFQ Document; (c) Advance contracting; (d) No e-GP
G-04	Procurement of Laboratory, Physiotherapy, and X-Ray	1.19	OCB	Prior	1S1E	Q4/2018	(a) Nationally advertised; (b) No PQ

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
	Equipment for Apex Hospitals						and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP Comments: Bidders from all eligible countries are permitted.
G-05	Procurement of Medical Equipment for Reproductive Health and Nutrition	0.5	OCB	Post	1S1E	Q4/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP Comments: Bidders from all eligible countries are permitted.:
G-06	Procurement of Dental Equipment	1.01	OCB	Post	1S1E	Q2/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP Comments: Bidders from all eligible countries are permitted.
G-07	Procurement of Medical Equipment for	0.05	RFQ	Prior		Q2/ 2019	(a) No PQ and No domestic

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
	NCDs						preference; (b) Goods Bidding Document; (c) Not under Advance contracting; (d) No e-GP Comments: Bidders from all eligible countries are permitted.
G-08	Procurement of ETU Equipment	0.75	OCB	Post	1S1E	Q4/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP Comments: Bidders from all eligible countries are permitted.
G-09	Procurement of Furniture for Quarantine Unit	0.03	RFQ	Post		Q1/2019	(a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under Advance contracting; (d) No e-GP
G-10	Procurement of Furniture for 45 facilities	0.16	OCB	Prior	1S1E	Q4/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							contracting; (e) No e-GP
G-11	Procurement of Medical Furniture for 45 facilities	0.3	OCB	Post	1S1E	Q4/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP
G-12	Procurement of Computers and Peripherals including GIS & HIT system for cluster facilities	0.73	OCB	Post	1S1E	Q4/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP
G-13	Procurement of computers and peripherals for QHRMS and other items for disease surveillance	0.11	OCB	Post	1S1E	Q4/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP
G-14	Procurement of computers for Quarantine Unit	0.08	RFQ	Post		Q1/2019	(a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under Advance contracting; (d) No e-GP

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
G-15	Procurement of 4 servers for Epidemiology Unit	0.02	RFQ	Post		Q1/2019	(a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under Advance contracting; (d) No e-GP
G-16	IT connectivity for DHs, PMCUs and epidemiology unit including monthly payment for 5 years	0.42	OCB	Post	1S1E	Q2/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under Advance contracting; (e) No e-GP
W-01	Procurement of Works – Round 1 - (5 PMCU/DH) Monaragala District	0.628	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-02	Procurement of Works – Round 1- (5 PMCU/DH) Badulla District	0.717	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-03	Procurement of Works – Round 1- (5 PMCU/DH) Kandy District	0.679	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-04	Procurement of Works – Round 1- (5 PMCU/DH) Matale District	0.559	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							contracts.
W-05	Procurement of Works – Round 1 - (5 PMCU/DH) Nuwara Eliya District	0.637	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-06	Procurement of Works – Round 1 - (5 PMCU/DH) Polonnaruwa District	0.56	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-07	Procurement of Works – Round 1- (5 PMCU/DH) Anuradhapura District	0.678	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							(d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-08	Procurement of Works – Round 1 - (5 PMCU/DH) Kegalle District	0.533	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-09	Procurement of Works – Round 1 - (5 PMCU/DH) Ratnapura District	0.609	OCB	Prior	1S1E	Q3/2018	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-10	Procurement of Works –	1.23	OCB	Post	1S1E	Q3/2019	(a) Nationally

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
	Round 2 - (10 PMCU/DH) Monaragala District						advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-11	Procurement of Works – Round 2- (10 PMCU/DH) Badulla District	1.28	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-12	Procurement of Works – Round 2- (10 PMCU/DH) Kandy District	1.25	OCB	Post	1S1E	Q3/2019	(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	Advertisement Date	Comments
							Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-13	Procurement of Works – Round 2- (10 PMCU/DH) Matale District	1.23	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-14	Procurement of Works – Round 2 - (10 PMCU/DH) Nuwara Eliya District	1.23	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							multiple lots and will be evaluated as multiple contracts.
W-15	Procurement of Works – Round 2 - (10 PMCU/DH) Polonnaruwa District	1.23	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-16	Procurement of Works – Round 2- (10 PMCU/DH) Anuradhapura District	1.22	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-17	Procurement of Works – Round 2 - (10 PMCU/DH)	1.27	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
	Kegalle District						and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-18	Procurement of Works – Round 2 - (10 PMCU/DH) Ratnapura District	1.29	OCB	Post	1S1E	Q3/2019	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under Advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-19	Civil works related to healthcare waste management	0.35	RFQ	Post		Q4/2019	(a) No PQ and No domestic preference; (b) Bidding Document for small works Document; (c) Not under Advance contracting;

Package Number	General Description	Estimated Value (in $ million)	Procurement Method	Review	Bidding Procedure	Advertisement Date	Comments
							(d) No e-GP Comments: To be clustered appropriately based on location, nature and cost of the work, etc.

Table 18: Consulting Services

Package Number	General Description	Estimated Value	Selection Method	Review	Type of Proposal	Advertisement Date	Comments
S-01	Design & supervision consultancy firm for infrastructure development	0.97	QCBS	Prior	STP	Q3/ 2018	Time Based; National experts; QCBS 90:10 Advance action? Y
S-02	Monitoring and Evaluation firm (baseline and endline)	0.49	CQS	Prior	BTP	Q3/2018	Time Based; national expert; Advance action? Y
S-03	Behavior Change Communication Marketing (firm)	0.77	QCBS	Prior	STP	Q4/ 2018	Time Based; National experts; QCBS 90:10 Advance action? N
S-04	Design and develop health IT system for continuity of care	0.34	CQS	Prior	BTP	Q4/2018	Lump Sum; national experts Advance action? N
S-05	Support development of ESP	0.02	ICS	Prior	-	Q4/ 2018	Time Based; national expert; Advance action? N
S-06	Develop PHC HRH plan for cluster work force plan (national)	0.02	ICS	Prior	-	Q4/ 2018	Time Based; national expert; Advance action? N
S-07	Develop operation policies and	0.02	ICS	Prior	-	Q4/ 2018	Lump Sum; Advance action? N

Package Number	General Description	Estimated Value	Selection Method	Review	Type of Proposal	Advertisement Date	Comments
	guidelines for cluster management						
S-08	GIS based planning and monitoring (national)	0.03	ICS	Prior	-	Q4/ 2018	Time Based; national expert; Advance action? N
S-09	IT specialist for epidemiology unit	0.06	ICS	Prior	-	Q4/ 2018	Time Based; national expert; Advance action? N
S-10	Financial Management Specialist	0.05	ICS	Prior	-	Q4/2018	Time Based; national expert; Advance action? N
S-11	Environment Specialist	0.04	ICS	Prior	-	Q4/2018	Time Based; national expert; Advance action? N
S-12	Gender and Social Safeguard Specialist	0.06	ICS	Prior	-	Q4/2018	Time Based; national expert; Advance action? N
S-13	Review and develop inbound assessment guidelines	0.02	ICS	Prior	-	Q4/2019	Time Based; national expert; Advance action? N
S-14	Review nutrition service & assist training in nutrition counselling for PHC staff	0.50	QCBS	Prior	STP	Q4/2019	Time Based; National expert; QCBS 90:10 Advance action? N
S-15	Health Care Waste Management Specialist	0.023	ICS	Prior	-	Q1/2019	Time Based; national expert; Advance action? N
S-16	Health Communications expert	0.038	ICS	Prior	-	Q1/2019	Time Based; national expert; Advance action? N

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).

Table 19: Goods, Works, and Nonconsulting Services

Package Number	General Description	Estimated Value	Procurement Method	Review	Bidding Procedure	Comments
G-17	Procurement of furniture for healthcare waste management	0.1	RFQ	Post		a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under advance contracting; (d) No e-GP
G-18	Procurement of equipment for healthcare waste management	0.08	RFQ	Post		a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under advance contracting; (d) No e-GP
G-19	Procurement of computers and peripherals for DLC	0.19	OCB	Post	1S1E	a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under advance contracting; (e) No e-GP
G-20	Procurement of furniture for DLC	0.03	RFQ	Post		a) No PQ and No domestic preference; (b) Goods Bidding Document; (c) Not under advance contracting; (d) No e-GP
G-21	Procurement of Furniture for 90 facilities	0.33	OCB	Post	1S1E	a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under advance contracting; (e) No e-GP
G-22	Procurement of Medical Furniture for 90 facilities	0.61	OCB	Post	1S1E	a) Nationally advertised;

Package Number	General Description	Estimated Value	Procurement Method	Review	Bidding Procedure	Comments
						(b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under advance contracting; (e) No e-GP
G-23	Equipment for essential package	1.96	OCB	Post	1S1E	a) Nationally advertised; (b) No PQ and No domestic preference; (c) Goods Bidding Document; (d) Not under advance contracting; (e) No e-GP
W-20	Renovation of 127 Field Health Centers	4.42	RFQ (for each FHC)	Post		(a) No PQ and No domestic preference; (b) Bidding Document for small works Document; (c) Not under advance contracting; (d) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.
W-21	Improvements to buildings - Distance Learning Centers	0.12	OCB	Post	1S1E	(a) Nationally advertised; (b) No PQ and No domestic preference; (c) Bidding Document for small works Document; (d) Not under advance contracting; (e) No e-GP Comments: Package contains multiple lots and will be evaluated as multiple contracts.

Table 20: Consulting Services

Package Number	General Description	Estimated Value	Selection Method	Review	Type of Proposal	Comments
S-17	Development of Distance Education Portal	0.02	ICS	Prior	-	Lump Sum; national expert
S-18	External Evaluation of course content for DLC	0.01	ICS	Prior	-	Lump Sum; national expert
S-19	Legal expert for quarantine unit	0.01	ICS	Prior	-	Lump Sum; national expert

D. Consultant's Terms of Reference

Table 21: Consulting Firms

Table 21.1: Design and Supervision Consulting Firm

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
Firm (National) (S-1)	54 months (2018 to 2022)	The firm to have at least 10 years' experience with the team leader and the deputy team leader being Civil Engineers and an architect with a team of 26 experts.	Complete construction of identified PHC facilities in the target provinces.	**1. Designing health facilities as identified** a. Prepare design sketches of proposed modifications for 90 PMCUs and 127 field health centres based on the Client's requirements stated therein; 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, submission of fees, and

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				monitoring of correspondence is carried out; i. Obtain approval for all structural drawings by the relevant authorities; j. Ensure that only such approved drawings are issued at site and the work is carried out in accordance to the said approved drawings; k. 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; l. Prepare Bills of Quantities with due diligence to establish accurate quantities; **2. Assisting the client in procurement of construction** 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 procedures; and the

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				preparation of Bid Evaluation Reports for approval by the bid evaluation committee; **3. 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)

Table 21.2: Monitoring and Evaluation Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (National) (S-2)	2018 to 2023 (but contract active period is 12 months (6 months in 2018/19 and 2023)	The firm should have at least 10 years' experience with similar work assignment. Firms with previous experience in the health sector will be given preference.	1. Inception note, including the methodology, (sampling design, data collection instruments, validation of tools, criteria to recruit data collectors, data analysis, plan for training and supervision during data collection. pretesting arrangements), the time plan, technical assistance plan, will be submitted for review by the ADB 2. Questionnaire/s and check lists (electronic versions) will be submitted for review and approval. 3. Baseline survey report and endline survey report. 4. All datasets in Excel format, including data definitions and codes, cleaned are to be submitted 5. A final comparison survey report that analyses the changes in outputs and outcomes related	1. To conduct baseline and end line surveys each of which will include a household / community survey, a health facility survey and a qualitative survey. 2. To evaluate the outcome of HSEP 3. Design appropriate survey methodologies for household surveys and health facility surveys in target provinces. 4. Prepare detailed protocols for surveys that also utilize GIS methodologies, the vulnerability mapping in the target provinces. 5. The protocol should include sample size, sampling methods, variable definitions, data collection methods and data analysis plan. 6. Prepare and validate data collection tools. 7. Conduct pilot surveys and pretesting of data collection instruments 8. Recruit and provide training and supervision for data collectors 9. Collect and analyze the data for all the surveys and prepare a report that provides the complete range of health indicator data for each of the outcomes specified in the DMF. 10. A report will be prepared for each survey. The final report after each survey must be submitted to the PMU, Ministry

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
			to the DMF, GAP and BCC plan.	of Health and to ADB on or before the time specified by the ADB. 11. The final report will provide information related to the two surveys (baseline and endline) and provide information / changes relevant to the project DMF, BCC plan and the GAP. 12. The selected firm will work closely with the Government of Sri Lanka counterparts during the implementation year to improve the standards of performance of the agreed results. In addition, the firm will work closely with the Government counterparts to improve their knowledge and capacity required when carrying out surveys.
Key personnel				
Specialist in Community Medicine (Public Health) (Team Leader)	12 months	MBBS, Post graduate degree in Community Medicine (MD, or PhD)	All reports as given in firm.	The Team Leader will be responsible for ethics clearance, managing the design, implementation, data collection and analysis and report writing of the baseline and end line surveys and in developing the final comparison survey report for the project. The team leader will work closely with ADB, GOSL and with the other partners like Census and statistics department, other relevant partners, during design, implementation and analysis stages.
Statistician (Co-Team Leader)	12 months	Minimum of Master's degree in Statistics and more than 5 years' experience in statistical analysis. Preference will be given to experience of working on DHS and other large health surveys.	1. Sampling methodology for the surveys. 2. Data collection tools. 3. Data analysis plan 2. Input to all reports.	The co-team leader will work closely with the team leader on developing the methodology, questionnaire and other data collection tools. She/he will support the team leader with the ethics clearance of the project, finalizing of the methodology and in leading the sampling strategy
Editor/ report writer	3 months	Degree in languages/ English with experience in editing and writing health/	Drafting, editing and proof reading of all reports.	To support the technical team to draft the reports and incorporate comments and proof read all deliverables in consultation with the technical team.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		social sector reports		

Table 21.3: BCCM Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (National) (S-3)	24 months	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	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.	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 MOHNIM, 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.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		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.		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 foot print at the PHCs and to assess the quality of care following the launch of the BCC campaign.
Key personnel				
Team Leader / Communications 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.
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
Communications 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.

Table 21.4: Information Technology Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (National) (S-4)	24 months	1. Minimum 10 years of experience in software development of implementations 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 4. Net worth of the Bidder should be positive in last 3 financial years	1. Submission of Inception Report (Project Plan, detailing schedule of work, key staff deployment, methodology, etc.) 2. Submission of Study Report- Assessment of existing Systems 3. Submission of Software Requirement Specification (SRS) Document 4. Development of integrated HHMIS software and demonstration to HMU 5. Completion of Software Testing- User Acceptance Testing 6. Roll-out of integrated software at pilot locations 7. Roll-out at all locations	**1. Profiling various use cases for Patient Based Systems for Sri Lanka.** Utilizing the health information technology assessment carried out for the project, the firm will identify the scalable, interoperable systems currently in use and will develop an inventory of all possible cases of Patient Based System (PBS). **2. The firm will engage with the MOHNIM and other relevant counterparts to design / develop a** national framework / blue print to establish an IT system that is interconnected to provide continuity of care to the patients or the community who seek preventive, or curative care at any level of health institution. The firm will define the requirements for establishing such a hospital information systems / patient management system with linkages to disease surveillance and hospital services (imaging, laboratory services, drug distribution, etc.) applicable to different hospital types in the country and guide on the use of a standard technological platform suitable for the evolution and scaling of hospital information systems. **3. Integrating systems in a common platform.** Design, develop and implement in the identified 9 clusters (approximately 25% of all PHC facilities in the 4 target provinces) an integrated system which has considered the existing systems running in the country, and which conforms to various national and global standards. Ensure a smooth change over for all system owners to the new system and provide a framework for assessing its progress. The consultant will: a. Develop SRS (Software Requirement Specification) and get Approval from Nodal officer of the Project b. Design and Develop additional software modules or new modules on HHMIS platform or other relevant platforms to integrate other software being used in Hospitals c. Upgrade HHMIS software or develop new software to make it

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				web-based and accessible across network hospitals. d. All software tools/ modules (Application & Database) should be developed on Open Source Platform/ Technology e. Suggest Hardware Infrastructure requirements for establishing this system in the 9 clusters supported under the HSEP. f. Hosting of integrated software modules on cloud/IT infrastructure as suggested by HMU g. Complete User Acceptance Testing (UAT) of developed software package **4. Implementation and Technical Support** a. Roll-out/ Implement integrated software on pilot locations (9 clusters) includes training to pilot location users b. Provide technical support to pilot locations and incorporate feedback in the software c. Share the findings/suggestions received in pilot implementation d. Roll-out in other locations (as required by the MOHNIM) e. Set-up a centralized help-desk for providing technical support to end users during the implementation period f. Conduct capacity building of end users for using this software
Key personnel				
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 blue print 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		The Software Engineers will develop the blue print 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.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		HHMIS/ DHIS systems		

Table 21.5: Review nutrition services and assist training on nutrition counselling for PHC staff

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (National) (S-14)	48 months	The firm should have at least 5 years' experience in the health sector and having experience in nutrition related interventions will be essential.	1. Inception note, should address the 3 tasks identified under the consultancy. (TOR section). The inception report should also include the additional staffing plan to support the identified tasks in the TOR and the plan for training and supervision during project implementation and the survey/ research plans for carrying out the material reviews, training program reviews and the qualitative surveys. 2. All training material, communication related AV material, Questionnaire/s and check lists (electronic versions) will need to be provided to the GOSL and ADB for review and approval. 3. Interim reports should be submitted every 6 months on each of the tasks assigned to the firm for approval and information to the GOSL and ADB. 4. The final report should be	The firm will carry out three main tasks: **1. Training on nutrition counselling.** a. The firm will also review the available training programs on nutrition counselling for PHC staff. The review will include course content, training material and reference material, mode of training, duration of the program, target group for the course etc. b. The review will be carried out in close collaboration with the Health Promotion Bureau, the Family Health Bureau, NCD unit, Environment unit, the RDHS and PDHSs and their respective officers, PHCs and the MOH offices. The firm will engage in discussions and consultations with all stakeholders to determine the need for a nutrition counselling course for all PHC staff and thereafter will develop a PHC level nutrition counselling course of required length. c. The firm will develop all related material for the course and in consultation with the RDHS and the PDHS of the target provinces and HPB and the FHB will help roll out a capacity building program on nutrition counselling to all PHC staff in the target provinces. **Task 2: Review and updating of all nutrition related material.** a. The firm will review all nutrition related material (print, digital, other AV etc.) addressed to mothers, children, adolescents, young adults, adults and elderly. The review will consider gender sensitivity, language sensitivity, appropriateness and clarity of messaging.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
			submitted at the end of the consultancy. 5. Consultant will be responsible for monitoring and achieving project activities related to nutrition and its associated indicators (anemia, low birth weight, stunting, etc.)	b. The firm will, in consultation with the MOHNIM, provinces and the RDHs will redesign / update/ rephrase nutrition material (social media, print media, etc.) for use via the MOH offices, PHCs and the RDHS offices. **Task 3: Supporting the provinces to improve the quality of nutrition interventions to improve nutrition outputs and outcomes in mothers and children.** a. The firm will support the RDHS to carry out a comprehensive qualitative assessment to best understand the local issues related to under nutrition in children and mothers. Considering the existing knowledge supported by the qualitative findings, the firm, in consultation with each of the 9 RDHS and the MOMCHs and Medical Officers of Health, will additionally provide the services of health promotion officers, nutrition counsellors to further improve the quality of the nutrition related interventions provided via the MOH offices and via the PHCs. b. Specifically, the firm will support to strengthen the nutrition counselling services and he follow up care given to low birth weight babies, underweight, wasted and stunted children and growth faltering children in the target provinces. c. The firm will also review the non-health factors that may support poor nutrition outcomes and will facilitate to address some of them via relevant departments or directly at the household level. d. The firm will also help establish a monitoring mechanism to assess the improvements gained with these interventions.
Key personnel				

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Specialist in Community Medicine (Public Health) with expertise in Nutrition (Team Leader)	48 months	MBBS, Post graduate degree in Community Medicine/ Public Health/ Nutrition (MD or PhD)		1. The Team Leader will be responsible for any clearances that are required, for managing all the tasks identified in the firm TOR. 2. The team leader will work closely with ADB, GOSL including the MOHNIM and Province and District levels in the target provinces.
Health Promotion Officers (one officer per district)	48 months	Degree in health promotion with experience related to nutrition		1. To support the 3 tasks and specifically to support t the district level to further improve the nutrition related interventions including the nutrition counselling services at the PHC level. 2. The Health promotion officer will also support the monitoring mechanisms.

Table 22: Individual Consultants

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
1. Essential Service Package (ESP) consultant (S-5)	National	12	• Post graduate degree in Public Health • At least 10 Years of work experience in public health system • Knowledge of existing MOHNIM policy document, strategic plans with strong research skills • Excellent interpersonal skills • Good analytical and computer skills • Excellent skills in speaking and writing English, Tamil and Sinhalese	The consultant will work closely with the WHO and the ADB to pilot the implementation of the ESP that is currently being defined and finalized by the WHO. The consultant will also work very closely with the Cluster Management and with the PHC HRH consultants throughout the assignment. • The consultant will initially review the ESP and define the services that can be piloted in the 9 clusters and develop a document related to the pilot introduction of the ESP. • Engage in consultations to seek agreement on the services that will be piloted in the clusters • Carryout advocacy at the MOHNIM, Province, District levels and within the 9 identified clusters to introduce the identified ESP interventions. • Define the guidelines, SOPs, protocols required to pilot the identified interventions / and or services in the clusters.

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• Identify the gaps in investments that need to be addressed to pilot the ESP in the clusters • Provide technical assistance to the PMU to purchase all required equipment for piloting the ESP. • Develop ESP guidelines and facilitate in dissemination of the guidelines.
2. PHC HRH Plan consultant (S-6)	National	12	• Post-graduate degree in Public Health/ Community Medicine/ Medical Administration • At least 7 years of professional experience in designing, implementing or researching Human Resources for Health (HRH) sector management capacity interventions • Demonstrated understanding of international best practices in HRH management systems • Professional experience related to developing training and capacity-development for health workers • Professional experience of working with the Ministry of Health Nutrition and Indigenous Medicine in Sri Lanka including Provincial health authorities	The consultant will: • Review the PHC HRH strengthening report, (developed as part of project preparation of the HSEP), the work load analysis report carried out by the WHO, and all other HRH related reports, plans, strategic documents and policies developed for HRH strengthening in Sri Lanka. • Consultant will coordinate with WHO, MOHNIM, development partners and all other stakeholders to emphasize the need for development of a HRH strategic plan for the next 10 years with a special strategic plan for development of PHC HRH in Sri Lanka. • Support the MOHNIM to implement short, medium and long-term recommendations identified in the recently developed HRH related reports. • Review PHC level Health Human Resources requirements, including institutional arrangements, staffing, skills and capacity development needs. • Develop a PHC HRH strategic plan in consultation with all stakeholders • Undertake a training Needs Assessments (TNA) for all categories of PHC staff in the target provinces and provide recommendations to address the training needs • Develop competencies / job descriptions needed for each level of PHC staff when attached to a cluster and if

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				attached individually to a PHC facility. • Develop performance appraisal tool for all PHC and project staff. • Cadre projection for the PHC system until 2023. • Identify and document the HR functions that impact on the Ministry / PHC services and make proposals for the rationalization and consolidation of HR functions in line with international best practices, such as WHO's HAF (Human resources for health Action Framework) • Conduct consultation workshops, field visits, and round table discussions with key stakeholders while developing all documents. • Identify and initiate institutional partnerships and arrangements with the apex Training Institute (NIHS), WHO, DDG-ET&R, regionally or in-country, for implementation of the project human resources capacity/ training programs
3. Cluster Management consultant (S-7)	National	12	• Post Graduate degree in Public health • At least 10 Years of work experience designing and implementation of referral network in public health system	The consultant will • Support the MOHNIM, Provinces and the respective districts under the HSEP to formally establish the identified 9 clusters in the 9 districts. • Engage in discussions with the MOHNIM to develop the required MOHNIM 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

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				various facilities under a cluster • Identify human resource, equipment and other requirements at each level to ensure the availability of services keeping in view cost efficiency • Develop the referral policy based on the services available at various level of facilities among a cluster • Identify the logistic requirements to maintain flow of drugs, reports and patients among the cluster facilities • Development of monitoring framework to ensure movement of patient from lower level of facility to higher based on actual requirement • Review the Essential Service package (ESP) recently developed by the WHO and define the services that will be additionally made available at each level of facility in the 9 pilot clusters • Identify the equipment and other investment gaps that need to be addressed for the implementation of the ESP in the 9 pilot clusters. • Provide implementation support to function the 9 clusters in each of the 9 districts.
4. GIS based monitoring and planning (S-8)	National	24 months	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	The consultant will: • Establish GIS units in the target 4 provinces and the respective 9 districts which will be linked to the MOHNIM, to the NIHS and to the Health Information unit of the Planning unit. • Coordinate with the MOHNIM 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.

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• 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
5. IT Specialist (Epidemiology Unit) (S-9)	National	60 months	A Bachelor's degree in computer science or a related field with experience in web-based systems. Experience in working with health-related systems will be preferred.	The consultant will be responsible to oversee and support the running of the web-based health information systems coordinated by the Epidemiology unit. The consultant will specifically • Support the daily running and management of the web-based systems

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				(includes the e health surveillance system) • Address any system failures/ troubleshooting of the web-based systems • support further development / updates of the web-based systems to meet the changing health and data needs • engage to further develop the data reporting aspects of the web-based systems • Provide training and address system issues in regional centers via telephone if possible and in person if necessary. • Develop training modules to provide regular updates to the users of the system at the PHC level and at regional, province and national levels • Document all technical details of the systems (codes, etc.) and update standard operating procedures as necessary Ensure data security of the web-based system by carrying out necessary modifications to the systems. • Advice as needed to ensure availability of backup arrangements for the web-based systems maintained by the Epidemiology unit.
6. Financial Management Specialist (S-10)	National	Intermittent (1st year – 6 months; 2nd year onwards – 3 months per year)	Post-graduate degree in Accounting (experience of ADB project will be an added advantage), at least 10 years of relevant experience	Build the capacity of PMU/ PIU Officers/ Accountants in ADB's disbursement procedures, other relevant ADB guidelines and assist/guide them in following activities: • Undertake project-based accounting and reporting • Preparation of ADB's withdrawal application, Statement of Expenditure and other related documents • Document the processes and bringing them in line with GOSL and ADB's procedures • Selection/customize the off-the-shelf accounting software

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• Efficient execution of financial procedures in PMU/ PIU and processes and reporting on the overall HSEP to EA, ERD and ADB • Establishment of communication protocols with each other w.r.t. all funding and FM related process and guide them in all project related aspects • Completion of all statutory documentation such as audits, internal audits, executive committee meeting minutes of PMU/ PIU, PSC/ Province Level Committee, approvals, signed contracts and other legal documents • Ensure that all accounts are maintained electronically with proper backup and supporting documents, and safety and security of all data and documentation using technology • Assist procurement expert in all procurement processes including bid evaluations and contract management • Preparation of Action Taken Reports for all audits (e.g., by AGD, internal auditor), placing them before the relevant authority and assist in implementing corrective measures for compliance • Manage adequate cash flows for timely payments and claims to ADB • Preparation of budget according to the proposed activities for the year, and update the budget based on revised project activities to ensure the budget is realistic reflection of planned activities • Preparation of quarterly projections for project contract awards and disbursements, periodically communicate with EA and ADB on projections, identify issues in shortfalls in contract awards and disbursements, and assist

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				preparing remedial actions if needed in coordination with relevant project implementation officers • Ensure that the project's FM action plan is implemented and updated as needed based on the project's implementation progress • Preparation of regular MIS on financial progress and lining the same with technical progress • Any other FM related matter not mentioned above and related to the project
7. Environment specialist (S-11)	National	60	• Master's Degree in Environment Science /Engineering Experience in General environmental safeguards management • Donor funded project experience is preferred.	• Assist PMU/PIUs in implementation of the project's Environmental Assessment and Review Framework (EARF) during the construction and operation of health facilities by providing the overall policy and technical direction for environmental safeguards management. • Co-ordinate closely with Deputy Directors in the PIUs in planning and managing environmental safeguards and provide necessary technical assistance to facilitate the implementation, management and monitoring of environmental safeguards • Review and endorse environmental screening reports prepared by the PIU and prepare IEEs for as per the guidelines provided in the EARF. Obtain concurrence from the ADB for IEEs and publicly disclose the documents as per the EARF • Ensure that EMPs are included in the design, and condition on compliance with EMP is included in the bidding documents as well as the contractor's agreement • Develop, organize and deliver environmental training programs and workshops for the staff of

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				the PIUs who will serve as safeguards focal points on data collection and screening, contractors and field supervision staff and other implementing agency officials (responsible for the supervision of Maintenance works), as needed, on safeguard requirements during construction • Preparation of Health Care Waste Management plans for all health care facilities supported under the project. Provide necessary technical, logistical and follow- up support • Obtain clearances from local environmental/other regulatory authorities, where applicable • Prepare bi-annual monitoring reports to the ADB on the overall environmental performance of the project • Hold regular review meetings with the environmental focal points of the PIUs and visit project sites to assess environmental planning requirements and to monitor implementation of the EMP by contractors
8. Gender and Social Safeguard specialist (S-12)	National	60	• Post graduate degree in Social Sciences and Gender from a recognized university • Ten years of experience in the development sector working on community development, gender studies, training, project management, impact evaluation, etc. • Skills and experience in research and survey methodologies – research design, data analysis and reporting, participatory evaluation and quantitative data collection	• Screening and assessment (together with infrastructure specialist) of PMCUs in four provinces • Develop a framework for mitigation of identified risks • Assess capacity of PIU and sub project office staff in relation to awareness of social safeguards and ability to identity risks • Assessment of Gender and social safeguard training needs of staff to identify and address knowledge and practice gaps • Planned and ad-hoc on-site visits to monitor compliance and provide guidance as required • Review the existing package for newly married couples from a gender

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
			• Proven capacity to conduct screening and impact assessments and structured reporting • Awareness of ADB and national guidelines on Indigenous Persons and Involuntary Resettlement • Previous experience working on ADB and or WB supported projects highly desirable. • Proficiency in Sinhala (and Tamil – ideal) and ability to write project reports in English • MS Office, Internet and Email Knowledge of data analysis software such as Stata, SPSS, NVivo preferred	perspective to identify gaps and provide recommendations for improvement • Analyze sex disaggregated data to identify gender related health issues and remedial action required • Monitor GRM and lead/convene meetings as required • Review the existing policies and strategic plans under units of FHB to revise and integrate gender dimensions • Submission of quarterly reports to the PMU on a predetermined structure. Assist in preparation of annual/bi annual reports • Support to PMU and PIUs on all matters pertaining to social safeguards and gender, e.g., adaptation and implementation, monitoring, risk mitigation • Conduct of due diligence and social monitoring assessments (second year) • Liaise with subcontractors, MOHNIM, PMU, PIU and SLRM on a needs basis
9. Inbound assessment review and guidelines consultant (S-13)	National	6 months	• Post Graduate degree in Community Medicine At least 6 Years of work experience in international health and regulations	• Review existing guidelines and procedures for inbound assessment • Identify international regulation and good practices for inbound assessments in other countries • Review the existing facilities, including infrastructure and skill sets available for inbound assessments • Develop guidelines and processes for inbound assessments • Develop infrastructure norms and linkages with points of entry for inbound assessment • Develop staffing norms and skill sets required for this • Conduct consultative workshops for inbound assessments • Orient the concerned MOHNIM officials on these

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• Monitor the implementation of these guidelines • Conduct periodic reviews of the inbound assessment faculties and suggest improvements based on processes, infrastructure and capacity building requirements
10. Health Care Waste Management consultant (S-15)	National	24 months (over the period of the project)	Master's Degree Environment Science / Engineering with specific experience in HCWM is an advantage	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

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				be introduced in the 9 clusters.
11. Health Advocacy Communications expert (writer) (S-16)	National	22 months over the 5-year project period (intermittent)	• Bachelor's Degree in communications or a related field with experience in health or social sectors. • Excellent writing skills in English is essential.	The consultant will work on two types of communications. **1. Project related communications** • The consultant will be responsible for developing project specific newsletters/media/newspaper op-eds/newspaper articles/etc. for health promotion and advocacy on regular basis (at least quarterly). • He/she can direct/organize the collection of stories from the field (at least one from each of the nine districts per year) including contributions from PMU/MOHNIM/FHB/NIHS/etc. other partners of the project) that may be of interest to promote PHC and the project's work. • He/she should also oversee the project website and/or share the content to be updated on the project website. **2. Support to BCCM** • Review the document on communications assessment and strategy to increase utilization of PHCs • Engage in discussions with the MOHNIM and update and finalize the strategy • Review and update the TOR for the communications consultancy • Support/ provide input to the development of the RFP for the consultancy • Provide technical input where necessary during the contracting process at pre-bid meetings, proposal scheduling and during evaluations etc. • Liaise with the selected firm to clarify task, provide technical input, coordinate technical input from the MOHNIM and the 4 provinces,

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• review all the deliverables of the BCCM communications firm and be the first contact person to manage the consultancies related to communications • Review and monitor the communications campaigns • Any other communications related activity including providing technical input for carrying out training related to communications.
12. Distance Education Consultant (S-17)	National	24 months (full time for 12 months and thereafter intermittent over next 24 months)	• Post-graduate degree in Public Health or Medical Education • At least 10 years of professional experience in designing, implementing and managing public health training programs • Professional experience related to developing training via distance learning techniques. • Professional experience of working with the Ministry of Health Nutrition and Indigenous Medicine in Sri Lanka including Provincial Health Authorities • Excellent computer skills with knowledge of Online Learning Management System (such as MOODLE) for eLearning program	• Develop distance learning program goals, standards, policies and procedures including technological requirements, quality assurance or course offering plans • Manage the arrangements for web space and installing of the online education platform • Identify the required support staff and develop the SOP for their hiring and training • Prepare and manage distance learning program budgets • Develop or provide technical resources, such as course management and videoconferencing systems, networking, and webcasting, for distance learning programs • Develop the mechanism to troubleshoot and resolve problems with distance learning equipment or application • Develop distance learning content (with remote access) and regularly review to ensure compliance of content with copyright, licensing, or other requirements • Develop an online assessment method for each of the training programs • Develop pre-and post-tests for each training program after receiving the technical content from the technical experts.

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				• Develop evaluation mechanisms for each training program • Develop trainee discussion forums for each training program • Analyze statistical data and prepare reports summarizing the program objectives and accomplishments for operational decisions • Create and maintain web sites or databases that support distance learning programs • Prepare and distribute schedules of distance learning resources, such as course offerings, classrooms, laboratories, equipment, and web sites • Communicate technical or marketing information about distance learning via podcasts, webinars, and other technologies • Negotiate with academic units or instructors and vendors to ensure cost-effective and high-quality distance learning programs, services, or courses. • Monitor technological developments and evaluate the effectiveness programs in promoting knowledge or skill acquisition • Monitor performance of organizational members or partners like vendors that provide product or service • Manage inventories of products or organizational resources
13. External Evaluation of the Distance Learning Consultant (S-18)	International	3 months (intermittent) (3 visits) (initially immediately after launch; 2 years after launch; and 4 years after launch of program)	• Master's Degree in Health / Medical education with experience in Distance education programs and in evaluation of such programs	• The consultant will evaluate the technology, the process, the platform for distance learning and will provide recommendations to expand / improve/ enhance / update or newly introduce the platforms, related to distance learning process used by the NIHS. • The evaluation will also include a content evaluation from the perspective of the mode of presentation of the

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				content (not the technical content of the course) • The consultant will also review the distance learning training programs overall in terms of education science and techniques suitable for distance education and provide recommendations for further strengthening the program.
14. Legal Expert (Quarantine unit) (S-19)	National	12 months	• 10 years' work/ professional experience in practicing law and be a qualified attorney with a post-graduate degree in Law, preferably with special knowledge in legislative drafting • Minimum of 5 years' experience in drafting legislation and policies and the preparation of drafting instructions, conducting legislative review, analysis and assessment, • Knowledge of national legislative system with in-depth knowledge of Quarantine and prevention of diseases ordinance of 1897, and International Health Regulations (IHR-2005), Quarantine act • Excellent report writing, communication and networking skills; • Ability to constructively engage at a senior government level and ministerial level, Good interpersonal skills and ability to work in a team in a consultative and collaborative manner. Good analytical and problem-solving skills to understand various business functions and requirements • Understanding of user perspectives and ability to suggest effective solutions	The consultant will: 1. Undertake a comprehensive review of the legislative, administrative, regulatory and governance framework with regards to the Quarantine Act including but not limited to: a. Identify all existing domestic legislation, regulations and other instruments relevant to the Quarantine Act b. Specify any legislation, regulations and other instruments which may potentially interfere or conflict with full or efficient implementation of the Quarantine Act and its regulations. c. Review the Quarantine Act, Maritime Regulations and other acts, identifying sections of these legislations requiring amendment. 2. Develop Legislative drafting instructions for submission to and acceptable by the Ministry of Justice and supporting Legal Dossier to enable amendment of the Quarantine Act, Maritime Regulations and other acts. 3. Ensure that the drafting instructions developed are based on the Constitution, health sector plans and policies of the MOHNIM, is in line with national and international guidelines and best practices and are compliant with the IHR (2005) and consider: the priority subject areas of the IHR (2005) for implementation indicated as below:

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
			• Excellent knowledge of IT	a. National IHR Focal Points designation and operations b. Detection, reporting, verification, and control of events, as well as related communications, domestically and internationally c. Communication and collaboration with WHO on implementation of IHR (2005) d. International Certificate of Vaccination and Prophylaxis (Annex 6) e. Maritime Declaration of Health (Annex 8), Health part of Aircraft General Declaration (Annex 9) f. Development of core public health capacities at Designated Points of Entry g. Development of capacities of ports authorized to issue Ship Sanitation Certificates 4. Conduct national stakeholder consultation meetings with relevant Government agencies, non-governmental organizations, civil organizations/groups, and other stakeholders, aimed at presenting the proposed drafting instructions and obtaining comments and consensus thereon. 5. The consultant will need to provide an Inception Report/Work Plan detailing the scope of work, program schedule, methodology and timelines. 6. At the end of the consultancy, submit a final consultancy report highlighting the nature of the work undertaken noting the level of success and constraints in terms of methodologies used, the nature and quality of stakeholder participations and any lessons learnt during the process with a table indicating the necessary amendments, to the act, regulations etc.

Consultant	National or International	No. of Person Months	Qualification and Experience	Terms of Reference
				7. The consultant will require to cooperate fully with the MOHNIM, the Quarantine unit and carry out such other tasks incidental to the foregoing as may be required by the MOHNIM and the Quarantine unit during the execution of this consultancy. 8. Review and ensure country's existing legal policy and guidelines related to border health comply to international standards 9. Guide and support MOHNIM in the development of policies, directives, regulations, interpretations 10. Recommend and develop policies that will facilitate the improvement in services of health offices at POEs (Airport and Ports) 11. Ensure the guidelines developed by the department for sanitation and management of Public health events in board ships and air transport are regularly updated and complies with international guidelines 12. Recommend the priorities and provide a guiding framework within which all stakeholders operate

VII. SAFEGUARDS

56. **Involuntary Resettlement (IR) Social Safeguard.** The project is classified as C for IR based on the screening and assessment of qualitative sample survey of 29 of 135 sites. Selected PMCUs and DHs in the nine districts will be supported via infrastructure upgrades and provision of equipment. Land acquisition and resettlement is not triggered as all civil works are aligned to reconstruction on existing centers which are owed by the Government of Sri Lanka. No temporary IR impacts were anticipated during the project preparatory technical assistance stage. As outlined in the due diligence report, requisite screening and evaluation for site selection against principles and edits set out in the ADB's Safeguards Policy Statement (2009) will be a mandatory component of pre-implementation assessment. Public consultation and disclosure are also identified as a priority, as such, a model for a grievance redress mechanism in **Annex 7**. In addition to direct (primary and secondary) stakeholders, guideposts will also be used to understand impacts on ADB defined vulnerable groups such as female headed households and the elderly.

57. **Indigenous peoples (IP).** The project is classified as C for IP based on ADB's guidelines. The due diligence confirms classification of C categorization for IP impacts. Screening and assessment outlined in the due diligence report show no impacts on the Indigenous Vedda population (the only IP group in the country) in both the Uva and North Central provinces (project areas with habitats). Compliance is facilitated by (i) availability of multiple options for PHC facility development thus ensuring minimal associated risks, and (ii) confinement of intervention activities to infrastructure reconstruction. Ownership of primary health centers and divisional hospitals is vested in the Government of Sri Lanka. Continuous vigilance and monitoring reporting will be implemented.

58. **Environment.** The project is classified as Category B for environment in accordance with ADB's Safeguards Policy Statement (2009). The project aims to improve health care services offered by the primary sector in four provinces in the country and is expected to generate many benefits to the local community as well as r-orient the national health services. Adverse environmental consequences of the project will be largely restricted to component 1 under which support will be provided to existing PHC facilities to upgrade 30% (135) of its primary medical care infrastructure facilities and small-scale repairs to field health centers. The nature of construction envisaged will be small-scale, simple and straightforward, mostly restricted to expansion of the outpatient departments for primary medical care facilities and repairs and refurbishment to field health centers. The 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 an asbestos management plan has been prepared and will be incorporated into environmental management plans (EMPs).

59. All the projected risks during construction and operation phase can be effectively addressed through the adoption of proper mitigation measures in the design, planning, construction, and operations phases. An Environmental Assessment and Review Framework (EARF) has been prepared to guide in the screening, categorization, assessment, and mitigation of impacts of the subprojects. Subprojects which are categorized as A for environment will be excluded from project financing. An initial environmental examination (IEE) has been prepared focusing on 45 primary medical care facilities that will be improved in the first phase of the project. The IEE provides an overview of the typical environmental impacts arising from the project and measures to address them. Similar IEEs will be prepared during project implementation for the remaining subprojects including EMPs and environment monitoring plans. The project will also prepare semiannual monitoring reports that describe progress of implementation and compliance

issues and corrective actions, if any. In accordance with ADB's public consultation and information disclosure policy, all key safeguard documents will be prepared in close consultation with key stakeholders and publicly disclosed.

60. In addition to the above, the MOHNIM 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.

61. **Monitoring and Evaluation**. The PMU at the central level and PIUs at the provincial level will manage screening, evaluation, and reporting with the support of assigned safeguards consultants and oversight by the PIU Project Engineers and MOHNIM. Areas of concern on impacts of ongoing works and projected work streams will be included in semiannual monitoring reports. The midterm and end term reviews will contain dedicated sections on both social and environment safeguards.

VIII. GENDER AND SOCIAL DIMENSIONS

62. 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.

63. 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, 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.

64. 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.

65. 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 heath 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, Nutrition and Indigenous Medicine (MOHNIM), 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 MOHNIM. 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.

66. **Gender and social dimensions monitoring.** The responsibility for monitoring output and activity related indicators of the gender action plan lies with the Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM) 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.

67. 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.

68. **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.

69. **Gender Action Plan.** The Gender Action Plan (GAP) for the ADB's Health System Enhancement Project (1 December 2018–30 November 2023) will be executed by MOHNIM. 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 MOHNIM 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.

Table 23: Gender Action Plan

Activities	Targets and Indicators	Responsible Agency	Timeframe
Output 1: Primary health care services enhanced in Central, North Central, Sabaragamuwa, and Uva provinces			
1.1 Ensure all upgraded or renovated PMCUs and divisional hospitals have gender responsive construction features	1.1.1 At least 30% upgraded or renovated PMCUs and divisional hospitals have separate toilets separate examination and changing areas for improved privacy for male and female patients 1.1.2 All PHC facilities providing ESP (25% of all PHC facilities in target provinces) have gender responsive designs with facilities for privacy during patient examination, and for changing clothes (Baseline: less than 10%)	PIU	By 2023
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 75% of PHC facilities in target provinces provide a gender responsive and inclusive essential service package (Baseline: 0) 1.2.2 All staff providing ESP services in the PHCs trained on gender sensitivity and responsiveness when providing ESP services (Baseline: 0) 1.2.3 Over 75% of women and men are reporting satisfaction over the services provided at PHC facilities	PIU and/or gender expert	By 2023
1.3 Develop a BCC campaign targeting increased 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 1.3.2 Use of PHC facilities is increased by 20% each for women and men	PIU and/or gender expert	By 2023
1.4 Encourage 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	PIU and/or gender expert	By 2023
1.5 Pilot male engagement approaches 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 Conduct TOT targeting at least 50 health officials and/or local organizations who can transfer knowledge to men at PHC facilities 1.5.3 Over 1,500 men reached though training and awareness	PIU/gender expert	By 2023
Output 2: Health information and disease surveillance capacity strengthened			
2.1 Introduce sex-disaggregated data to the eRHMIS, Annual Health Bulletin of FHB and to the eHealth	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 eHealth surveillance system (Baseline: 0)	FHB, Gender and Women's Health Unit and Epidemiology Unit	2020

Activities	Targets and Indicators	Responsible Agency	Timeframe
surveillance system on the 29 notifiable diseases in Sri Lanka	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 Ensure all operation policies and guidelines developed for health sector are gender mainstreamed	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.	PIU/gender expert	By 2023
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 polices and guidelines with gender dimensions are developed for (i) delivering a comprehensive package of PHC; (ii) management and functioning of cluster hospitals; and (iii) GIS-based planning and monitoring in health sector 3.2.2 By 2020, 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 2019, the package for newly married couples is reviewed and finalized 3. 2.4 By 2023, nine advocacy workshops conducted as one per district (9 districts) with registrars of marriages (Baseline: 0)	FHB and Gender and Women's Health Unit	2019–2023
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 2019, a gender expert recruited 3.3.2 By 2019, a gender training needs assessment conducted and a TOT training module for PHC staff developed (Baseline: 0) 3.3.3 By 2020, nine TOTs on gender conducted as one per district (at least 40% women) (Baseline: 0) 3.3.4 By 2023, at least 25% PHC staff from PMCUs, divisional hospitals, and MOHs (of whom 35% are women) are trained on gender sensitivity, gender-related policies and interventions (Baseline: 0)	Gender and Women's Health Unit of the FHB, gender expert	2019–2023
3.4 Introduce an updated training program on gender sensitive nutrition counselling and primary health care	3.4.1 At least 75% of PHMs trained on gender sensitive nutrition counselling program (Baseline: 0) 3.4.2 At least 25% of medical officers and other staff of PMCUs and divisional hospitals (of whom 35% are women) in target provinces are trained in PHC (family medicine)	Gender and Women's Health Unit of the FHB, gender expert	2023
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 counseling and family mediation induction course developed for PHMs and PHIs (Baseline: Not available) 3.5.3 75% of PHMs and PHIs trained on life skills and family mediation (at least 50% women) (Baseline: 0)	Gender and Women's Health Unit of the FHB	2019–2023
3.6 Develop new guidelines for preventive health staff to address occupational health issues	3.6.1 New guidelines developed for field-based staff to address occupational issues faced by estate sector women workers, men and women engaged in unskilled labor and other occupations.	Gender and Women's Unit of the FHB	2020

BCC = behavior change communication, eRHMIS = electronic reproductive health management information system, ESP = essential service package, FHB = Family Health Bureau, GIS = geographic information system, GBV = gender-based violence, MOH = medical officer of health, 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

70. The project supports vulnerable geographical areas in Sri Lanka to achieve three main outputs defined by a set of performance indicators. The design and monitoring framework (DMF) which summarizes the project result will guide the overall project throughout. The project intends 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. Project Design and Monitoring Framework

Impact the Project is aligned with
A healthier nation is ensured with a more comprehensive PHC system (National Health Policy, 2016–2025)[a]

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

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

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

Key activities with milestones

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

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

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

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

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

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

Inputs

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

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

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

Source: Asian Development Bank.

B. Monitoring

71. **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.

72. 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 HSEP 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.

73. 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.

74. 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 HSEP such as functionality of electronic health information system 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.

75. 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[13] 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.

76. 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.

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[13] 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

77. **Compliance monitoring.** 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

78. **Safeguards monitoring.** The screening and assessment based on the qualitative sample survey of the 45 centers selected for the readiness package, confirm a C categorization for the project for Involuntary Resettlement (IR) and Indigenous People (IP). The PMU at a central level and PIUs at provincial level will manage screening, evaluation and reporting with the support of the safeguard consultants and oversight by the PIU Project Engineers and the MOHNIM. A mechanism for regular upstream reporting by the sub project offices and PIUs to the PMU will be established.

79. Further, EMPs for civil works will be included into the bid documents. The PIUs and PMU will regularly monitor compliance with EMP conditions as well as with the environmental monitoring program and report to the ADB through bi-annual environmental monitoring reports.

80. **Gender and social dimensions monitoring.** The GAP highlights the following main areas 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 Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM) 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.

C. Evaluation

81. 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.

82. The completed project will be subject to self-evaluation and the Project Completion Report (PCR) will be prepared 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.

D. Reporting

83. MOHNIM 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.

E. Stakeholder Communication Strategy

84. Based on the ADB public communication policy and ADB safeguard policy statement, the 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, MOHNIM, Provincial Councils, civil servants, plantation managers, Epidemiology Unit, FHB, Health Promotion Bureau, Education training and research unit of the MOHNIM, Quarantine Unit of MOHINM, academia, civil society, and the media.

85. 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.

86. 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 the details are in **Annex 7**.

87. 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

88. ADB reserves the right to investigate, directly or through its agents, any violations of the Anticorruption Policy relating to the project.[14] All contracts financed by ADB shall include provisions specifying the right of ADB to audit and examine the records and accounts of the executing agency and all project contractors, suppliers, consultants, and other service providers.

[14] Anticorruption Policy: http://www.adb.org/Documents/Policies/Anticorruption-Integrity/Policies-Strategies.pdf

Individuals and/or entities on ADB's anticorruption debarment list are ineligible to participate in ADB-financed activity and may not be awarded any contracts under the project.[15]

89. To support these efforts, relevant provisions are included in the loan agreement/ regulations and the bidding documents for the project.

90. 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

91. 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.[16]

XII. RECORD OF CHANGES TO THE PROJECT ADMINISTRATION MANUAL

92. 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.

[15] ADB's Integrity Office web site: http://www.adb.org/integrity/unit.asp
[16] Accountability Mechanism. http://www.adb.org/Accountability-Mechanism/default.asp.

ANNEX 1: PROJECT DESCRIPTION

I. The Project

1. The project outputs are as follows:

(i) Output 1: Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces
(ii) Output 2: Health information system and disease surveillance strengthened
(iii) Output 3: Policy development, capacity building, and project management supported

1. Output 1: Primary health care enhanced in Central, North Central, Sabaragamuwa, and Uva provinces

2. This project output intends to strengthen the primary health care (PHC) services in the target provinces of Central, Sabaragamuwa, Uva, and North Central 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 curative level facilities (Primary Medical Care Units (PMCUs) and the Divisional Hospitals (DHs), and via the preventive health network of Medical Officer of Health areas led by the Medical Officers of Health). Approximately, 469 PMCUs and DHs and 132 Medical Officer of Health areas are located in the target provinces.

3. Output 1 of the project intends to address the following aspects of PHC services defined into 4 sub-outputs.

(i) Development of primary medical care services.
(ii) Development of primary preventive care services.
(iii) Public awareness and behavior change communication for increasing PHC utilization.
(iv) Strengthen PHC management for continuity of care.

a. Development of Primary Medical Care Services

4. Under this output, the project supports the development of curative PHC facilities (this includes DHs and PMCUs). The health facilities were identified by a two-stage objective analysis using a vulnerability index[17] and the GIS tool[18] in consultation with the MOHNIM and the four provinces. In the first stage, the vulnerability index was used to identify the vulnerable population in the target provinces and the GIS tool was able to link the nearest PHC to the vulnerable populations. Based on this calculation, the priority list of PMCUs and DHs that require development was identified. Thereafter, in the second stage, in discussion with the provinces, the

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

[18] A model was developed by the ADB team in consultation with the MOHNIM and the 4 provinces, to identify the target population of the project. The model used 3 variables to develop the list of GNs: (i) the census vulnerability index, (ii) the dependency ratio of the GN populations (population over 60 years and the children below 15 years/ population of adults 15 to 59 years) and (iii) the distance to the nearest primary medical care facility (PMCU or a DH).

respective districts, and the MOHNIM, two additional criteria, (i) any facility without basic services water, electricity, sanitation services, (ii) any facility that needed development based on local knowledge and needs were considered to finalize a list of 15 facilities per district as the priority list of PMCUs and DHs that require to be developed under the project. This amounts to 29% (135/469) of all PMCUs and DHs in the four provinces.

5. This output will develop the physical infrastructure of the identified facilities based on a prior agreed, MOHNIM approved, physical space norm for providing the expected expanded service functions in PMCUs and DHs outpatient care units. The designs for the renovation and upgradation will be based on this standard. The list of 135 facilities in the four provinces identified for development is in **Annex 4.**

6. This output will also support to purchase the immediate medical equipment needs which were identified by carrying out a stocktaking of gaps against current guidelines. Equipment required for improving laboratory services, emergency treatment services, dental services, and non-communicable disease related clinical services are included. The medical and general furniture required to furnish the renovated and developed PMCUs and the DHs will be procured as soon as the renovations are completed by the second year of project implementation.

7. In addition to the immediate medical equipment needs, the MOHNIM and the provinces are reviewing the existing package of essential health services to identify the service package that is required to expand the primary health care functions. This assessment is expected to be completed by the MOHNIM by end-2018. The additional equipment that would be needed to address these essential service package (ESP) at the PHC level will be procured from the second year of project implementation. The additional services may include services for elderly care, services for mental health, and more comprehensive non-communicable diseases and risk factor prevention related care at the PHC level, rehabilitation and disability care services and additional laboratory services.

b. Development of primary preventive care services

8. The preventive health services are provided via the medical officer of health areas which are geographically demarcated. Each Medical officer of health area serves a catchment population of about 60,000 to 100,000. Preventive health services are provided by field level officers from grass root level (public health midwives) to public health Inspectors and are supervised by the medical officers of health at the divisional level and at the regional level by the medical officers for maternal and child health, for epidemiology, for non-communicable diseases, for mental health, dental services etc. The preventive health clinics for maternal, child health, nutrition services are held at medical officer of health offices or in the field health centers. There are approximately 8-15 field health centers distributed across each of the 132 medical officer of health areas in the four provinces. The field health centers also include the staff quarters required for field health staff (public health midwives) and office space for the field health staff (PHMs) and Public Health Inspectors (PHIs).

9. Under this sub-output, the project intends to renovate and refurbish at least one field health center per medical officer of health area (132 medical officer of health areas in the four provinces). The designs and renovations will also be based on the MOHNIM approved physical space norm for PHCs.

10. In addition, under this sub-output, the project will enhance the mobility levels of the field health staff, especially the medical officers to expand and further improve and better supervise

the preventive health services. Approximately 40 vehicles will be provided to medical officers of health and to regional level medical officers for maternal and child health services for supporting improved preventive and promotive health services in the 4 provinces. In addition, this output will support the within district drug distribution system with the purchase of 9 covered trucks for each of the regional medical supplies divisions under the districts.

11. The output 1.2 also supports 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. This output will support the hiring of a firm to review of the available nutrition related information, education and communications material with a view to updating and developing IEC material and for developing material for nutrition advice and guidance on complimentary feeding with suggestions on quantity, diversity and frequency for feeding children between 6 months to 2 years, to provide training in nutrition and reproductive health counseling and to further support interventions for mothers and children under 5 years and to promote community health and nutrition promotion and use of PHC.

c. Public awareness and behavior change communication for increasing PHC utilization

12. The objective of this output is to create demand and support a behavior change of health seekers who regularly bypass PHC services. This output will also support to encourage utilization of nutrition services and wellness and healthy living promotion in the community. Public awareness campaign will inform and encourage the community, adult men and other difficult to reach groups, mothers of children under 2 years, etc. to seek care at the nearest PHC facility (MOH office or the PMCU or DH) for preventive and curative care respectively. Moreover, the campaign will also promote the nine selected clusters and the related MOH areas for (i) wellness and healthy lifestyle; (ii) integrated services such as nutrition, NCDs, and elderly care; and (iii) for convergence with other vertical programs (malaria, HIV, tuberculosis, leprosy, sexually transmitted diseases, etc.). This output will also support better utilization of the nutrition clinics by mothers with children under 2 years of age with the support of additional targeted nutrition promotion programs in high child malnutrition areas in the provinces. This output will help further develop the communications strategies for this purpose and finalize the scope of work for a consultant firm to carry out the design and implementation of the campaign. This task will be facilitated, monitored and managed by a consultant (communications specialist) financed under this output.

13. This output will also support the purchase of nine health promotion vehicles for each of the district level health education officers to support and enhance the health promotion activities in the four target provinces.

d. Strengthen PHC management for continuity of care

14. **Strengthen PHC management for continuity of care:** This sub-output will strengthen mechanisms to establish continuity of care and provide a higher quality, more comprehensive, package of care primarily to PHC level health seekers in the target provinces. As part of this effort, on a pilot basis, each of the 9 districts identified a cluster consisting of PHC level hospitals that will be functionally linked to one apex secondary care level facility. This sub-output will support the provincial and regional health staff to propose and implement strategies to improve continuity of care in these clusters via district specific proposals submitted to each of the PIUs. In addition, to activities related to clusters, this sub-output will support province and district health staff to develop proposals (which will include detailed activity plans) to further support better delivery of

PHC services under five broad areas: (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 counseling; (iii) IT for better patient management and disease control, including e-Health cards, linking preventive and curative care, referral systems, medical supplies, geographical information system, distant learning services, 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). Upon approval of proposals by the provincial coordination committee, funds will be managed by the respective PIU on behalf of the project proposal implementing team.

15. The implementation arrangement for utilizing the resources based on proposals is described in detail in a guideline (**Annex 3**). It is expected that, towards the final years of project implementation, successful pilots on reforming PHC service delivery models can get incorporated as national reforms to improve PHC service delivery in Sri Lanka.

2. Output 2: Health information system and disease surveillance strengthened

16. This output intends to strengthen health and disease surveillance to provide real time sharing of health information across levels of facilities and across different episodes of care for an individual patient. This will help enhance the disease surveillance capacity of the system and will establish a system for continuity of care to health seekers. This system will initiate to establish a real time link from curative to preventive primary health care for early initiation of disease investigation of the notifiable diseases by the field based public health inspectors attached to the medical officer of health areas.

17. In addition, this output intends to also support the government of Sri Lanka to implement the recommendations of the Joint External Evaluation of the International Health Regulations with a special focus at the points of entry and inbound health assessment services. In addition, this output will support infection prevention and control (IPC) via capacity development and strengthened health care waste management initiatives introduced in the pilot nine clusters.

18. Output 2 of the project intends to address the following two sub-outputs:

(i) Adopt health Information technology (HIT) for better continuity of care and disease surveillance.
(ii) Implement International Health Regulations (IHR) recommendations.

a. Health information technology for better continuity of care and disease surveillance

19. The output will first strengthen medical information to provide real-time sharing of health information vertically and horizontally across health facilities and across different episodes of patient care. This will help enhance the referral system, quality of patient care, and establish a system of continuity of care for health seekers. In each of the nine districts, at least one cluster of linked facilities (all PMCUs and divisional hospitals, Medical Officer of Health services, one apex hospital, a secondary health services facility) will be identified based on health-seeking behavior. The total number of facilities that will establish the system would be approximately 111 facilities

grouped across the 9 clusters in each of the 9 districts and approximately 40 Medical Officer of Health areas connected or falling within the clusters.

20. This sub-output will initially hire the services of a software consultancy firm to review, adapt and develop architectural design, data flow and management and administrative functions for an inter-operable HIT system for piloting in each of the 9 clusters. The firm is expected to utilize the current knowledge and experience of the existing services and platforms in the health sector. In addition, the necessary changes to connect modules that are necessary to produce disease surveillance information to the Epidemiology unit and disease management information linked to the medical statistics unit of the MOHNIM will be included. In addition, the Medical supplies management information system which is currently operational up to the level of regional drug stores in each of the districts will be further linked to each of the PHCs in the four provinces to further enhance the drug distribution and estimation systems at the PHC level. The project will also support the patient e-Health card system, referral system, staff training, computers, and peripherals required for this system along with the investments for internet connectivity.

21. The cluster HIT will also be used to strengthen disease surveillance, including for the timely reporting of the 28 notifiable diseases of Sri Lanka. The project will support the MOHNIM Epidemiology Unit with servers and consulting services for software to link the cluster health information system with disease surveillance.

22. This sub-output will also support 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 MOHNIM. The GIS services will include mapping of patients with identified diseases (e.g., chronic kidney disease of unknown origin, malnourished children, etc.) or help in mapping disease outbreaks. The province and district planning units will be strengthened with equipment for GIS mapping and analysis and a local consultant will be hired to develop the capacity of the province and district staff to use GIS for monitoring, planning and disease and facility mapping in the health sector.

23. Using HIT, the MOHNIM, the medical statistics unit, medical supplies division and the management and development planning unit, NIHS will also be linked to the four provinces to strengthen GIS based cluster planning and management, facility management including drug supply management, construction and environmental monitoring, and waste management.

24. The Regional Epidemiologists (medical officers responsible for disease surveillance and monitoring) are district based medical officers and are responsible for communicable disease prevention and control activities including disease surveillance. They carry out supervision and monitoring of case-based investigations at the community level and are held with the responsibility of communicable disease outbreak investigations and early attention for health emergencies. Therefore, under output 2.1 of the project, the regional epidemiologists are provided with mobility support with the purchase of the four vehicles for their use (required only for the districts of Anuradhapura, Nuwera Eliya, Badulla and Matale as the other five districts have vehicles for their respective regional epidemiologists).

b. Implement International Health Regulations (IHR) recommendations

25. Quarantine Unit is the main body involved with implementation and coordination of International Health Regulations (IHR 2005) and maintain the border health security to prevent incoming health threats to Sri Lanka. There are eight port and airport health offices under

quarantine unit and technical staff of quarantine unit monitors and supervises these activities. Out of the ports of Sri Lanka, four ports are authorized to issue ship sanitation certificates and two are designated. Based on the joint external evaluation (JEE) carried out by the MOHNIM in collaboration with WHO in 2017, some of the identified key gaps and recommended priority actions related to strengthening ports of entry (POEs) to improve their core capacities are supported under the project.

26. Under output 2.2, equipment required to meet the core capacity levels at the POEs are supported (to all 8 POEs) and mobility is enhanced at the two designated ports (with 2 vehicles). In addition, to further strengthen the disease surveillance related tasks carried out by the quarantine unit, the currently ongoing web-based surveillance system for notifiable diseases is further strengthened. In addition, this output supports developing of soft skills such as training of health personnel on IHR and quarantine, and other training related to use of quarantine manual, surveillance, and vector control. This sub-output will also seek the services of a local consultant to review and develop the legal regulatory framework for better implementation of IHR in Sri Lanka.

27. In addition, output 2.2 will support infection prevention and control activities in the cluster facilities. This will include improving of soft skills and knowledge on infection prevention and control of primary health care staff in the cluster facilities. In addition, this output will support health care waste management services with the purchase of required equipment for the cluster facilities in the 9 districts and will support to develop health care waste management plans for each of the clusters.

28. As part of national health security, the MOHNIM has recognized the need to address health issues of inbound migrants. A service agreement is operational between MOHNIM and International Organization for Migration (IOM) for a period of 3 years with effect from 2018 for IOM to carry out inbound migrant’s health assessment. But at the end of the 3 years (from 2021) this function is expected to be carried out by the MOHNIM. Therefore, this output will support the development of the designs for the facility and also support developing the required documentation via consultancies.

3. Output 3: Policy development, capacity building, and project management supported

29. The output 3 of the project intends to support policy development to enhance the impact of the project activities. As the project envisages to strengthen PHC in Sri Lanka with a focus in the lagging provinces to provide a responsive and a comprehensive package of services to the population, it is essential to focus in a few prioritized policy areas that need to be addressed for successful implementation of the project. This output will support policy related tasks to improve PHC services in Sri Lanka, as well as capacity development, and support to project management and results monitoring.

30. The output 3 of the project intends to support the following tasks described in the three sub-outputs.

(i) Policy development support
(ii) Capacity development
(iii) Project management and results monitoring

a. Policy development support

31. This sub-output will support policy and strategy development for comprehensive PHC and continuum of care, especially for vulnerable groups living in plantations, and with priority to nutrition and reproductive health. A package of essential health services is being developed by MOHNIM including for NCDs and emergency services. Facility and equipment standards are also being developed. MOHNIM is also developing a national policy for human resources for health. The project will provide selective support in the form of consulting services and workshops for various policy initiatives of MOHNIM. This will include (a) development of clusters to explore strategies for strengthening PHC using the PHC Innovation Fund; (b) personnel workforce planning with a special focus on PHC workforce; (c) development of policies and guidelines related to the implementation of the Essential service package including the development of policies, management reforms, new guidelines and standard operating procedures for implementing the ESP related new interventions at the PHC level in the target provinces; (d) review and development of the reproductive health related guidelines etc.

b. Capacity development

32. This sub-output will support MOHNIM with capacity building / training/ resources for workshops for nutrition and health promotion, cluster planning and management, infection prevention and control, distance learning for GIS and other areas including family health, gender actions, and environmental monitoring and waste management. In addition, this sub-output, will provide resources for training for relevant MOHNIM staff for PDHS, RDHS and their PHC staff to expand knowledge, by attending local and international conferences and by attending exposure visits for observing primary health care delivery in selected countries and by undergoing structured 2-4-week local training programs on family health, gender, infection prevention and control, health care waste management, monitoring and evaluation methodologies. This sub-output will also support the implementing of the gender action plan and environmental and social safeguards, and support training in procurement and financial management.

33. In addition, sub-output 3.2 will also support the development of a distance learning center at the National Institute of Health Sciences initially for introducing distance learning training programs on GIS use in PHC, family health, gender mainstreaming, HCWM, PHC training to PHC health staff in the target provinces.

c. Project management and results monitoring

34. The project will also support the operating costs (both fixed and variable) related to central and provincial project management and coordination, operating project management unit (PMU) and the 4 project implementation units (PIUs), establishing a project planning and results-monitoring systems in place. In addition, this sub-output will support the conduction of a baseline and an end line survey including case studies and impact evaluations. In addition, this sub-output will support the consultancy firm to carry out design and supervision of civil works assignments identified under the project.

ANNEX 2: TERMS OF REFERENCE FOR PROJECT MANAGEMENT STAFF

Designation	Qualification and Experience	Terms of Reference
Project Director	A Bachelor's Degree in relevant field recognized by the University Grants Commission with at least 12 years of post-qualification experience at managerial level with minimum 6 years at Senior Managerial level Or A Bachelor's Degree in relevant field recognized by the University Grants Commission and a Post Graduate Degree in the relevant field or full membership of a recognized professional institution in the relevant field with minimum 10 years post qualifying experience at managerial level.	• Provide necessary support and guidance for preparing detail project report for Health System Enhancement project • Conduct meetings with senior authorities of the government to finalize the project documents and project management system • Facilitate procurement and technical evaluation committees in consultation with ministry to initiate procurement process and ensure PMU staff follows GOSL/ADB guidelines to implement the procurement plan where applicable • Provide necessary guidance and ensure technical advice to ensure effective project implementation by the PMU and PIU project staff in provinces • Establish project monitoring and supervision system and provide required project performance related reports to the national Project Steering committee (PSC) and ADB • As the secretary to the PSC and will support the chairperson of PSC to conduct review meetings as required. • Ensure submission of monthly/quarterly project performance reports and annual accounts reports to GOSL/ADB • Ensure preparation of consolidated financial statements for the project and submission to GOSL/ADB. • Review implementation issues and take necessary actions to mitigate the same in consultation with relevant agencies • Organize procurement processes; Technical Evaluation, documentation, bidding documents, specifications, bid evaluation reports, etc., for procurement activities under the project • Oversee procurement decisions taken by PMU and PIUs and provide advice as appropriately. • Ensure that the PMU & PIU follow ADB procurement and financial management guidelines • Ensue establishment of a proper project filing system at PMU and PIU to keep all project correspondents for reviewing and auditing • Perform any other duties and responsibilities as assigned by the Secretary of MOHNIM or Ministerial Project Steering Committee
Deputy Project Director	A Bachelor's Degree in the relevant field recognized by the University Grants Commission with minimum 11 years of post-qualifying experience at Managerial level out of which 05 years at Senior Managerial level Or A Bachelor's Degree recognized by the University Grants Commission and Post Graduate Degree in the relevant field or	• Support the Project Director to provide necessary assistance and guidance when required. Oversee Project Director's responsibilities in his/her absence. • Support and guide the project preparation and also provide oversight during project implementation. • Facilitate PMU staff to implement the procurement plan according to the ADB guidelines and establish project procurement committee and

Designation	Qualification and Experience	Terms of Reference
	full membership of a recognized professional institution in the relevant field with minimum 9 years post qualifying experience at managerial level. Class 1 officer of a Government All Island services or a similar status in the relevant field with minimum 08 years' experience at the Class 1 post.	technical evaluation committee in consultation of the Ministry to start procurement process • Provide necessary guidance and technical advices to PMU and PIU project staff for project implementation • Support for establishing project monitoring and supervision system and provide project performance reports to the national Project Steering Committee (PSC) and ADB • Work as the Secretary of PSC and organize PSC meetings in the absence of the Project Director. • Facilitate submitting quarterly project performance reports and annual accounts reports to ADB • Ensure preparation of consolidated financial statements for the project as a whole, for submission by the Project Director to the PSC and the ADB • Support the Project Director for review of implementation issues and in taking necessary actions to mitigate them in consultation with relevant agencies/units. • Support the Project Director in procurement processes; Technical Evaluation, documentation, bidding process, specifications, bid evaluation reports, etc., for procurement activities under the project • Ensure that the PMU & PIU follow ADB procurement and financial management guidelines • Ensue establishment of a proper project filing system at PMU and PIU to keep all project correspondents for reviewing and auditing • Oversee PMU functions when the Project Director is away from office. • Perform any other duties and responsibilities as assigned by the Project Director
Project Coordinator	A Bachelor's Degree in the relevant field recognized by the University Grants Commission with minimum 11 years of post-qualifying experience at managerial level and a minimum of 5 years at Senior Managerial level. Or A Bachelor's Degree recognized by the University Grants Commission and a Postgraduate Degree or full membership of a recognized professional institution in the relevant field with at least 09 years post qualifying experience in managerial level. Or Class 1 officer of a Government All Island services or a similar status in the relevant field with minimum 07 years' experience at the Class 1 post.	• Assist Project Director/Deputy Project Director in various activities such as budget monitoring, procurement planning, office management and organizing meetings (High Level Ministerial Project Steering Committee, Project Management Unit etc.,) • Ensure that regular reviews are conducted as per timelines, necessary updates etc., are shared with concerned units and organizations (Provinces, ADB), and action taken, reports are collected and presented to concerned authorities. • Bring to the attention of the Project Director any operational challenges in a timely manner and propose solutions and alternative strategies for overcoming these issues • Assist Project Director/Deputy Project Director and other technical officers in ensuring the project adhere to framework and all documentation is maintained appropriately • Maintain and monitor project plans to facilitate within the given timelines. Identify and resolve operational problems, improvements required to

Designation	Qualification and Experience	Terms of Reference
		meet the standards in processes in consultation with the Project Director/Deputy Project Director. • Work closely with Project Implementation Units (PIUs) in 4 Provinces and other strategic partners to ensure project interventions, implementation is in line with ADB/GOSL policies, procedures, rules and regulations where applicable. • Collate project risks and issues from various sources (PMU, PIU, other stakeholders, vendors) and present it to Project Director/Deputy Project Director for initiating required action. • Ensure that Project Management Unit (PMU) and all Project Implementation Units (PIUs) team members understand the scope of the project and their individual responsibilities. • Provide administrative support to PMU and PIUs as and when needed • Any other duty and responsibility assigned by the Project Director/Deputy Project Director.
Procurement Specialist	A Bachelor's Degree in the relevant field recognized by the University Grants Commission with minimum 10 years of post-qualifying experience at managerial which includes minimum 5 years at Senior managerial level Or A Bachelor's Degree in relevant field recognized by the University Grants Commission and a Postgraduate Degree or full membership of a recognized professional institution in the relevant field with minimum 8 years of post-qualifying experience at managerial level. Or Class 1 officer of a Government all Island services or a similar status in the relevant field with minimum 7 years' experience in the Class 1 post.	• Support and assist the Project Director/Deputy project Director in all procurement and contract management matters • Facilitate development of Procurement plan with timelines for all procurement under the project (Central and Provincial) levels. • Assess the capability of relevant PMU and PIU staff in procurement and contract management and ensure their capacity development for following ADB systems and good practices • Preparation of bid documents for goods, civil works and services, and implementation of the procurement process according to the ADB guidelines • Support in finalization of procurement plan and initiate all procurement activities including advance procurement. • Guide and advise PMU and PIU staff and ensure all activities related to bid invitation, evaluation, contract awarding, contract implementation, works supervision and reporting, is undertaken on a timely basis. • Coordinate with project Finance Manager for computation of payments, communications with contractors, assessing suggested contract variations and timely payment to suppliers. • Development of procurement performance monitoring system and ensure adherence by the PMU and PIUs. • Ensure procurement procedures followed are in compliance with legislation, policies, guidelines, systems and procedures of ADB, and the relevant updates • Monitor and report compliance with required procurement and contract management systems including any improvements to them • Assist the Ministry, PMU and PIUs Procurement Officers in ensuring compliance with applicable documentation requirements i.e. ADB No Objection Letter Policy

Designation	Qualification and Experience	Terms of Reference
		• Provide technical advice on procurement strategies for packaging works for subprojects and consultant services to PMU and PIUs; • Ensure any non-compliance in procurement and contract management is detected through verification of claims and reported to the PMU management, and others. Required action is taken based on agreements and suggestions for improvements • Ensure monitoring reports are regularly prepared on Tender Evaluation Committee processes and circulated • Carry out any other procurement and contract management related activities in the program assigned by Project Director/Deputy Project Director
Finance Manager	A Bachelor's Degree in the relevant field recognized by the University Grants Commission with at least 10 years of post-qualifying experience at Managerial level out of which 5 years should be at Senior Managerial level. or A Bachelor's Degree which is recognized by the University Grants Commission and a Postgraduate Degree or full membership of a recognized professional institution in the relevant field with at least 8 years post qualifying experience at Managerial level. or Class 1 officer of a Government All Island Services or a similar status in the relevant field with at least 7 years' experience in the Class 1 post.	• Make the necessary arrangements to obtain the funds from the ADB imprest account • Establish and maintain imprest and other accounts acceptable to the government and ADB. • Establish appropriate systems for financial control, checks, and balances for financial matters and expenditure items according to ADB guidelines • Prepare recurrent and capital expenditure budgets for the project in line with approved funding arrangements • Finalization of annual accounts of project and submit it to ADB for review and Auditor General for auditing • Check withdrawal applications and submit to ADB for replenishment according to ADB Disbursement Handbook • Establish financial management system for all expenditure of the project Prepare annual budget requirement of the project and submit to MOHNIM to include in the annual budget proposal • Provide advice to the preparation of project accounts in PIUs on project financial management system and review monthly accounts statements submitted by PIU. • Provide a fund utilization report with project disbursement progress to national Project Steering Committee (PSC) for review • Maintain separate records and accounts adequate to identify the financing resources received and expenditures made on the Project, including the goods, works, and services financed out of the loan proceeds and out of counterpart funding. • Use Statement of expenditure (SOE) procedures to reimburse eligible expenditures and to liquidate advance made into the imprest accounts • Coordinate with the Accountants of PIUs regarding financial management matters. • Implementation of financial management assessment recommendations by ADB • Coordinate with the project internal auditor to facilitate conducting audit checks and strengthen internal control mechanisms for PMU and PIUs

Designation	Qualification and Experience	Terms of Reference
		• Any other duties and responsibilities assigned by the Project Director/Deputy Project Director.
Internal Auditor (PS 4)	A Bachelor's Degree in the relevant field recognized by the University Grants Commission or having passed the intermediate examination of a recognized professional institute in the relevant field with minimum 07 years post qualifying experience in the relevant field. or An officer of the Government All Island Services Class III/II or above or similar status in the relevant field with at least 7 years' experience in Class II/III post	• Perform assessment of the project financial management system, including internal controls. This would include aspects such as adequacy and effectiveness of accounting, financial and operational controls exercised by the implementing unit/s and suggestions of improvement, if any • Ensure utilization of funds for the allocated activity in accordance with the relevant financial procedures and regulations with due attention to economy and efficiency • Ensure Accounting Principles are followed by all entities that are authorized to incur expenditure under Health System Enhancement Project • Ascertain the reliability of integrity, controls, security and effectiveness of the operation of computerized system, identify constraints, if any, and in adhering to the internal control procedures • Assessment of the adequacy of financial and administrative delegation and segregation of duties and controls and assessing expenditures incurred/ advances provided are duly authorized • Review and report on Implementation of recommendations of the Financial Management Assessment and Procurement Capacity Assessment prepared by ADB • An assessment of efficiency and timeliness of funds flow and reporting mechanism at the level of PMU and PIUs in provinces implementing project activities • Ensure Expenditure Statements submitted by PMU and PIUs have been correctly accounted for and disbursements made to them are as prescribed under ADB/GOSL rules, regulations, procedures and guidelines. • Ensure expenditure incurred are in reference to the budget allocation approved by MOHNIM/ADB and in accordance with the prescribed operational guidelines and agreement or any other clarifications issued from time to time. Procurement procedures have been followed per ADB procurement guidelines including the establishment of grievance redresses mechanism relevant for unsuccessful bidders • Adequate and proper supporting documents, namely, purchase orders, tender documents, invoices, vouchers, receipts, pay bills, TA bills etc. are maintained and linked to the transactions • Reconciliation of bank statements and project account/s is regularly carried out on a monthly basis and necessary corrections on account of Bank's credits/debits and stale cheques are accounted for concurrently. • Assets: completeness, existence, recording, safeguard and utilization for the purpose intended including, physical verification of sample of assets. • The scope of work will additionally include detailed review of the issue of advances, staff advances

Designation	Qualification and Experience	Terms of Reference
		and cash payments for items purchased including petty cash imprest account. • Prepare quarterly internal audit reports for Management review. • Any other duties and responsibilities assigned by the Project Director/Deputy Project Director
IT Specialist	Bachelor's Degree in the relevant field recognized by the University Grants Commission or having passed the intermediate examination of a recognized professional institute in the relevant field with minimum 7 years post qualifying experience or An officer of the Government All Island Services Class III/II or above or similar status in the relevant field with at least 7 years' experience in Class II/III post	• Ensure implementation of ICT related recommendations/activities under the project while ensuring adherence to any existing standards, guidelines and procedures of GOSL and ADB. • Providing advice and assistance in procurement of new ICT equipment for the project and provision of technical specifications and information on best options available in both local and international markets • Monitoring of backup and restoration procedures for both server and local drives where applicable. • Organize periodic training for projects staff operating ICT equipment. • Review the GIS data base and establish software package for the implementation of Cluster system PHC management. • Provide advice, guidance and support to PMU staff and PIU staff in provinces on ICT related matters • Establishing MIS procedures and systems for ensuring data being added to MIS, while ensuring information and data security by implementing sound procedures • Provide easy to use MIS manuals and troubleshooting guidelines • User test the MIS system and ensure adaptation necessary and provide troubleshooting support • Any other duties and responsibilities assigned by the Project Director/Deputy project Director.
Project Secretary	GCE (O/L) examination passed in six (6) subjects with three (3) credits passes including English and Sinhala/Tamil language with a secretarial course from a recognized institution or appearing in Chartered Secretary examination leading to with minimum 4 years' experience in relevant field. or A chartered Secretary with 3 years' experience in relevant field. Basic knowledge on MS Office package and operating computers Good knowledge in written and spoken English	• Receive telephone calls and forward them to concern PMU staff • Receiving and dispatching all office communication by e-mail, fax, post, etc. with the support of Office Assistant • Maintain adequate system for receiving filing and dispatching communications. Distribute these communications to the relevant recipients for action or information (assures copying and further distribution) • Maintaining appropriate logs and chronological files of all written communication as well as the general archive of the office • Regularly check the incoming & outgoing postal mail on due time • Maintaining an updated address and phone lists of project counterparts, staff and all Implementing Agency staff working on the project • Providing secretarial services as required by Project Director (i.e. write correspondence, phone calls, photocopies, etc.) • Arranging appointments of the Project Director and other senior staff • Administrative support for the PMU.

Designation	Qualification and Experience	Terms of Reference
		• Follow up logistical arrangement for staff missions and other travel arrangements and maintain the mission log • Organize travel arrangements and hotel bookings for staff and visitors. • Any other duties and responsibilities assigned by the Project Director/Deputy Project Director and other senior staff
Project Office Assistant	Passed six subjects in GCE (O/L) including Mathematics, and Sinhala or Tamil. Not less than 1-year work experience in a permanent carder of a government entity. Experience in a foreign funded development projects implemented by Government entities would be an added qualification. Basic knowledge on computer and office equipment. Working knowledge in English	• Will support the office secretary for screening and directing telephone calls when required • Receives, greets and directs visitors, facilitates hospitality for official meetings • Receives and prepares for sending the office mail (postage & courier), faxes etc. • Files and log correspondence, including incoming and outgoing communications as instructed by senior staff members. Ensure files and records are maintained in good order while maintaining its confidentiality • Photocopies or scans materials upon request • Assist and provide administrative and logistics support to office • Assists in receiving and safekeeping of office supplies. Archiving documents/folders in consultation with the office secretary. • Maintains contact lists of phone and postal mail addresses of government units, organizations and institutions • Provide support and assistance to project related activities • Perform any other duties and responsibilities as assigned by the Project Director/Deputy Project Director and other senior staff.
Driver	Completed Secondary Level education with 3 years of work experience as a driver with a safe driving record. Should have knowledge of driving rules and regulations, local routes	• Drive the assigned vehicle for the Project Director/authorized staff and personnel on official business travel • Ensure day-to-day maintenance of the assigned vehicle; checks oil, water, battery, tires, etc.; Get minor repairs done and timely inform arranging for any other repairs necessary to keep the vehicle in good running condition. Keep the vehicle safe and technically sound at all times; maintain the vehicle in clean conditions. • Ensure all required documents/supplies including vehicle insurance, vehicle registration, vehicle logs, fuel and mileage records etc., are regularly updated. . • Assist in the delivery of mail/supplies etc., • Render service during Saturdays, Sundays and holidays and beyond the designated official working hours when required • Perform other official duties as may be directed by the Project Director /authorized staff
Project Officer Monitoring	Bachelor’s Degree in the relevant field recognized by the University Grants Commission or having obtained a certificate of proficiency not below than	• Develop required monitoring system and formats for regular monitoring of project activities at different levels in line with the DMF and the M&E plan

Designation	Qualification and Experience	Terms of Reference
	the NVQ level 7, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 4 years' experience in the required area of specialization Having obtained a certificate of having obtained a certificate of proficiency not below than the NVQ level 6, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 9 years' experience in the required area of specialization Having obtained a certificate of having obtained a certificate of proficiency not below than the NVQ level 5, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 14 years' experience in the required area of specialization	• Support the IT expert in setting up program monitoring systems for activities and results and ensure the accuracy of data • Monitoring and Evaluation of progress and performance against planned work against DMF. • Plan for and manage periodic evaluation activities for the project • Provide technical advice on performance indicators and ensure that realistic mid-term and end-term project targets are defined; provide timely and required information for periodic review reports for the ministerial steering committee and other stakeholders. • Visit project areas for field monitoring of activities and suggest required action • Work closely with the MOHNIM across the project area to ensure that relevant data for measuring project performance is collected (based on project indicators) • Arrange dissemination of information obtained from reviews, monitoring and evaluation and other publications of relevant organizations. • Build capacity within the project for M&E function • Perform any other duties and responsibilities as assigned by the Project Director/Deputy Project Director
Project Officer Technical	Bachelor's Degree in the relevant field recognized by the University Grants Commission or having obtained a certificate of proficiency not below than the NVQ level 7, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 4 years' experience in the required area of specialization Having obtained a certificate of having obtained a certificate of proficiency not below than the NVQ level 6, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 9 years' experience in the required area of specialization Having obtained a certificate of having obtained a certificate of proficiency not below than the NVQ level 5, issued by a technical/ Vocational training institute accepted by tertiary and vocational education Commission for a post related to a technical field and at least 14 years' experience in the required area of specialization	• will be responsible for supporting in project planning, implementation, and monitoring activities at PMU level • Facilitate Developing detailed project implementation plan and share relevant guidelines to provinces • Supporting the project officer (monitoring) in developing the M&E framework for the project. • Provide technical inputs to the procurement staff in related activities • liaise with provincial/project implementation units and guide them for project implementation as per the overall implementation plan • Undertake field visits for assessing project related activities at PIU and field level • Review project monitoring report and suggest remedial actions • Perform any other duties and responsibilities as assigned by the Project Director/Deputy Project Director

A. Project Implementation Unit

Designation	Qualification and Experience	Terms of Reference
Deputy Project Director	A Bachelor's Degree in the relevant field which is recognized by the University Grants Commission with at least 11 years post qualifying experience at Managerial Level out of which 5 years should be in the Senior Managerial Level A Bachelor's Degree recognized by the University Grants Commission and a Post Graduate Degree in the relevant field or full membership of a recognized professional institution in the relevant field with at least 09 years post qualifying experience at Managerial level. Class 1 officer of a Government All Island services or a similar status in the relevant field with minimum 08 years' experience at the Class 1 post.	• Lead the Project Implementation Unit (PIU) in the Province and work in close coordination with Chief Secretary's office, Provincial Secretary of Health, Deputy Chief Secretaries of Planning and Engineering, members of the MOPCLG, Regional Health Director and Design and Supervision Consultants. • Advise procurement officer at PIU to implement the procurement plan according to the ADB guidelines and establish project procurement committee and technical evaluation committee in consultation with Chief Secretary's office to start procurement process, • Provide necessary guidance and technical advices to PIU staff for project implementation, • Establish project monitoring and supervision system and provide project performance reports to the Project Director at PMU. • Work as the Secretary of Project Coordinating Committee (PCC) and organize PCC meetings bi-monthly or quarterly as required, • Ensure development of project financial statements and review for timely submission to PMU. • Review implementation issues and take necessary actions to mitigate them in consultation with relevant agencies, • Facilitate the procurement processes at PIU level through ensuring preparation of bidding documents, specifications, bid evaluation reports, etc. as per ADB guidelines. • Ensure the internal audit function at PIU is carried out by the PMU Internal auditor on a periodic basis. • Establish project monitoring and supervision system and provide required project performance related reports to the Project Coordinating Committee (PCC) and ADB • As the secretary to the PCC will support the chairperson of PCC to conduct review meetings on a bi-monthly basis. • Ensure submission of monthly/quarterly project performance reports, consolidated accounts report to PMU for GOSL/ADB review • Review implementation issues and take necessary actions to mitigate the same in consultation with relevant agencies • Perform any other duties and responsibilities as assigned by the Ministerial Project Steering Committee or PCC (Project Coordinating Committee) or Project Director

Designation	Qualification and Experience	Terms of Reference
Procurement Officer	A Bachelor's Degree in the relevant field which is recognized by the University Grants Commission or having obtained a certificate of proficiency not below than the NVQ level 7 issued by a technical/vocational training institute accepted by tertiary and vocational education commission for a post related to a technical field and minimum 2 years' experience in the required area of specialization. Having obtained a certificate of proficiency not below than the NVQ level 6 issued by a technical/vocational training institute accepted by tertiary and vocational education commission for a post related to a technical field and minimum 7 years' experience in the required area of specialization Having obtained a certificate of proficiency not below than the NVQ level 5 issued by a technical/vocational training institute accepted by tertiary and vocational education commission for a post related to a technical field and minimum 12 years' experience in the required area of specialization	• Support the Deputy Project Director and the Procurement Specialist (PMU) in all procurement and contract management matters; • Strengthen capacity of PIUs staff in all procurement and contract management matters, ensuring that they have a sound understanding of the ADB systems and good practices; • Prepare bid documents for goods, civil works and services, and implementation of the procurement process according to the ADB guidelines, • Ensure the procurement performance monitoring system is integrated into PIU's monitoring system. • Ensure that procurement procedures are in line with systems/procedures as suggested by Deputy Project Director. • Monitor and report compliance with required procurement and contract management systems including any improvements to them; • Assist the Ministry and PMU and Procurement Specialist in the preparation of tender documents and review tender documents for correctness and compliance with applicable documentation requirements which includes documentation required for the ADB No Objection Letter Policy; • Provide necessary support in developing procurement strategies for packaging works for subprojects and consultant's services to PMU. • Ensure any areas of non-compliance in procurement and contract management are detected through verification of claims and reported to Deputy Project Director (PIU) and provide recommendation for remedial action. • Prepare regular Monitoring reports for Tender Evaluation Committees. • Carry out any other procurement and contract management related activities in the program assigned by Deputy Project Director
Project Engineer	A Bachelor's Degree in the relevant field which is recognized by the University Grants Commission or having passed the intermediate examination of a recognized professional institute in the relevant field and at least 7 years post qualifying experience in the relevant field. or An officer of the Government All Island Services Class III/II or above or similar status in the relevant field with at least 7 years' experience in Class II/III post	• Provincial project civil works supervision and delivery of all aspects including but not limited to procurement, safeguards, detailed engineering design, financial and social development for all outputs • Develop strong working relationship with executing agency and provincial agencies, implementing agencies, civil society organizations and PIU staff, and ensure smooth coordination among them. • Confirm commitments to implementation of civil works from all stakeholders. • Coordinate and work with the Team Leader of Detailed Design and Supervision Consultant to develop detailed time bound implementation schedules. • Assist PIU to comply with the relevant policies and guidelines of the government and ADB for implementation of civil works.

Designation	Qualification and Experience	Terms of Reference
		• Review and recommend the detailed designs, cost estimates, resettlement plan, EMP, GAP, and other contract documentations as necessary. • Assist PIU staff and local consultants in the management of civil works and goods contracts and in the supervision of construction and subsequent commissioning of works. • Assist in arranging for smooth handover of the project facilities to the agencies responsible for operation and maintenance including advice and assistance on the preparation of all documentation necessary (i.e. as-built drawings) to close out contracts. • Monitor and review proper and timely submission of regular progress reports on civil works to executing agencies and PMU, particularly the progress against target indicators. • Initiate actions in the event of any adverse, oblique and / or other variances against the original plan. • Assist and review in ensuring all resettlement and environmental impact mitigation measures are fully implemented, ensure associated reporting is completed, and minimize adverse environmental impacts during construction • Provide site management guidance to PIUs and local consultants in relation to the construction. • Assist in project planning, scheduling, and reporting of sub-project activities of civil works. • Assist in ensuring the quality of all of the infrastructure components. • Assist the procurement officer in updating the procurement plan from time to time (at least annually). • Assist in the detailed monitoring and evaluation surveys. • Provide overall support for selection of contractors and suppliers, contract management, and quality control and inspection. • Ensure implementation of gender and social development measures, covering GAP and community participation plan. • Assisting in maintaining records, correspondence, and diaries; and provide the Client/ Employer with complete records and reports within the area of responsibility; • Ensuring efficient provision of on the job training to the staff members of PIUs in all relevant aspects of the efficient management and implementation of the Project procedures • Undertaking any other project management activities, as necessary, and assigned by the Deputy Project Director
Project Accountant	A Bachelor's Degree in the relevant field which is recognized by the University Grants Commission or having passed the intermediate examination of a recognized professional institute in the	• Make arrangements to obtain the necessary funds from the ADB imprest account; • Establish and maintain imprest and other accounts acceptable to the government and ADB;

Designation	Qualification and Experience	Terms of Reference
	relevant field and at least 7 years post qualifying experience in the relevant field. Or An officer of the Government All Island Services, Class III/II or above or similar status in the relevant field with at least 7 years' experience in Class II/III post.	• Establish appropriate systems for financial control, checks, and balances for financial matters and expenditure items according to ADB guidelines; • Prepare recurrent and capital expenditure budgets for the project in line with approved funding arrangements; • Maintain separate records and accounts adequate to identify the financing resources received and expenditures made on the Project, including the goods, works, and services finance out of the loan proceeds and out of local funds; • Assist the Deputy Project Director in preparation of disbursement plans in accordance with the Project Administration Manual • Prepare quarterly financial forecasts and requests for advancement of funds • Prepare budget estimates for all project activities, trainings/workshops/seminar • Review, arrange payment, and record all the project expenditure's vouchers in accordance with financial regulations of ADB and the Government • In-coordination with PMU/PIU summarize project expenses and prepare periodic financial reports and statements as required by GOSL/ADB and for other relevant units, entities and authorities • File all financial documents and prepare necessary facilities and support to work with audit agencies or financial inspection agencies as required • Provide guidance and update project staff at the PIU on financial and accounting procedures, regulations, reporting and record keeping. • Work closely with the Project Finance Manager (PMU) and Project Internal Auditor (PMU) to facilitate implementing project related activities per GOSL/ADB rules, regulations, guidelines and procedures • Closely liaise with PMU and PIU staff regularly to facilitate in executing accounting functions • Any other duties and responsibilities assigned by the Deputy Project Director
District Project Officer		• Adopt the monitoring systems and formats developed by PMU for district requirements related to regular monitoring of project activities. • Monitoring and Evaluation of progress and performance at the province. • Plan for and manage periodic evaluation activities for the project • Provide support to PMU/PIU for developing performance indicators for project mid-term and end-term targets. • Visit districts/project areas for field monitoring of activities and suggest required action

Designation	Qualification and Experience	Terms of Reference
		• Work closely with the District secretary's office and with provincial health ministry to ensure that relevant data for measuring project performance is collected (based on project indicators) • Arrange dissemination of information obtained from reviews monitoring and evaluation and other publications of relevant organizations. • Assist in conducting and organizing project steering committee meetings • Any other duties and responsibilities assigned by the Deputy Project Director
Project Secretary	Having passed the GCE (O/L) examination in six (6) subjects with three (3) credits passes including English and Sinhala/Tamil language with a secretarial course from a recognized institution or pursuing examinations leading to chartered Secretary with minimum 04 years' experience in relevant field. or A chartered Secretary with 3 years' experience in relevant field	• Receive telephone calls and forward them to concern PIU officers /staff • Receiving and dispatching all office communication by e-mail, fax, post, etc. with the support of Office Assistant • Maintain adequate system for receiving filing and dispatching communications. Distribute these communications to the relevant recipients for action or information (assures copying and further distribution) • Maintaining appropriate logs and chronological files of all written communication as well as the general archive of the office • Regularly check the incoming & outgoing postal mail on due time • Maintaining an updated address and phone lists of project counterparts, staff and all Implementing Agency staff working on the project • Providing secretarial services as required by Deputy Project Director (i.e. write correspondence, phone calls, photocopies, etc.) • Arranging appointments of the Deputy Project Director and other senior staff • Administrative support for the PIU. • Follow up logistical arrangement for staff missions and other travel arrangements and maintain the mission log • Organize travel arrangements and hotel bookings for staff and visitors. • Any other duties and responsibilities assigned by the Deputy Project Director and senior staff in PIU
Office Assistant	Passed six subjects in GCE (O/L) including Mathematics, and Sinhala or Tamil. Not less than 1-year work experience in a permanent carder of a government entity. Experience in a foreign funded development projects implemented by Government entities would be an added qualification. Basic knowledge on computer and office equipment and Working knowledge in English.	• Will support the office secretary for screening and directing telephone calls when required • Receives, greets and directs visitors, facilitates hospitality for official meetings • Receives and prepares for sending the office mail (postage & courier), faxes etc. • Files and log correspondence, including incoming and outgoing communications as instructed by senior staff members. Ensure files and records are maintained in good order while maintaining its confidentiality • Photocopies or scans materials upon request

Designation	Qualification and Experience	Terms of Reference
		• Assist and provide administrative and logistics support to office • Assists in receiving and safekeeping of office supplies. Archiving documents/folders in consultation with the office secretary. • Maintains contact lists of phone and postal mail addresses of government units, organizations and institutions • Provide support and assistance to project related activities • Perform any other duties and responsibilities as assigned by the Deputy Project Director and other senior staff in the PIU.
Driver	Completed Secondary Level Education Three years of work experience as a driver with a safe driving record Knowledge of driving rules and regulations, knowledge about local roads and conditions	• Drive the assigned vehicle for the Deputy Project Director/authorized staff and personnel on official business travel • Ensure day-to-day maintenance of the assigned vehicle; checks oil, water, battery, tires, etc.; Get minor repairs done and timely inform arranging for any other repairs necessary to keep the vehicle in good running condition. Keep the vehicle safe and technically sound at all times; maintain the vehicle in clean conditions. • Ensure all required documents/supplies including vehicle insurance, vehicle registration, vehicle logs, fuel and mileage records etc., are regularly updated. • Assist in the delivery of mail/supplies etc., • Render service during Saturdays, Sundays and holidays and beyond the designated official working hours when required • Perform other official duties as may be directed by the Deputy Project Director /authorized staff

ANNEX 3: GUIDELINES FOR PRIMARY HEALTH CARE INNOVATION FUND

A. Planned PHC Development in Sri Lanka

1. Sri Lankan's demand for health services is evolving because of population aging, changing lifestyle and disease burden, and medical and socio-economic developments. To maintain past achievements and respond to new challenges for universal health coverage, the country's public health system must be adjusted and scaled up.

2. Sri Lanka has developed an extensive network of preventive and curative health services with substantial human resources providing quality of care at low cost. However, with free patient choice to use any public health services. PHC services are often being bypassed in favor of secondary and tertiary hospitals (and private services for diagnostics).[19] This has resulted in less use and inefficiency of PHC and overloading of secondary and tertiary hospital with routine cases. A mix of factors likely contribute to this trend including public perceptions of health needs and services, staff and supply shortages, lack of diagnostic services and specialized care, limited preventive services for noncommunicable diseases (NCDs), and lack of a sound referral system.

3. The Government remains firmly committed to the unique Sri Lankan model of free choice of health services at no cost, which is a major driver for the country's strong health sector performance is. The Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM) notes that PHC is lagging behind in terms of its share of resources and investments compared to larger hospitals, and is planning to make PHC services more responsive to public demand by scaling up PHC providing a comprehensive package of health services and continuum of care with referral services. While this is expected to improve demand, MOHNIM also desires to explore innovative strategies to further improve PHC services, also for vulnerable groups.

4. In 2009, the MOHNIM Policy and Analysis Unit carried out an analysis of the existing health service structure and policies.[20] This led to the understanding that the health system was not geared to prevention and continuity of care for lifestyle related and chronic diseases. Proposed developments were shared at the National Policy Forum for Strengthening PHC in 2010. Protocols, tools and monitoring plans were developed to improve PHC. This included the development of a personal health record and clinic record for adults, emergency care guidelines, education material for health staff, an essential medicines list for NCDs, lifestyle guidance tools, checklists for institutional assessment for infrastructure and logistics and a social marketing tool.

5. In 2013, to increase demand for and quality of PHC, a "shared care cluster system" was proposed whereby a specialist hospital serves surrounding primary level hospitals.[21] This was based on the assumptions that (i) strengthening PHC will be overall cost-neutral for the sector, (ii) this will allow maintaining people's free choice of health services, and (iii) implementation of private sector price and quality control of services will reduce workload for public services.

6. According to the Master Plan 2016–2025, the aim is to improve the fully accessible PHC to provide personalized, family centered, continuity of care of good quality, where good health outcomes can be achieved with reduced out of pocket expenditure to the people. This is conceived as the basis for achieving universal health coverage.

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[19] MOHNIM. *Health Sector Plan 2016–2020.* Colombo.
[20] MOHNIM. *National Health Strategic Master Plan, 2016–2025.* Vol IV Health Administration and HRH. Colombo.
[21] Sharing both patient care and resources.

7. The Policy on Healthcare Delivery for Universal Health Coverage, 2018[22] provides details for strengthening PHC to address the changing disease burden and challenges in service delivery. Its objectives are to (i) respond to evolving needs with quality years to life added, resulting amongst others in elders living with less disability; (ii) reduce catastrophic health spending for lower and middle-income groups, and (iii) improve overall satisfaction of people and health experience.

8. Priority areas of the policy are quality first contact, family-centered approach, continuity of care, equitable access to specialized services, health literacy and rational health seeking behavior, protection from financial risks, and monitoring and adaptation. This is to be implemented through the shared care cluster system including e-Health, improving HRH including 1 family doctor for every 5000 people and community workers, access to essential medicines, access to laboratory services, access to emergency services, and improving management and monitoring. Expanding PHC services, for diagnostics, should also reduce out of pocket spending.

9. The Concept note on Management Support for Primary Care Strengthening[23] and related Results Framework propose improvements in (i) cluster management including monitoring, supervision and community participation; (ii) advocacy, education and outreach; (iii) infrastructure; (iv) HRH including training of family doctors and community workers; (v) and improving the essential package of health services (NCDs, diagnostics and emergency services).

10. The cluster approach needs to be further tested. A set of interventions is proposed to be implemented in selective clusters and compared to standard services outside these clusters, to find ways for strengthening PHC. The set of cluster interventions will not be standardized but will be based on local priorities to address gaps in the services based on the scope as provided in the policy and results framework.

11. As clusters and services are different, the main point of interest is to compare trends. An assessment mechanism is to be included. Drivers of change in demand for PHC services are likely to be multiple and mutually reenforcing, and will be difficult to pin down to individual interventions. The entire range of PHC functions will be assessed to identify improvements, including management and monitoring, outreach, referral, diagnostic services and NCD services.

B. Proposed PHC Innovation Fund

12. The Sri Lanka Health System Enhancement Project (HSEP) is a $60 million project financed by the Asian Development Bank (ADB) and the Government of Sri Lanka to (i) upgrade PHC in a total of 9 districts in Central, North Central, Sabragamuwa, and Uva provinces; (ii) strengthen medical information technology and disease surveillance systems; and (iii) improve PHC related policies and capacities.

13. Under output 1, HSEP includes a $2 million PHC Innovation Fund (PIF) to provide grants to explore PHC Development based on the shared-care cluster system for a subdistrict population. In each cluster, preventive and curative health services will be expanded and interlinked with one apex hospital for referral services using information technology. Under the HSEP, one cluster will be developed in each of the nine districts in these four provinces.

[22] MOHNIM. 2018. *Policy on Healthcare Delivery for Universal Health Coverage.* Colombo.
[23] MOHNIM Management, Development and Planning Unit. 2018. *Concept Note: Management Support for PHC Strengthening, and Results Framework*. Colombo.

14. The PIF will support local health officials to use their own insights to improve PHC in terms of access, range, quality or efficiency of services. Preference is given to developing the cluster system in the targeted clusters/subdistricts, but other interventions will also be considered. The grant is provided to prepare, implement and monitor a grant-financed project within the approved scope and conditions as provided.

15. MOHNIM / PMU will request each Provincial Governments of the four provinces to establish a PIF chapter at provincial level that will be managed by the provincial project steering committee. Provincial health directors of the four provinces will invite eligible government health offices to submit grant proposals of up to $100,000 to explore innovative strategies for PHC improvement. The PIU will issue guidelines and application forms to potential grant applicants and assist these applicants with the preparation of proposals.

16. The focus of the proposal will be on PHC development, preferably in the clusters, to demonstrate how PHC could be improved. This may include activities for community engagement, other sectors, and referral hospitals. Based on the MOHNIM policy and concept paper, 5 groups of interventions have been identified, which may be packaged to enhance impact:

(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).

17. A strong before-and-after assessment and monitoring system will be put in place in all clusters to be able to assess progress using both quantitative and qualitative instruments. The instruments will track all functions of the PHC system at all levels, but probably limited to the apex hospital, 2-3 PHC services, and related MOH and outreach services.

18. The implementation arrangements for the PIF are in Attachment 1. The draft application form is in Attachment 2.

ANNEX 3 - Attachment 1: Guidelines for Primary Health Care Innovation Fund

A. Purpose

1. The Sri Lanka Health System Enhancement Project (HSEP) is a US$60 million project financed by the Asian Development Bank (ADB) and the Government of Sri Lanka to (i) upgrade PHC in a total of 9 districts in 4 provinces; (ii) strengthen health information technology and disease surveillance systems; and (iii) improve PHC related policies and capacities.

2. Under output 1, HSEP includes a $2 million PHC Innovation Fund (PIF) to provide grants to explore PHC Development based on the shared-care cluster system for a subdistrict population. In each district, one cluster will be developed: preventive and curative PHC will be expanded and interlinked with one apex hospital for referral services using information technology.[24] MOHNIM is considering engaging a cluster manager for this purpose or nominate a person from the regional health office or divisional hospital to perform such a task.

3. The MOHNIM requests provincial health offices to invite eligible government health offices in the four provinces to submit grant proposals of up to a maximum of $100,000 per office to explore innovative strategies for PHC development in the nine districts targeted under the project, preferably in the clusters. The PIF will support local health officials to use their own insights to improve PHC in terms of access, range, quality or efficiency of services. Eligible government health offices are all provincial and regional health offices, divisional hospitals, primary medical care units and medical officers of health.

B. Scope

4. Targeted districts are Polonnaruwa and Anuradhapura districts (North-Central Province); Nuwara Eliya, Matale, and Kandy districts (Central Province), Badulla and Monaragala districts (Uva Province); and Ratnapura and Kegalle districts (Sabaragamua Province).

5. Within each of these nine districts, one subdistrict area has been selected as a cluster, with each an apex hospital and a range of PHC services. It is proposed that, rather than using PIF for interventions scattered across the district, most of PIF support will be used to target these clusters, in terms of providing **investments to upgrade PHC services in that particular cluster**, so as to be able to see the results of these efforts. This focus may not be 100%, as certain investments like for repair of facilities or training may have a wider coverage, but the idea is to demonstrate if the cluster approach can make a difference.

6. Secondly, to make implementation more practical, it is proposed to **use a package approach**, combining various interventions in one approach for PHC upgrading/development, which may be more efficient and easier to implement. For example, management improvement could be combined with improving the range of services, setting up a referral system, and improving information technology (IT).

7. The focus of the proposal will be on PHC, and may include support for community, other sectors, and referral hospitals. Based on the MOHNIM policy and concept paper, 5 groups of

[24] PHC in the contact of the Sri Lanka public health sector includes curative services provided by divisional hospitals and primary medical care units (PMCU), and preventive services provided by the Medical Officer of Health and staff in Field Health Stations.

interventions have been identified. It remains to be decided which interventions are mandatory for all clusters:

(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 counseling.

(iii) **IT 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).

8. The grant 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. For example, Sri Lanka has several ongoing initiatives to improve NCD services, nutrition interventions, health management information systems, and medical waste management.

C. PIF Application

9. A national Project Steering Committee (PSC) will provide project oversight including for PIF. A Project Management Unit (PMU) headed by a Project Director has been established in MOHNIM. The PMU will support 4 Provincial Implementation Units (PIU) established under the Provincial Council to implement the project in each province. Each PIU will report to the provincial project coordination committee (PCC) headed by the Chief Secretary. The PMU will manage the PIF on behalf of the PSC, and establish provincial PIF in each of the provinces. The provincial PIF will be managed by the PIU on behalf of the PCC.

10. **The PIF application process will be managed and supported by the PIUs**. Following internal circulation inviting eligible government offices to apply, each applicant downloads the guidelines and application form, and expresses interest to the PIU to confirm eligibility for the PIF. As only government offices are eligible for PIF support, the PIF invitation will be sent directly to all eligible government offices in the 4 provinces and will be advertised in the project website.

11. Any eligible office can submit one proposal for grant financing a time, up to $100,000. The lead officer applying for the grant and accountable for its proper use will be a senior civil servant working in the health sector in the province.

12. The applicant may seek information and assistance from the PMU/PIU for completing the application (email addresses to be provided). The applicant may also submit to the PIU a two-page proposal and budget to apply for preparation money up to $1,000 for consultations and field assessment, Additional funding may be requested for feasibility studies or baseline assessment. In case of proposed infrastructure development, the provincial engineer will be consulted.

13. The indicative application form is in Attachment 2. The proposal will basically state the problem(s) being addressed, the objective and purpose, for whom, how, by whom, when and where, how much it would cost, expected results and how these will be measured and shared, and risks.

14. Specifically, the proposal will include a description of the location and target population and targeted beneficiaries including vulnerable groups.

15. The projects should preferably take less than 3 months to prepare and be implemented within one year. Progress is reported on a quarterly basis. The final report should be submitted within 3 months of completion of the project.

16. In terms of measuring results, a before-and-after community survey will not be warranted for most PIF grants. A before-and-after assessment and monitoring system focused on providers and use of services including client satisfaction will be able to track relevant PHC functions at all levels including the apex hospital, 2-3 PHC services, and related MOH and outreach services.

17. A standard budget will be prepared as shown in Attachment 2. Following are eligible expenditures:

(i) Salaries of project staff[25]
(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

18. The applicant will assess if there are any major feasibility issues or implementation risks and, if so, propose how these shall be mitigated. The following project risks may be considered:

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

19. The PAM provides details on gender action plan and safeguards requirements[26] which are also applicable for the use of the PIF. The PIU will (i) inform potential grant applicants regarding ADB's gender action plan and social and environmental safeguards; (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 SPS 2009 even if they may be exempted from national environmental regulations.

[25] Project staff are persons not already paid for services by MOHNIM either as regular or contractual staff. MOHNIM pensioners are eligible as project staff.
[26] ADB. 2009. Safeguard Policy Statement. Manila.

20. All completed applications will be officially submitted to the PCC in the Provincial Council, via the concerned RDHS and PDHS, with copy to the PIU as the secretariat of the PCC. The PIU will forward a copy to the PMU for any comments prior to the PCC meeting.

D. Grant Evaluation

21. The Chief Secretary or deputy will chair the PCC including for PIF grant approval and monitoring. It includes as members the PDHS or deputy, the RDHS, the deputy project director heading the project implementation unit (PIU) (secretary), and 2 other persons to be nominated by the PCC. The PCC will meet quarterly to review and approve grants and record decisions.

22. The PCC may decide to assess the proposal in the field or request experts to review the proposal. The PCC may also invite the lead project officer to present the proposal in a briefing meeting. The PCC may share its observations and recommendations in writing, but this is not for negotiation.

23. All proposals will be considered for funding based on several criteria to be reviewed, revised and adopted by the PCC (the selection committee). Following selection criteria may be considered:

(i) Focus on PHC cluster approach
(ii) Support for system development
(iii) Targeting vulnerable populations
(iv) Potential results and sustainability
(v) Management and participation
(vi) Financial arrangements
(vii) Risks and Safeguard issues
(viii) Monitoring arrangements

24. The PCC may reject the proposal for funding, suggest necessary amendments for the proposal or approve the proposal. The decision of the PCC shall be minuted and signed and is considered as final. After PCC approval, the project is eligible to receive money from the fund.

25. An MOU will be signed between the Chief Secretary/PDHS and the lead applicant stipulating the scope, implementation arrangements, and terms and conditions for use of the grant. The PIU headed by the Deputy Project Director will monitor utilization of the grant funds.

26. The MOHNIM steering committee, in consultation with the Provincial Councils, can adjust the scope and implementation of the PIF subject to ADB concurrence.

E. Implementation Arrangements

27. Implementation arrangements for the PIF will use the overall project management structure, and in the case of civil works may also use the Ministry of Local Government and Provincial Council. The grant applicant and supervising office are responsible for project implementation. The PIU is responsible for supervision of the grant project to ensure proper use of grant funds. All procurement related activities will be managed by the PIU at the request of the lead project officer of the approved project and like the rest of the project, the ADB procurement and disbursement guidelines will be followed. For training, authorized advances for training will be provided to the lead project officer who would be required to submit the expenditure details to

the PIU. Additional training advances will be provided only following the submission of expenditures to the earlier advance by the lead project officer.

28. After grant approval, the successful applicant will submit an updated project schedule with proposed activities. The quarterly progress report submitted to the PIU shall describe the progress of work according to the time frame submitted before applying for the next instalment.

29. 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. 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 lead project officer must comply with the final technical, administrative and financial project completion reporting obligations.

30. For overall project implementation, MOHNIM will establish a project account at a state owned commercial bank managed by the PMU. The PMU will transfer funds including for PIF to the four provinces into the respective sub-project bank accounts for project related activities. These sub-project accounts established at a state-owned commercial bank will be managed by the PIUs including for PIF. ADB will provide project funds including for PIF based on an annual project plan approved by the PSC, which is based on plans for project activities at central and provincial levels.

31. The PMU will be responsible for reconciliation of the accounts. monitoring and auditing of sub-project accounts at the PIUs, and preparation and submission of withdrawal applications for replenishment of the advance accounts. Project funds will be disbursed in accordance with ADB's Loan Disbursement Handbook (2017, as amended from time to time), and detailed arrangements agreed upon between the Government and ADB. The PIUs will be responsible for all activities that are managed at the PIU level which will mainly include civil works, training and PIF activities.

32. The project accountant of the PIU in each of the provinces will provide oversight of all PIF related activities. The applicant/implementing office will be responsible for grant implementation, monitoring and reporting. The implementing office/ lead project officer will request all procurements in the approved proposal to be carried out by the PIU and will only seek cash advances for training programs. The PIU will manage the reconciliation and replenishment 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.

33. All expenditures under a single proposal will be less than $100,000. The PMU and PIUs 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 PIU 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.

34. MOHNIM and the provinces (PMU and the 4 PIUs) will maintain, or cause to be maintained, separate books and records by funding source for all expenditures incurred on the project. Sri Lanka has a system of project wise budget in their computerized accounting system CIGAS and the same is proposed to be used in the ADB project. All funds under the Project shall be routed through the PMU and the province level PIUs which will ensure that ADB project accounts are separately recorded and maintained. MOHNIM will prepare consolidated project

financial statements which shall include at a minimum, a statement of receipts and payments with accompanying notes and schedules.

35. All procurement of works, goods and services under the PIF will follow ADB procurement guidelines (like the rest of the project). 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.

ANNEX 3 – Attachment 2: Grant Application Form for the PHC Innovation Fund under the ADB Health System Enhancement Project

Application Form

1	**Title of the Proposed Grant Project**	
2	**Date of Application**	
3	Applicant's Office (*details in table 1)*	
4	Oversight's Office	
5	Short problem Statement (*details in table 2*)	
6	Purpose of the Project	
7	Project Location *(details in table 3)*	
8	Link to Government Policy and Targets	
9	Relevant thematic area (details *table 4*)	PHC management and monitoring Information technology Scaling up health services Rehabilitating facilities HRH development and training
10	Targeted beneficiaries or services	
11	Proposed starting and ending dates	Starting date: year/month Completion date: year/month
12	Is the project part of ongoing project (see table 5)	
13	Proposed Project Objectives	
14	Proposed Project Outputs	
15	Proposed Key Activities *(add details in table 6)*	
16	Implementation schedule *(add details in table 7)*	
17	Requested Budget (*add cost estimates in table 8)*	
18	Sources of Financing *(add details in table 9*)	
19	Management arrangements	
20	Monitoring arrangements	
21	Reporting arrangements	
22	Procurement arrangements	
23	Disbursement arrangements	
24	Proposed project preparation	
25	Project preparation and seed money required	
26	Current baseline and expected results	
27	Proposed monitoring arrangements	
28	Proposed dissemination	
	Complete with assistance of PIU	
29	Link to Project result framework	
30	Assessment of feasibility and risks	
31	Gender, safeguards and risks rating (*see table 10*)	
32	Ethical clearance (*see table 11*)	
33	Need for technical support	
34	Need for administrative support	
35	Need for financial management support	
36	Declaration of the lead officer *(see table 12)*	
37	Questions and comments of the lead officer	

Table 1: Applicant's Office Details

Full Names of the Project Team	Designation	ID	Role
			Lead Officer

Office Address	
Office Phone Number	
Office Fax Number	
Mobile Phone Number	

Home Phone Number	
Home Address	
Email Address	

Table 2: Problem Statement

Table 3: Location

Province	District	Divisions GN/ PHI/ PHM areas	Towns	Facilities / MOH areas	Villages
Central	Nuwara Eliya				
	Matale				
	Kandy				
North Central	Polonnaruwa				
	Anuradhapura				
Sabaragamua	Ratnapura				
	Kegalle				
Uva	Badulla				
	Monaragala				

Table 4: Thematic 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	

Table 5: Part of another project?

Is this project/part of this project ongoing?	**Yes/No**	**Title and Sponsor**	
If 'Yes', when did the project commence? *	**Year**	**Month**	**Day**

*** Please attach a progress report of the project from the start-up to today**

Table 6: Key Activities: What, Where, When, by Whom and How

Nr	Activity	Where	When	By Whom	How

Table 7: Implementation schedule

nr		Year 20..				Year 20..			
	Activity								

Table 8: Detailed Cost estimates

		Cost items	Rate	Amount	3 monthly Cost Breakdown							
					20..				20..			
1.	Personnel											
	Salary											
	Travel allowance											
	Other											
2.	Civil Works											
	Repair facility											
	Water supply											
	Waste management											
	Other											
3.	Transport											
	Fuel											
	Motorcycle											
4.	Equipment											
	Medical											
	Laboratory											
	Other equipment											
5.	Furniture											
6.	Workshops											
7.	Training											
8.	Services											
9.	Information Technology											
10.	System development											
11.	Recurrent expenses											
12.	Other (specify)											
	TOTAL											

Add rows as required, budget in SLR

Table 9: Financing

Total project cost (see Table 8)	
Total Amount Requested for ADB PHC innovation fund financing including taxes	
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

Table 10: Gender, Safeguards and Risks

Gender/Safeguard/Risk	Rating	Remarks*
Gender and Development	GM	
Ethnic minorities	B/C	
Resettlement	C	
Environmental safeguards	B/C	
Financial Risks	M	
Procurement Risks	M	

* Add appendix using ADB guidelines in case of major gender issues, safeguards A/B, and/or substantial or high financial and procurement risks.

Table 11: Ethics approval for the project

Is ethics approval for this project required, e.g., for research?	Yes/no
If 'Yes', state the date of approval of the ethics review committee*	

* Attached copy of approval of ethics review committee

Table 12: Declaration of the Lead Project Officer and Provincial Representative

Declaration of the Lead Project Officer

I hereby agree to the terms and conditions laid down by the Ministry of Health in approving and providing funding for the district health innovation projects under the ADB-supported Health System Enhancement Project and that the declared details furnished above by me are true and correct.

……………………………………….

Date: ……………………….. Signature of the Lead Project Officer

Observations and Recommendations of the Province

I hereby recommend and forward the above Application for the Project Proposal for funding under ADB Health System Enhancement Project

……………………………………….

Date: ……………………….. Signature, Stamp, and Designation of the Provincial Representative

ANNEX 4: CIVIL WORKS FOR PRIMARY HEALTH CARE FACILITIES

I. Introduction

1. The Health System Enhancement Project (HSEP) is for $60 million (comprising $37.5 million in concessionary loan and $12.5 million grant from ADB, and $10 million equivalent from Government of Sri Lanka in counterpart funds). It will be delivered through a project investment modality and is expected to be effective from 2018 and will close in 2023.

2. The main objective of the project is to strengthen primary health care (preventive and curative) delivery system to ensure a more responsive and comprehensive primary health care system to the populations living in the provinces of Central, North Central, Sabaragamuwa, and Uva and with a special focus on the geographically, socially, and economically-deprived populations in these provinces.

3. Primary healthcare in Sri Lanka is provided as primary medical care and preventive health services by Primary Medical Care Units (PMCUs) and Divisional Hospitals (DHs A, B, C) and Medical Officer of Health (MOH) areas. There are approximately 473 PMCUs, 482 DHs and 341 MOH areas in the country. In the four target provinces, there are 469 PMCUs and DHs and 132 medical officer of health areas and more than 1,500 field health centers.

4. Improvements to infrastructure in primary level medical institutions can help reverse the trend of bypassing primary health facilities and has the potential to provide a higher quality care at the primary care level. It can also help establish up-and-back referral system so that the patient gets the best possible care for the illness condition via the primary health care provider. This will also help reduce the out of pocket expenses of the patient. Infrastructure strengthening is therefore essential to:

- (i) improve the image of the hospital thereby improving the patient utilization of PHCs
- (ii) improve the environment in which health team can provide care
- (iii) improve the residential facilities provided to health team to favor retention of medical officers and other staff in rural and difficult areas

5. Under output 1 of the project which intends to develop the primary healthcare services in four target provinces, one of the major components for development of primary healthcare services is infrastructure strengthening.

II. Selection of Facilities

6. The health facilities for infrastructure development were identified by a two-stage objective analysis. In First stage, facilities were identified based on following criteria:

- (i) Newly developed GIS tool for the health sector
- (ii) Dependency ratio of the GN divisions
- (iii) Distance to the nearest primary medical care facility (PMCU or DH)
- (iv) Vulnerability index developed by the Department of Census and Statistics, Sri Lanka

7. Thereafter, in the second stage, in discussion with the provinces, the respective districts, and the MOHNIM, two additional criteria were followed:

(i) PMCU or DH having limited access to basic facilities (electricity, water and sanitation)
(ii) any facility that needed development based on local knowledge and needs

8. Using the selection criteria defined above, a total of 135 facilities (15 per district) were finalized as the priority list of PMCUs and DHs that require to be developed under the project. This amounts to 29% (135/469) of all PMCUs and DHs in the 4 provinces.

9. Further, discussions were conducted with Provincial and Regional Director of Health services to identify the first round of facilities that were to be developed and 45 facilities (5 from each district) were identified from the priority list of 135.

10. In addition, to further improve preventive health care, one field health center (FHC) was identified from every medical officer of health area in the 4 target provinces for development. The final list of 127 FHC are identified for development. The civil works for these FHCs will be carried out with the second round of PMCUs and DHs development.

III. Development of draft physical space norms

11. Meetings were conducted with MOHNIM (Planning Unit) to develop standard guidelines for the basic infrastructure to be made available or expanded at each level of facility. Based on services available and expected to include with the development of the essential services package, efforts will be taken to increase the floor space to include gender disaggregated toilets, disability access, larger waiting areas for patients, more spacious consultation rooms and staff service facilities and office space and quarters for staff. The physical space norm is expected to be finalized by July 2018.

IV. PHC facilities to be renovated/ expanded or reconstructed

12. Total number of facilities to be renovated are provided in the following table:

Number of Health Facilities

SN	Type of Facility	Sabargamuawa	Uva	Central	North Central	Total
1	DHA	5	1	2	0	8
2	DHB	2	9	8	4	23
3	DHC	8	10	18	7	43
4	PMCU	15	10	17	19	61
	Total Facilities	**30**	**30**	**45**	**30**	**135**

13. Total estimated cost for renovation/repairs/expansion of the PMCUS, DHs and the FHCs is in the range of SLR 3.00 billion ($19.6 million).

ANNEX 4 – Attachment 1: LIST OF PMCUs and DHs FOR CIVIL WORKS DEVELOPMENT*

SN	Province	District	Hospital Name	Hospital Type
1	**Central**	**Nuwara Eliya**	***Nanuoya***	***PMCU***
2			***Pundaluoya***	***PMCU***
3			***Lindula***	***DHB***
4			***Laxapana***	***DHC***
5			***Kotagala***	***DHB***
6			Rupaha	PMCU
7			Hatton	PMCU
8			Gonapitiya	DHC
9			Mandarannuwara	DHC
10			Ketabula / Kotimale	PMCU
11			Agarapatana	DHC
12			Munwatta	PMCU
13			Bogawanthalawa	DHB
14			Hanguranketha	DHC
15			Hangarapitiya	PMCU
16		**Matale**	***Kimbissa / Sigiriya***	***DHC***
17			***Kalundawa***	***PMCU***
18			***Madawalaulpatha***	***PMCU***
19			***Galewela***	***DHB***
20			***Paldeniya***	***PMCU***
21			Pallepola	PMCU
22			Elkaduwa	PMCU
23			Maraka	DHC
24			Handungamuwa	DHC
25			Madipola	DHB
26			Leliambe / Rehabilitation	DHC
27			Nalanda	DHC
28			Dullewa	PMCU
29			Gurubebila	PMCU
30			Ukuwela	PMCU
31		**Kandy**	***Madulkele***	***DHB***
32			***Galaha***	***DHC***
33			***Deltota***	***DHB***
34			***Dolosbage***	***DHC***
35			***Hataraliyadda***	***DHC***
36			Ambagahapelessa	DHC
37			Kurunduwatta	DHC
38			Katugasthota	DHA
39			Minipe	DHC

SN	Province	District	Hospital Name	Hospital Type
40			Suduhumpola	PMCU
41			Marassana	DHB
42			Morahena	DHC
43			Digana-Rajawella	PMCU
44			Hasalaka	DHC
45			Kolongoda	DHC
46	**North Central**	**Polonnaruwa**	***Ellewewa***	***PMCU***
47			***Sevanapitiya***	***PMCU***
48			***Aralaganwila***	***DHB***
49			***Damminna***	***PMCU***
50			***Ambagaswewa***	***PMCU***
51			Meeguswewa	PMCU
52			Singhapura	PMCU
53			Aselapura	PMCU
54			Madagama	PMCU
55			Parakrama Samudraya	PMCU
56			Weheragala	PMCU
57			Attanakadawala	DHC
58			Mannampitiya	DHB
59			Jayanthipura	DHC
60			Wijepura	PMCU
61		**Anuradhapura**	***Horowpathana***	***DHC***
62			***Galenbindunuwewa***	***DHB***
63			***Koonwewa***	***PMCU***
64			***Negampaha***	***DHC***
65			***Tittagonewa***	***PMCU***
66			Ethakada	PMCU
67			Katiyawa	PMCU
68			Labunoruwa	PMCU
69			Andiyagala	DHC
70			Mahasenpura	PMCU
71			Habarana	DHC
72			Wahalkada	PMCU
73			Mahawilachchiya	DHC
74			Ratmalgahawewa	DHC
75			Poonewa	PMCU
76	**Uva**	**Moneragala**	***Hambegamuwa***	***PMCU***
77			***Thanamalwila***	***DHB***
78			***Deliwa***	***PMCU***
79			***Dambagalle***	***DHC***
80			***Dobmagahawela***	***PMCU***

SN	Province	District	Hospital Name	Hospital Type
81			Kotagama	PMCU
82			Pitakumbura	DHC
83			Okkampitiya	DHC
84			Rathmalgahaella	PMCU
85			Nannapurawa	PMCU
86			Bakinigahawela	PMCU
87			Madagama	DHB
88			Buddama	PMCU
89			Kotiyagala	PMCU
90			Dewathura	PMCU
91		**Badulla**	***Koslanda***	***DHB***
92			***Haldumulla***	***DHC***
93			***Meegahakiula***	***DHB***
94			***Kandeketiya***	***DHB***
95			***Ettampitiya***	***DHC***
96			Metigahatenna	DHB
97			Udaweriya (EH)	DHC
98			Wewegama	DHC
99			Kirkills	DHC
100			Haputale	DHB
101			Spring Valley (EH)(Baddagama)	DHC
102			Uva Paranagama	DHB
103			Galauda	DHC
104			Passara	DHA
105			Lunugala	DHB
106	**Sabaragamuwa**	**Ratnapura**	***Delwala***	***PMCU***
107			***Endana***	***DHC***
108			***Ranwala***	***DHC***
109			***Narissa***	***PMCU***
110			***Dodampe***	***PMCU***
111			Pothupitiya	DHB
112			Kolonna	DHA
113			Paragala	PMCU
114			Kirimetithenna	PMCU
115			Galpaya	PMCU
16			Pinawala	PMCU
117			Rajgaha	PMCU
118			Belihuloya	DHC
119			Kaltota	DHA
120			Marathenna(EH)	DHB

SN	Province	District	Hospital Name	Hospital Type
121		Kegalle	***Hewadivela***	***PMCU***
122			***Minuwangamuwa***	***PMCU***
123			***Uyanwatta***	***PMCU***
124			***Aranayaka***	***DHA***
125			***Bolagama***	***PMCU***
126			Kitulgala	DHA
127			Hinguralakanda	DHC
128			Dedugala	DHC
129			Pothdenikanda	PMCU
130			Gantuna	DHC
131			Maliboda (ERH)	DHC
132			Dothaloya (ERH)	DHC
133			Boralankada	PMCU
134			Basnagala	PMCU
135			Udugoda	DHA

* PMCUS and DHs that are in ***bold, italics*** are in the first round of facilities that will be renovated.

ANNEX 4 – Attachment 2: LIST OF FIELD HEALTH CENTERS FOR CIVIL WORKS DEVELOPMENT

SN	Province	District	MOH Area	Field Health Center
1.	North Central Province	Polonnaruwa	Dimbulagala	Piburattewa
2.			Walikanda	Ginidamana
3.			Thamankaduwa	Singhaudagama
4.			Lankapura	Gamunupra
5.			Hngurakgoda	Kithuluthuwa
6.			Medirigiriya	Veheragala
7.			Elahara	Karadagolla
8.		Anuradhapura	Mihinthale	Katukeliyawa
9.			Thalawa	Ihalahalmillewa
10.			Kahatagasdigiliya	Mukariyawa
11.			Medawachchiya	Rambakulama
12.			Palagala	Upulwehera
13.			Galenbidunuwewa	Gatalawa
14.			Kekirawa	Kumbukwewa
15.			Galnewa	Bulnewa
16.			Kabithigollawa	Halmillawetiya
17.			Nochchiyagama	Sinharagama
18.			NPE	Bandialankulama
19.			NPC	Halambewa
20.			Rajanganaya	Track 13 & 14
21.			Padaviya	Aliwanguwa
22.			Horowpothana	Anawolendewa
23.			Thambuththegama	Thelhiriyawa
24.			Thirappane	MOH office repair (MCH clinic)
25.			Ipalogama	Dampalassagama
26.			Rambewa	Sangalikanadarawa
27.	Uva	Moneragala	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)

SN	Province	District	MOH Area	Field Health Center
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	Dihigama
46.			Bandarwela	Liyanghawela watta
47.			Haputhle	kadrugamuwa
48.			Ella	Hidagala Estate Clinic Center
49.			Lunugala	Cocagala Estate Clinic Center
50.			Meeghakuila	Ballagolla 2 Clinic Center
51.			Mahiyangana	Dehigolla
52.			Girandurukotte	Hobariyawa
53.	Sabaragamuwa	Kegalle	Aranayake	Dippitiya
54.			Mawanella	Makadawara
55.			Rambukkana	Weligamuwa
56.			Kegalle	Athurupana
57.			Galigamuwa	Galigamuwa
58.			Warkapola	Yakdehimulla
59.			Ruwanwella	Ruwanwella
60.			Dehiovita	Imbulpitiya
61.			Deraniyagala	Udabage
62.			Yatiyanthota	Yatiyanthota
63.			Bulathkohupitiya	Bulathkohupitiya
64.		Ratnapura	Balangoda	GHC Thalangama
65.			Eheliyagoda	GHC Paleegala
66.			Embilipitiya	GHC Panamura
67.			Udawalawa	GHC Kolombageara
68.			Nivithigala	G H C Colombugama
69.			Godakawela	GHC Makandura
70.			Pelmadulla	GHC Pathakada
71.			Kuruwita	GHC Pussella
72.			Imbulpe	GHC Pallewela
73.			Kalawana	GHC Rabuka
74.			Ratnapura (PS)	G H C Banagoda

SN	Province	District	MOH Area	Field Health Center
75.			Ratnapura (MC)	GHC Mihindugama
76.			Elapatha	GHC – Niriella
77.			Kiriella	GHC - Mudunkotuwa
78.			Kolonna	GHC - Abagahayaya
79.			Kahawatta	GHC Gabbela
80.			Weligepola	G H C Ambavila
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	Rahathungoda
89.			Kotagala	Chrystler's farm
90.			Kotagala	Mayfield
91.			Kothmale	Labukele
92.			Kothmale	Wedamulla
93.			Maskeliya	Norwood
94.			Maskeliya	Strathspey
95.			Mathurata	Kabaragala
96.			Nuwaraeliya	Radella
97.			Nuwaraeliya	Pedro
98.			Ragala	St. Lenards
99.			Ragala	Ragala
100.		Kandy	Akurana	Dunuwila
101.			Bamberdeniya	Clinic at Bamberdeniya MOH
102.			Doluwa	Megodakalugamuwa PMCU Clinic Center
103.			Galagedara	Uduwa
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	Central Clinic at Gangawata Korale MOH
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	Mapakanda PMCU Clinic
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	Nagala (estate health center)
122.			Naula	Habaragahamada
123.			Dambulla	Welihena
124.			Galewela	Aluthwewa
125.			Pallepola	Kadewatta
126.			Wilgamuwa	Aliyawala
127.			Yatawatta	Walawela

ANNEX 5: CLIMATE CHANGE AND DISASTER RISK RESILIENCE

A. Climate Change

1. Climate mitigation is estimated to cost $1.80 million and climate adaptation is estimated to cost $3.56 million. ADB will finance 100% of mitigation costs and 90% of adaptation costs ($3.2 million). Please see detailed table on the activities contributing to climate change mitigation and adaptation.

2. The Health System Enhancement Project (HSEP) 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. As part of these activities, the project supports climate adaptation by increasing the responsiveness of medical officers who carry out disease outbreak investigations and control against 10 vaccine preventable diseases. The project, therefore, only supports the purchase of energy efficient new vehicles to replace vehicles that are more than 15 years old or are not roadworthy. The project further supports climate adaptation, by enhancing the capacity of health staff on disease surveillance and risk communication in target provinces to mitigate against possible disease outbreaks in the communities. The project also strengthens disease surveillance capacity by establishing IT systems in identified clusters of PHC hospitals for timely reporting of the 28 notifiable diseases for Sri Lanka.

3. Furthermore, the project supports climate mitigation by preventing the health and environmental hazards due to poor health care waste management by PHC facilities in the 4 target provinces. The introduction of a sound system for segregating and disposal of all health care waste, and with capacity building programs introduced for infection prevention and control including efforts to reduce antimicrobial resistance are some of the initiatives that support climate mitigation.

4. Highly efficient architectural designs and building techniques for energy efficiency and ventilation will be used to reduce energy consumption. Buildings for medical wards and outpatient departments (OPDs) are being designed with half walls which will be open for natural ventilation and sunlight during the daytime. Total estimated building area for 135 PMCUs and DHs is about 34,490 square meters. During the night, LED blubs will be used to minimize energy consumption. During the daytime, if we consider zero energy consumption for the medical wards and OPD area, estimated reduction of CO_2 is about between from 4,500 to 6,500 tons per annum. The project also identified 50 PMCUs to provide solar panels to use renewable energy for power supply as a climate change mitigation under the project.

5. The project is also designed to provide proper drainage system for rain water and waste water 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. CO_2 emission reduction calculation

6. 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) *34,490 (total PCMUs and DHs building area in square meters))/1000

Calculation of CO_2 emission reduction = 0.76*250*34,490/1000 = 6,553 CO_2 tons per annum (on basis of zero energy consumption)

B. Disaster Risk Resilience (DRR)

SN	Activities that contribute to climate change mitigation and adaptation	Total Cost of Activity directly impacting climate change ($ million)
	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 disease, and (iii) sharps injuries	0.60
2	Energy-efficiency improvement in lighting (LED instead of incandescent or fluorescent bulbs), appliances and equipment, etc.	0.50
3	Retrofit of existing buildings: architectural designs or building changes with open medical wards that enable reduction of energy consumption (climate/shade/wind consideration for passive design, cross ventilation, etc.)	0.70
	Total	**1.80**
	Adaptation	
4	Improved monitoring of diseases due to changing climatic conditions via shared care services and timely reporting of the 28 notifiable diseases	0.25
5	Improved disease surveillance for monitoring changes in disease outbreaks and disease surveillance under IHR with new IT equipment	0.28
6	Supporting improved 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	0.33
7	Capacity building on design, operations and maintenance of civil works/infrastructure to ensure their proper upkeep and resilience to climate change	0.10
8	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
9	Incorporate climate resistant design in zones affected by typhoons/ hurricanes/storm surges/flood/drought/etc.	1.50
10	Construction and rehabilitation of drainage system for rain water and waste water to protect soil erosion	0.60
11	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	0.30
	Total	**3.56**

7. Since identified PMCUs and DHs for new construction and rehabilitation are in existing locations, these buildings and locations were not severally affected by floods, droughts, or heavy winds. Because of climate change vulnerability, increased rainfall intensity during monsoon period has substantially increased the surface runoff volume, especially at hilly terrains causing landslides and soil erosion. Embankment protection measures shall be proposed by designing steep terrains around PMCUs and DHs for the present vulnerable conditions. Capacity of the surface drainage lines will be increased after close monitoring of the drainage volumes during monsoon periods. Under the civil work cost, 2.5% has been allocated for new construction and rehabilitation of drainage systems for rainwater and wastewater management.

8. The project will also consider landscaping surrounding PMCUs and DHs to undertake soil conservation measures such as planting soil strengthening plant varieties, providing soil conservation bunds, and soil traps along the drainage paths. TOR for design and supervision consultants will be included requirements to address DRR and included an experienced Engineer to the team of consults.

ANNEX 6: EQUIPMENT REQUIREMENT AND DISTRIBUTION

I. Introduction

1. The Health System Enhancement Project (HSEP) is for $60 million (comprising $37.5 million concessionary loan and $12.5 million grant from ADB, and $10 million equivalent from Government of Sri Lanka in counterpart funds). It will be delivered through a project investment modality and is expected to be effective from 2018 and will close in 2023.

2. The objective of the HSEP is to strengthen the primary health care (preventive and curative) delivery system to provide a comprehensive package of health services to the population living in four target provinces (Central, North Central, Sabaragamuwa, and Uva). The project seeks to focus on the geographically, socially and poor populations in these provinces.

3. The project aims to achieve this objective through 3 outputs:

i. Output 1: Primary health care strengthened in the target provinces
ii. Output 2: Health and disease surveillance strengthened
iii. Output 3: Policy development and project management supported

II. Rationale for investing in Equipment

4. The Sri Lankan health system provides a comprehensive package of preventive and curative services to the population via primary, secondary and tertiary level facilities, which are situated across the country. Preventive health services are provided via medical officers of health and their field staff covering the population living in the geographically demarcated areas.

5. The services provided at primary healthcare includes emergency care, maternal and child health, family planning, non-communicable disease, dental, nutrition, child care, school health services, occupational and environmental services (including food safety, vector control, disease surveillance and outbreak and individual case investigations). Primary medical care includes care given to patients of all ages at the Primary Medical Care Units (PMCUs) and Divisional Hospitals (DHs) A, B, C. Few services like type of lab diagnostic tests availability vary depending upon type of facility. The PMCUs and DHs based on the level of the facility, and the medical officer of health areas use standard, prior approved types of equipment and investigations.

6. In addition, the HSEP is supporting to establish nine pilot clusters in each of the nine districts. The clusters will link PHC facilities to one apex secondary care level facility to ensure continuity of care and better quality of care to the patient who seeks services at the nearest PHC facility.

7. Furthermore, the MOHNIM is currently in the process of reviewing the current service package provided at PHC level and a new essential services package is being developed /defined and this is expected to be ready towards end-2018. Therefore, the HSEP, has provided an unallocated amount of resources to purchase additional equipment that would be needed to implement the essential services package in the pilot clusters that are identified for the project.

8. To provide these services in an efficient and effective manner at grass root level, it is important to ensure the availability of equipment to service providers at PHC facilities and at the apex secondary care facilities.

III. Methodology

9. The equipment needs were assessed using various methods. Initially, a list of equipment was developed from available MOHNIM standards and guidelines and a gap assessment was carried out with the respective provinces and the districts to identify the equipment for each level of level of facility.[27,28,29,30,31] In addition, the equipment gaps based on request of the province and district health teams were considered. For health care waste management, the environment expert, identified the types and quantities of equipment needed to provide better health care waste management based on the site visit assessments carried out during project preparation. Finally, province-wise discussions were conducted with officials and stakeholders at provincial and district level to understand their needs based on their daily experience of managing primary and secondary health care facilities. The MOHNIM officials from relevant departments were consulted, especially the laboratory unit to best understand the standards and services expected at secondary and PHC facilities.

10. Based on the guidelines wherever available and the discussions with stakeholders, list of equipment was developed. Equipment were categorized on basis of services provided:

(i) Laboratory, Physiotherapy and X- ray equipment (for apex hospital)
(ii) ETU equipment
(iii) Dental equipment
(iv) Equipment for Non-Communicable Disease
(v) Equipment for reproductive health, nutrition and maternal and child health
(vi) Health care waste management related equipment

11. List thus developed was shared with the districts to finalize the equipment needs as well as their actual requirement. Repeated discussions were conducted to rationalize the demands to ensure the effective utilization of equipment being proposed under the project.

12. Detail equipment list with district wise distribution thus finalized is as follows:

LIST OF EQUIPMENT WITH DISTRIBUTION

S. no.	EQUIPMENT	Sabragamauwa		Central Province			Uva		North Central		
		Kegalle	Ratnapura	Nuwara Eliya	Matale	Kandy	Badulla	Moneragala	Polonnaruwa	Anuradhapura	Total
	Under Output 1.1: Equipment support to Primary health facilities										
	PACKAGE 1 - LABORATORY, PHYSIOTHERAPY AND X - RAY EQUIPMENT (Apex Hospitals)										
	Lot -1										
1	Fully Automated Biochemistry Analyser	1	1	0	0	0	3	0	0	0	5

[27] Manual on Laboratory Services.
[28] Guidelines for Management of Cardiovascular Patient for Primary Health Care Providers.
[29] Institutional Maternity Care: Norms for Services, Equipment and Drug.
[30] Guidelines for establishment of healthy life centers in health care institutions.
[31] Approach and Guideline for strengthening healthcare at primary level.

S. no.	EQUIPMENT	Sabragamauwa		Central Province			Uva		North Central		
		Kegalle	Ratnapura	Nuwara Eliya	Matale	Kandy	Badulla	Moneragala	Polonnaruwa	Anuradhapura	Total
2	Semi-Automated Biochemistry Analyser	0	0	2	1	1	1	0	1	0	6
	Lot - 2										
3	Semi-automated coagulation analyser	0	0	2	0	1	0	0	8	1	9
4	Five-part Haematology analyser	0	0	0	0	1	0	0	0	1	1
5	Three Part Haematology Analyser with reagent	0	2	1	0	1	2	0	1	1	8
	Lot - 3										
6	Incubator	0	0	1	0	0	0	0	1	10	12
7	Hot Air Oven	0	0	1	0	1	2	0	5	10	19
8	Autoclave	2	2	2	0	2	0	0	2	2	12
9	Microscope Binocular	0	8	2	3	4	4	8	1	9	39
10	Centrifuge (16 bucket)	0	14	2	2	3	2	8	1	5	37
	Lot -4										
11	Digital Radiographic Panel (2 per apex hospital)	2	2	2	2	2	2	2	2	2	18
	Lot -5										
12	Infrared Lamp(750W) with Stand	0	0	0	0	2	0	0	0	0	2
13	Short Wave Diathermy (SWD)	0	0	0	0	2	0	0	0	0	2
14	Combination Therapy Machine	0	0	0	0	2	0	0	0	0	2
15	Wax Bath for Hand	0	0	0	0	2	0	0	0	0	2
16	Interferential & nerve stimulator machines (IFT & NMES)	0	0	0	0	2	0	0	0	0	2
16	Postural mirror	0	0	0	0	2	0	0	0	0	2
17	Wall Bar	0	0	0	0	2	0	0	0	0	2
18	Adjustable parallel bars	0	0	0	0	2	0	0	0	0	2
19	Stair Case	0	0	0	0	2	0	0	0	0	2
20	Statistic Bicycle	0	0	0	0	2	0	0	0	0	2
21	Suspension Unit	0	0	0	0	2	0	0	0	0	2
22	Gym ball	0	0	0	0	2	0	0	0	0	2
23	Balance Board Shoulder Wheel	0	0	0	0	2	0	0	0	0	2
24	Tilting Bed	0	0	0	0	2	0	0	0	0	2
	Total										
	PACKAGE 2 - ETU EQUIPMENT										
	Lot -1										
25	ECG machines (also for Apex)	27	35	12	0	19	32	17	27	2	171
26	Sphygmomanometer (also for Apex)	50	50	32	0	0	30	8	40	0	210
27	Multipara monitors	27	42	5	1	11	38	10	11	2	147

S. no.	EQUIPMENT	Sabragamauwa		Central Province			Uva		North Central		
		Kegalle	Ratnapura	Nuwara Eliya	Matale	Kandy	Badulla	Moneragala	Polonnaruwa	Anuradhapura	Total
28	Peak flow Meter	15	15	21	0	0	14	5	0	0	70
	Lot -2										
29	Suction Apparatus	24	24	1	0	4	14	8	0	0	75
30	Oxygen Concentrator	3	12	0	4	9	20	8	0	0	56
31	Spot lamp	15	15	0	0	0	32	8	0	0	70
32	Mini Autoclave	20	20	0	0	0	20	8	0	0	68
33	**Lot - 3**										
34	Portable Ventilator (in Apex hospital)	**1**	**0**	1	1	1	1	0	0	0	5
	Total										
	PACKAGE 3 - DENTAL EQUIPMENT										
	Lot - 1										
35	Dental Chair and Unit (for Apex as well)	0	0	12	2	2	3	2	3	3	27
36	Light Cure Machine	10	10	0	3	0	3	0	0	0	26
37	Ultrasonic Scalar	10	10	12	6	3	2	2	5	9	59
38	Mobile Dental Box	10	10	5	0	0	0	0	0	0	25
39	Air Rotor Hand Piece	15	15	0	0	20	0	0	0	0	50
40	Dental X-ray processing unit	0	7	10	0	1	1	0	1	2	22
	Lot - 2										
41	Mobile Dental Chair and unit	**0**	**0**	12	0	0	4	11	3	3	33
	Total										
	PACKAGE 4 - MEDICAL EQUIPMENT FOR NCDs										
	Lot - 1										
42	Sphygmomanometer	26	63	0	0	44	50	59	25	73	340
43	Nebulizer (also for the ETUs)	28	28	0	0	8	0	7	10	31	112
44	Spot Lamp	0	0	0	0	0	4	0	0	0	4
	Total										
	Output 1 - 1.2 Development of Primary Preventive Care Services										
	PACKAGE 5 - MEDICAL EQUIPMENT FOR REPRODUCTIVE HEALTH AND NUTRITION										
	Lot - 1										
45	Standard weight set	11	14	6	0	0	32	34	28	28	153
46	Length board	22	14	123	0	0	40	17	28	28	272

S. no.	EQUIPMENT	Sabragamauwa		Central Province			Uva		North Central		
		Keg alle	Ratna pura	Nuw ara Eliya	Mat ale	Kan dy	Ba du lla	Mon erag ala	Polo nnar uwa	Anur adha pura	Total
47	Spring balance	50	28	28	0	0	40	17	28	28	219
48	Height Rod (wall mounted height measuring tape)	100	100	210	0	0	20	17	28	28	503
49	Beam infant scale	0	14	45	0	0	40	17	28	28	172
	Lot -2			-							
50	Large instrument sterilizer 50x30x25 cm (1 per clinic)	0	0	20	0	0	20	0	28	0	68
51	Forceps jar (1 per clinic)	0	0	55	0	0	60	0	28	0	143
52	Cheatle forceps 27 cm (2 per clinic)	0	0	110	0	0	120	0	56	0	286
53	Rectangular tray with lid - 35x25x6 cm (2 per clinic)	0	0	110	0	0	120	0	56	0	286
54	Cusco's bivalve specula - medium - 90x35 cm (20 per clinic)	0	0	240	43	0	240	0	92	0	615
55	Sponge holders 24 cm (6 per clinic)	0	0	165	0	0	120	0	64	0	349
56	Vulsellum forceps 25 cm curved (6 per clinic)	0	0	165	0	0	120	0	64	0	349
57	Uterine sounds 32 cm (6 per clinic)	0	0	165	0	0	120	0	64	0	349
58	Scissors - 14.5 cm blunt/sharp curved (6 per clinic)	0	0	165	0	0	120	0	64	0	349
59	Long artery forceps - for IUD removal - 20 cm (2 per clinic)	0	0	110	0	0	120	0	56	0	286
60	Kidney trays - large - 825 ml (2 per clinic)	0	0	110	0	0	120	0	56	0	286
61	Lotion bowl - 600 ml (2 per clinic)	0	0	110	0	0	120	0	56	0	286
62	Dressing jars (2 per clinic)	0	0	110	0	0	120	0	56	0	286
63	Stainless steel bowl 180 ml (2 per clinic)	0	0	110	0	0	120	0	56	0	286
64	Examination Lamp (spot) (1 per clinic)	0	0	20	0	0	20	17	28	0	85
65	Pail Plastic - 15 litre (1 per clinic)	0	0	55	0	0	0	0	28	0	83
66	Adjustable revolving stool (1 per clinic)	0	0	55	0	0	60	17	28	0	160
67	Coplin jar (2 per clinic)	0	0	110	0	0	120	0	28	0	56
	Output 2 - 2.2 Strengthening of IHR Implementation										
	<u>HEALTHCARE WASTE MANAGEMENT Equipment and medical furniture</u>										
68	Needle Cutters (1 per PMCU, 6 per DH, 3 to Rehab Hosp, 10 per BH, 1 per MOH)	81	59	74	33	51	74	25	55	15	467
70	PPE (1 per PMCU, 6 per DH, 3 to Rehab Hosp, 10 per BH, 1 per MOH)	81	59	74	33	51	74	25	55	11	463
71	Waste Carts (1 per PMCU, 2 per DH, 2 to Rehab Hosp, 4 per BH, 1 per MOH)	31	25	28	15	24	28	11	21	5	188

S. no.	EQUIPMENT	Sabragamauwa		Central Province			Uva		North Central		
		Kegalle	Ratnapura	Nuwara Eliya	Matale	Kandy	Badulla	Moneragala	Polonnaruwa	Anuradhapura	Total
72	Color Coded Bins (2 per PMCU, 7 per DH, 3 to Rehab Hosp, 10 per BH, 1 per MOH)	97	73	88	41	60	88	30	64	11	552

ANNEX 7: 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 (HSEP) 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 HSEP to strengthen grievance redress mechanism during planning and implementation of the HSEP 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 HSEP. 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

- **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.

- **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 HSEP (Chairman of the committee) and its members will include: Deputy Director General (Planning) of the MOHNIM, 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.

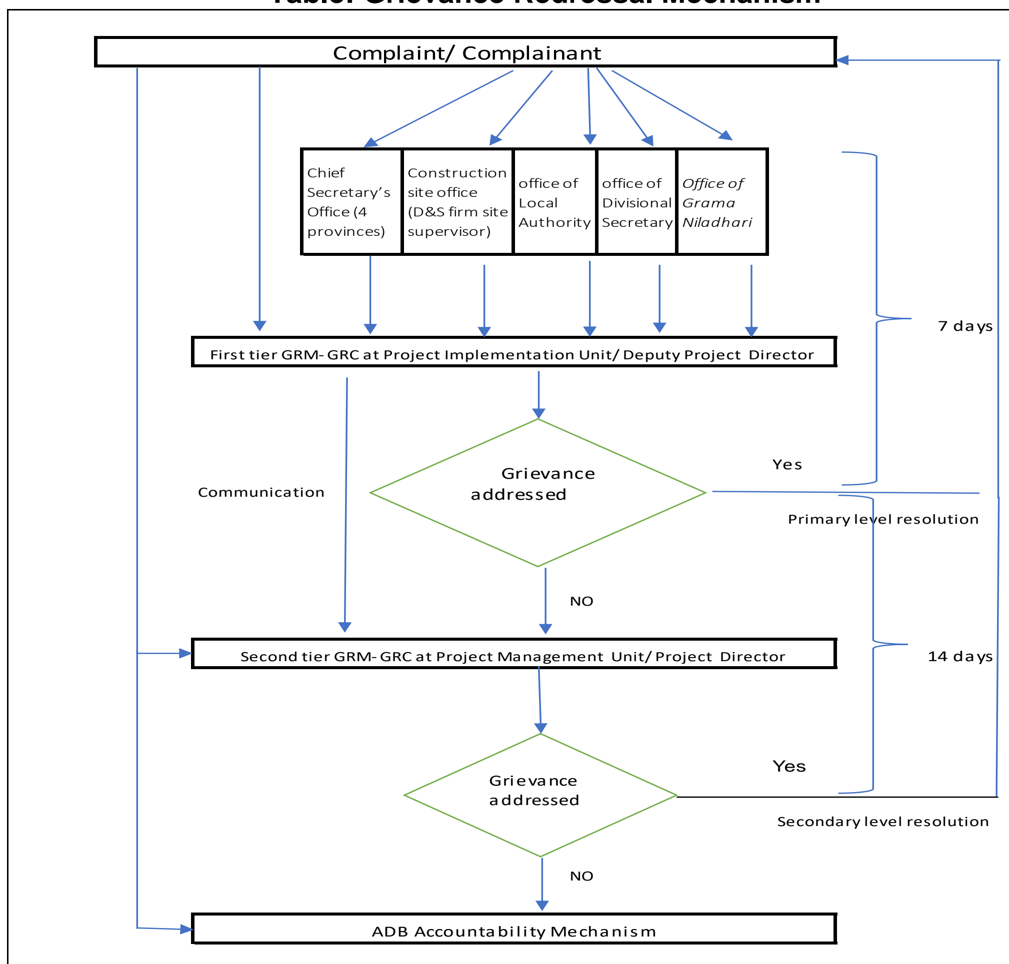
5. The GRM will not impede the AP's decision to use the legal system at any time.

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:

- enter the grievance in the Complaints register of the respective PIU or the PMU;
- open a grievance file for the specific case;
- maintain records of the GRC meetings; and
- 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 semi-annual environmental monitoring report submitted to ADB and will be disclosed to ADB website as required by SPS 2009.

Table: Grievance Redressal Mechanism



Sample GRM complaint form

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

(Sinhala, Tamil and English)

The MOHNIM/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 8: VEHICLE FLEET ANALYSIS AND REQUIREMENT

I. INTRODUCTION

1. The Health System Enhancement Project (HSEP) is for US $ 60 million (comprising $37.5 million in concessionary loan and $12.5 million grant from ADB, and $10 million equivalent from Government of Sri Lanka in counterpart funds). It will be delivered through a project investment modality and is expected to be effective from 2018 and will close in 2023.

2. The main objective of the project is to strengthen primary health care (preventive and curative) delivery system to ensure a more responsive and comprehensive primary health care system to the populations living in the provinces of Central, North Central, Sabaragamuwa, and Uva with a special focus on the geographically, socially, and economically-deprived populations in these provinces.

3. The project considers an equity perspective in planning and delivering of essential primary health services. It expects to further inform and operationalize government primary health care (PHC) reform initiatives, while improving underserved communities' access to primary health services, and address selected gaps in core public health capacities in line with the international health regulations (IHR).

4. The beneficiary population of the project is approximately 7,000,000 which is 33% of the Sri Lanka population (21,000,000) while the target population within the four provinces, is estimated to be approximately 2,300,000.

5. The expected project impact is to ensure a healthier nation by supporting a more responsive and comprehensive primary health care system in Sri Lanka. The project outcome is to improve efficiency, equity and measures for public health security in the health system.

II. RATIONALE FOR INVESTING IN VEHICLE

6. Primary health care in Sri Lanka is provided via both curative services and preventive services managed by the provincial and district health authorities under the policy and strategic direction of the MOHNIM.

7. Preventive services are managed by medical officers of health for a demarcated geographical area and are supported by his/her field-based team. The activities of this preventive health team are supervised and supported by a district level medical officer for selected disease groups. These include dedicated medical officers for maternal and child health, epidemiology, mental health, dental services, non-communicable diseases, tuberculosis. Planning units and the district and provincial health administrators support the tasks of these district level officers. The preventive services for maternal, child health, nutrition, dental services, and disease prevention and control activities for prevention and control of communicable and non-communicable diseases including screening and disease outbreak control and health promotion activities are provided at the medical officer of health offices and in field health centers that are located closer to the community. Based on current administrative guidelines, all these field officers at the district and at the medical officer of health levels are allocated dedicated vehicles for providing these field-based services. In addition, the provincial and district administration oversees the within district drug distribution for all primary and secondary health care institutions.

8. Primary curative care is provided via the primary medical care units (PMCUs) and the divisional hospitals (DHs) under the management of the relevant provincial and regional directors of health services. All DHs are required to provide inter hospital patient transfer services at no cost to the patient and therefore all DHs are required to have at least one ambulance parked in the hospital premises. PMCUs currently function only as outpatient units for 6 hours (8 to 12 noon and 2 to 4 pm) of the day and are therefore are not provided with ambulances.

9. In the four target provinces of Central, North Central, Sabaragamuwa, and Uva, and there are approximately 570 vehicles providing preventive and curative services. It is noted that as much as 323 vehicles (57%) are either older than 15 years or are in poor running condition which are often between 10 to 15 years old which are currently incurring large amounts of maintenance expenses to the government. Out of these 323 vehicles (57%) that are older and in poor running condition, 175 (54%) are ambulances primarily belonging to the primary health care hospitals (DHs) while the other 148 (46%) are mainly double cabs that are supporting preventive functions in the districts. Given that as much as half the vehicle fleet in these 9 districts (4 provinces) are old, and as the MOHNIM is planning to replace ambulances, the HSEP is proposing to replace 62 vehicles from the 148 (42%) that are not road worthy. This is a 46% (62) replacement of non-ambulance vehicles (148 double cabs, vans, trucks) that mainly provide preventive health services and amounts to replacing 20% (62) of the older vehicle fleet (323) that provides preventive and curative health services in the four provinces.

III. PROPOSED INVESTMENT RELATED TO VEHICLE

10. The project followed the following criteria to identify the offices that would have a vehicle replacement.

- Non-availability of a vehicle for the Regional Epidemiologist or to the Medical Officer Maternal and Child Health or if their vehicle is older than 15 years.
- Existing vehicle for the Medical Officer of Health, Health Education Officer and the Regional Drug Store is not road worthy or older than 15 years

11. The 5 vehicles allocated to the MOHNIM followed need-based criteria and are allocated to the Planning unit, Project Director and the Quarantine unit.

12. The project intends to include the purchase of 62 vehicles to the provinces and 5 vehicles to the MOHNIM which are to be distributed as in the table below.

Table 1: Proposed distribution of vehicles that are to be procured under the HSEP

Description	ıt project output	Type of vehicle	No of vehicles
Medical officers of Health in the 9 districts	Output 1.2	Double cabs	38
Medical officers providing maternal and child health in selected districts	Output 1.2	Double cabs	2
Health Education officers in each of the districts	Output 1.2	Vans	9
Regional Medical Supplies division in the 9 districts	Output 1.2	Covered trucks	9
Medical Officers providing Epidemiology and disease surveillance	Output 2.2	Double cabs	4
Quarantine unit for designated ports	Output 2.2	Double cab and Van	2
Management and Development Planning Unit	Output 3.3	Vans	2
Project Director	Output 3.3	Van	1
Total			67

IV. DISTRIBUTION OF VEHICLES

13. The proposed distribution of vehicles across provinces and districts is provided in the table below:

Table 2: Proposed distribution of vehicles across provinces and districts

S.No	Description	Type of vehicle
I	**North Central Province**	
A	**Polonnaruwa**	
1	MOH Dimbulagala	Double cab
2	MOH Elahera	Double cab
3	MOH Siripura	Double cab
4	Health promotion Officer (district level)	Van
5	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
B	**Anuradhapura**	
6	MOMCH	Double cab
7	Health promotion Officer (district level)	Van
8	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
9	MOH Palugaswewa	Double cab
10	MOH Nachchaduwa	Double cab
11	MOH Mahawilachchiya	Double cab
12	MOH NPE (Nuwaragam palatha)	Double cab
13	MOH Nochchiyagama	Double cab
14	MOH Kebithigollewa	Double cab
15	MOH Horowpatana	Double Cab
II	**Uva Province**	
A	**Moneragala**	
16	MO MCH	Double cab
17	Health promotion Officer (district level)	Van
18	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
19	MOH Thanamalwila	Double cab
20	MOH Kataragama	Double cab
21	MOH Sewanagala	Double cab
B	**Badulla**	
22	Regional Epidemilogist	Double cab
23	Health promotion Officer (district level)	Van
24	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
25	MOH Office Soranathota	Double cab
26	MOH Office Mahiyanganaya	Double cab
27	MOH Office Bandarawela	Double cab
28	MOH Office Hali Ela	Double cab
29	MOH Office Lunugala	Double cab
III	**Sabaragmuwa Province**	
A	**Kegalle**	
30	Health promotion Officer (district level)	Van
31	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
B	**Ratnapura**	

S.No	Description	Type of vehicle
32	Health promotion Officer (district level)	Van
33	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
34	MOH Elapatha	Double cab
35	MOH Imbulpe	Double cab
36	MOH Embilipitiya	Double cab
37	MOH Niwithigala	Double cab
IV	**Central Province**	
A	**Nuwera Eliya**	
38	MO MCH	Double cab
39	Regional Epidemiologist	Double cab
40	Health promotion Officer (district level)	Van
41	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
42	MOH Kothmale	Double cab
43	MOH Maskeliya	Double cab
44	MOH Walapane	Double cab
B	**Matale**	
45	Regional Epidemiologist	Double cab
46	Health promotion Officer (district level)	Van
47	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
48	MOH Pallepola	Double cab
49	MOH Galewela	Double cab
50	MOH Dambulla	Double cab
51	MOH Ambangangakorale	Double cab
52	MOH Yatawatta	Double cab
53	MOH Ukuwela	Double cab
C	**Kandy**	
54	Health promotion Officer (district level)	Van
55	Regional Medical Supplies Division (RMSD) (district level)	Covered Truck
56	MOH Thalatuoya	Double cab
57	MOH Panvila	Double cab
58	MOH Galagedara	Double cab
59	MOH Udunuwara	Double cab
60	MOH Werallagama	Double cab
61	MOH Gangawata Korale	Double cab
62	MOH Bambaradeniya	Double cab

ANNEX 9: HEALTH INFORMATION TECHNOLOGY SYSTEMS

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 (HSEP), 20 such systems were reviewed. 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 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 hospital wards or 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. As all the hospitals are not fully computerized electronic data availability from hospitals is not shared across and are incomplete. 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.

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

I. RECOMMENDATIONS

a. Establishment of a high-level coordination body within the MOHNIM

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 mater 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 MOHNIM 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.

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

6. 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.

7. 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.

8. 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.

9. It is proposed that a "cluster-based patient information system (CBPIS)" system is developed and piloted in the selected nine clusters supported via the HSEP 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.

10. It is recommended that the MOHNIM 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).

11. The investments related to the introduction of cluster-based information system will be financed by the HSEP. The investments include establishing internet connectivity to all facilities and networking within each facility. The details of computers and peripherals, other supporting items that would be procured for introducing the cluster-based HIT system are given below in Table 1.

Table 1: Investments related to the pilot HIT in cluster facilities (9 clusters in the 9 districts)

Description	**No of PMCUs in clusters**	**No of DHs in cluster**	**No of MOH areas to be linked to clusters**	**No of Apex Hospitals in clusters**	**Total**
For HIT in Clusters					
No of facilities in clusters	38	56	40	9	143
Computers and peripherals to be provided					
Computers (4 per PMCU,5 per DH, 1 per MOH office, 4 per Apex H)	4*38	5*56	1*40	4*9	508
UPS (1 per facility)	1*38	1*56	1*40	1*9	143
Server (1 per facility)	1*38	1*56	1*40	1*9	143
Laser printers (2 per PMCU and DH, 1 per MOH office, 4 per Apex H)	2*38	2*56			
Sticker printer (1 per facility)	1*38	1*56	1*40	1*9	143
Web cam (1 per computer)	4*38	5*56	1*40	4*9	508

12. The HSEP will also support the introduction of a geographical information system (GIS) for encouraging spatial based health planning and monitoring in the four target provinces. An individual (local) consultant will be supported under the HSEP to support establishment and utilization of GIS based technology to the four provincial and nine district health offices linked to the management and development planning unit (MDPU) and the National Institute of Health Science (NIHS) of the MOHNIM. The following investments related to this activity are envisaged.

Table 2: Support to GIS services in target provinces

Description	PDHS offices (4)	RDHS offices (9)	Total
Computers (2 per facility)	2*4	2*9	26
Tablets (5 per RDHS office)	0	5*9	45

13. In addition, as part of capacity development, the HSEP will support the establishment of a Distance Learning Center at the NIHS, MOHNIM linking the four provinces for carrying out training related to primary health care and other areas as needed.

Table 3: Support to the establishment of a Distance Learning Center

Description	NIHS	PDHS Office /Regional Training Centers	Total
Computers and UPS	50	40	90

ANNEX 10: BEHAVIOR CHANGE AND COMMUNITY MOBILIZATION STRATEGY

1. Changing disease and demographic profile of Sri Lanka is posing a significant challenge to its health systems. As an attempt to meet the changing patient needs and health profiles, todays health system has evolved to meet the population health needs via its secondary and tertiary care networks in the public health sector. This led to a gradual underinvestment at the primary medical care level. PHC facilities which include primary medical care units (PMCUs) and divisional hospitals (DHs) which are nearer to the patients are bypassed for secondary and tertiary care facilities which impacts the health system and health outcomes in many ways. Increased cost of treatment on the government and on the patient due to overuse of higher-level hospital services, inadequate availability of primary preventive care especially related to noncommunicable disease related risk factors and unequal access to health facilities within the population are among the key health sector challenges.

2. To support the government initiative of people centered health system providing 'health for all', ADB financed Health System Enhancement Project (HSEP) aims to strengthen primary care in vulnerable areas of Sri Lanka, provide a comprehensive package of services, enhance PHC utilization and address selected gaps in public health capacities in line with the international health regulations (IHR, 2005). The project will be implemented in four provinces, namely North Central, Central, Uva and Sabragamuwa, in which the share of lagging areas and vulnerable population is higher than in other provinces in Sri Lanka. Once the enhancement of the service delivery is complete, the project intends to support the implementation of a targeted behavior change communication and community mobilization (BCCM) strategy to increase PHC utilization to help provide a comprehensive service package via the primary health care facilities to the beneficiaries in the target provinces.

3. As part of project preparation, a comprehensive document was developed to outline the draft BCCM strategy and the implementation plan that is intended to be supported under the output 1 of the HSEP. 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, also supported under output 1 of HSEP, to improve PHC infrastructure and service package in the target provinces.

A. Assessment methodology

4. 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.

5. 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

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

7. 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.

8. 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.

9. 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.

10. 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

11. 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.

The primary audience to be engaged will include: (i) current users of the PMCUs/DHs and MOHs; (ii) 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

12. 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 HSEP

13. 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.

ANNEX 11: INDICATIVE HUMAN RESOURCE DEVELOPMENT PLAN

1. To support the government initiative of a people centered health system providing 'health for all', ADB-financed Health System Enhancement Project (HSEP) aims to strengthen primary care in vulnerable areas of Sri Lanka, provide a comprehensive package of services, enhance PHC utilization and address selected gaps in public health capacities in line with the international health regulations (IHR 2005). The HSEP intends to also support the governments proposed PHC reform with the piloting of '9 shared care cluster models'. The project will be implemented in four provinces, namely North Central, Central, Uva and Sabragamuwa, in which the share of lagging areas and vulnerable population is higher than in other provinces in Sri Lanka.

2. The training activities related to HSEP will be managed by the Project Director supported by a PMU staff member and the respective four Deputy Project Directors of the HSEP.

3. The HSEP will support training related to (i) PHC service provision, system enhancement, PHC design and piloting of PHC reforms; (ii) measures to introduce climate adaptation, and communicable disease surveillance and control and prevention including the implementation of the IHR in Sri Lanka. The training is expected to provide opportunities to expose PHC staff in the target provinces to PHC services and PHC models in other countries and for participating in PHC conferences. Disease surveillance, prevention and control is supported with the training related to infection prevention and control, health communication including risk communication to manage outbreaks and disease control and training on the implementation of the IHR in Sri Lanka. The training will also provide opportunities to establish the 'distance learning mode' to PHC training in Sri Lanka.

4. The proposed participants for undergoing the training programs include: (i) policy makers and administrative officials mainly from the 4 target provinces and relevant staff from the Ministry of Health, Nutrition and Indigenous Medicine (MOHNIM); (ii) PHC service providers from the four target provinces; and (iii) all categories of staff from the nine pilot clusters in the four target provinces.

5. An indicative human resource development (HRD) plan is given below.

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
PHC training					
Training / exposure visit on PHC service provision in selected countries (Thailand)	International	10 PHMs per province	40		PMU/PIUs
		5 PHIs per province	20		
		1 SPHM per province	4		
		1 SPHI per province	4		
		10 PMCU and DH staff per province	40		
		RDHS	9		
		1 representative from each province	4		
			121	7 (10 programs for 12 people over 5 years)	
Cluster care training					

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
Observation of shared care services to understand how the services are carried out in other countries Singapore)	International	4 per district consisting of 1 MO, 1 cluster head, 1 matron, 1 (PMCU and/or DH)	36		PMU/PIUs
		and 1 PDHS / Ministry or RDHS per district	4		
			40	**7**	
Health communications training					
Training on Health communications techniques including on risk communication	International	2 from the HPB (1 CCP/MO,1 HEO)	2		PMU/PIUs
		1 HEO from each district	9		
		1 from the FHB	1		
		1 Medical Officer of Health from each district	9		
			21	14	
Long-term care training					
Exposure visit to observe provision of long-term care for elderly	International	2 from each of the 9 clusters	18		PIUs
		1 from each province	4		
			22	6	
Attending PHC and Health systems related conferences					
Attending PHC conferences	International	1 per province per year	20		PMU/PIUs
		2 from the MOHNIM per year	10		
			30	5	
Hospital design and related training					
Training on Hospital designing including medical architectural planning, hospital engineering systems design, medical equipment, furniture planning, use of green technology and climate adaptation and mitigation technology	International	1 Structural engineer from each province	4		PIUs
		1 Architect from each province	4		
		1 Quantity surveyor from each province	4		
		1 Biomedical engineer from each province	4		
		1 Medical Officer (PDHS or a Dep PDHS) from each province	4		
			20	14	
Gender Related Training					
Gender training / sensitivity (will be offered as a course via Distance learning	National	2 PHC staff from 209 PMCUs	418		PMU/PIU
		10 PHC staff from 260 DHs	2600		

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
as well) (2 days face -to-face training)		50 staff from each 9 secondary Apex hospitals	450		
		20 from each 132 medical officer of health areas	2640		
			6108	244 programs each with 25 participants	
Resource person workshop for Gender related module development	National	25 participants from FHB and invited resource persons	25	1	PMU
Training program on Gender for Training of Trainers (TOT) to carry out district level training on gender	National	2 trainers from each of 9 districts	18	5	
		FHB and other invitees	7		
			25	1	
HCWM Training					
Consultative seminar to develop health care management plans for the 4 provinces	National	2 from each of the 9 districts	18		PMU
		1 from each of the provinces	4		
		Environment and Occupational Health unit officials	3		
			25	1	
Training on conducting HCW audit in selected health facilities in the 4 provinces and preparing institutional HCWM plans (1 program per district)	National	1 from each of the secondary Hospitals in the districts)	2 to 5		PIUs
		District level officials	5		
		15 developed Hospital representatives	15		
		Environment and Occupational Health unit officials and PMU	3		
			25 to 30	9 1-day programs	
Training on managing HCW in cluster facilities includes carrying out audit, preparing cluster HCWM plans (1 program per cluster)	National	4 from each of the Apex hospitals	4		PIUs
		District level officials	2		
		1 from each of the cluster linked hospitals	20		
		1 representative from each of the linked MOH offices	20		
		Environment and Occupational Health unit officials and PMU	4		
			50	9 1-day programs	

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
Safeguards Training					
ADB Safeguards principles, procedures, monitoring and reporting (one for each province and PMU)		Officials from MOHNIM	5		
		D and S firm representatives	10		PMU/PIUs
		PMU, PIUs (2 from each PIU) and 1 from PMU	9		
		Provincial and Regional Director	13		
		Chief Engineer's Office	13		
			50	1-day programs	
Finance Training					
Training on ADB's disbursement procedures	National	PMU/ PIU Accountants and other related project staff	25	1-day program	PMU
Procurement Training					
Comprehensive procurement training on ADB guidelines	National	Procurement staff and other officials directly responsible for project procurement	25	1-day program	PMU
Procurement awareness program on ADB regulations	National	Other staff including members of the Technical Evaluation committees and Procurement committees.	50	4 Intermittent 1/2-day programs	PMU
DLC training					
Training on Distance Learning techniques and methodology for the health sector	International	3 from NIHS	3		PMU
		1 from DDG ETR unit	1		
		TOT trainers from various units for family health, GIS, gender related courses	3		
			7	**14**	
Workshop costs for carrying out in class distance learning training programs	National	Participants (50 for each class)	50	40 programs each 50 participants)	PMU
IHR/ quarantine related training					

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
IHR and quarantine activities training of staff of Quarantine Unit, Port and airport health offices	International	2 from Quarantine unit, 2 from 6 POEs and 4 each from the 2 designated Ports	20	14	PMU
Vector control at Points of Entry training of staff of Quarantine Unit, Port and airport health offices	International	1 officer each from 6 POEs and 2 each from the 2 designated ports	10	14	PMU
Flight inspection/ship sanitation training of staff of Quarantine Unit and airport/port health offices	International	1 officer each from 6 POEs and 2 each from the 2 designated ports	8	14	PMU
Quarantine IT system training including web maintenance training of staff of Quarantine Unit	International	1 MO Informatics from Quarantine Unit	1	14	PMU
Training of staff on Web QHRMS (Quarantine Health Record Management and Surveillance System)	National	Staff from 8 POEs and others from MOHNIM etc.	25	3	PMU
Training on Infection prevention and control					
Training for IPC PHC module development	National	1 College of Microbiologist	1		PMU
		1 Microbiologist from NIHS	1		
		1 College of Physicians	1		
		9 Infection Control Nurse from each Province	9		
			12	7	
Training of PHC staff on IPC (to also be coordinated via distance learning)	National	2 PHC staff from 209 PMCUs	418		
		8 PHC staff from 260 DHs	2080		
		35 staff from each of the 9 Secondary Apex Hospitals	315		
		PHIs (approx. 750) from Medical Officer of Health areas	750		
			3563	143 Programs each with 25; 3 (intermittent)	
Health information technology training					

	International / National	Participant staff category	Total number of participants	Number of days of training	Implementing Unit
HIT staff training for use of PHN, disease surveillance, in cluster facilities and the MOH offices	National	10 PHC staff from 110 cluster linked PMCUs and DHs	1100		
		40 staff from each of the 9 Secondary Apex Hospitals	360		
		2 from 40 Medical Officer of Health areas	80		
			1540	62; 3 (intermittent)	
Observing a health inter-hospital HIT system which issues PHN and to understand the roles and responsibilities of hospital staff (South Korea)	International	2 per district: Cluster head or Dep RDHS and focal point for HIT in each cluster,	18		PMU/PIUs
		Director HI of the MOHNIM	1		
		2 from each province	8		
			27	7	

ANNEX 12: HUMAN RESOURCE FOR HEALTH FOR STRENGTHENING PRIMARY HEALTH CARE

1. The health indicators in Sri Lanka are comparable to some developed countries despite it being a lower middle-income country (LMIC) due to sustained investments on education and health over 75 years. The overall health outcomes are achieved at a very low cost.[32] However, this success also contributed to the twin phenomena of demographic transition and epidemiological transition. Sri Lanka's population is ageing with as much as 12% in the elderly age group in 2015 with a dependency ratio of 60. The rapidly ageing population, linked with the success in combating the major communicable diseases (CDs), a maternal and child mortality, the disease burden has rapidly shifted towards noncommunicable diseases (NCDs) including heart diseases, cancers, chronic lung diseases, diabetes mellitus, mental illness, accidents and injuries. Most chronic NCD patients require lifelong treatment and present with complications needing extensive human resources to manage and rehabilitate.[33] This is further fueled by the lack of general long-term care and specialized care for elderly. Sri Lanka also faces the challenge of acute and long-term care needs for injury and disability management.

2. To support the government initiative of reforming the public health system to a more people centered health system providing 'health for all', the ADB-financed Health System Enhancement Project (HSEP) aims to strengthen primary care in vulnerable areas of Sri Lanka, provide a comprehensive package of services, enhance PHC utilization and address selected gaps in public health capacities in line with the international health regulations (IHR 2005). The project will be implemented in four provinces, namely North Central, Central, Sabragamuwa, and Uva in which the share of lagging areas and vulnerable population is higher than in other provinces in Sri Lanka.

3. As part of project preparation, a comprehensive report on human resources for health for strengthening PHC was developed. The objective of this report is to review the HRH situation with regards to PHC provision in Sri Lanka and provide recommendations to further improve the PHC HRH situation with a special focus in the target provinces. The report is presented in three sections; (i) Introduction and context and a brief description on health service governance and delivery system focusing on PHC, (ii) HRH situational analysis with a focus on PHC: review of HRH imbalances and requirements in project provinces; assessment of human resource management (HRM) capacity needs; problems and gaps in HRH issues and the present system of training programs implementation, (iii) recommendations on HRH strengthening for PHC with specific recommendations for the target provinces. This Annex is a summary of the HRH report.

A. Public health system, HRH context and governance

4. The public sector health system in Sri Lanka is delivered via a decentralized system since 1987. The central ministry of health, nutrition and indigenous medicine (MOHNIM) provide tertiary care services, drug supplies, all HRH training and are responsible for formulating health policies, guidelines, setting standards, enacting legislation, setting uniform training standards for health staff, and ensuring availability of health staff across the country. The provincial health ministries located in each of the 9 provinces provide primary and secondary care services and preventive

[32] World Health Organization. 2018. *World Health Statistics 2018*. Washington DC. http://www.who.int/gho/publications/world_health_statistics/2018/EN_WHS2018_TOC.pdf?ua=1

[33] Engelgau M, Okamoto K, Navaratne KV, Gopalan, S. *Prevention and control of selected chronic NCDs in Sri Lanka: policy options and action.* World Bank's Human Development Network. 2010.

care services. Each province has a provincial director of health services (PDHS) who is responsible for total health care delivery within the province. S/he is supported by a regional director of health services (RDHS) who oversees a health district. The districts are further divided to medical officer of health areas which focus on preventive health services. PHC services and most secondary care services are provided and managed by the provinces. The Government also regulates the private sector health services through a parliamentary act[34] and constituting a regulatory council called the private health services regulatory council (PHSRC).[35] PHSRC is responsible for licensing, regulation and monitoring the standards of private medical institutions.

5. Governance of healthcare services is undertaken by the central MOHNIM and other licensing and regulatory authorities. The medical services act specifies the services, recruitment criteria and other matters related to the operation of the MOHNIM. The establishment code and financial regulations of the Government of Sri Lanka apply to all government health staff. These regulatory mechanisms govern the disciplinary codes and use of resources in government services. Other special circulars, rules and procedures issued by the MOHNIM give further guidelines on administration matters.

6. PHC in Sri Lanka is delivered via two parallel services: (i) *community/ preventive health services;* and (ii) *primary curative services.*

7. *Community/ preventive PHC services* in the public health care system are provided throughout the country, demarcated by distinct geographical areas conforming to local administrative divisions based on the medical officer of health area system. The services provided include maternal and child health, nutrition, family planning, and on communicable diseases prevention and control and health education and promotion strategies. The health units have defined catchment areas that coincide with local administrative units and currently number 341 areas. Generally, people register for and access free preventive health services within their area of residence.

8. *Curative PHC services are provided via 482 divisional hospitals* (DHs) providing both hospitalization and ambulatory services and 473 primary medical care units (PMCUs) providing only ambulatory care. All PHC services are provided by general (non-specialist) medical doctors and other staff.[36] But people have autonomy in accessing any level of curative facility (primary, secondary or tertiary care hospitals) for first contact care. A referral system is not in place.

B. HRH situation

9. The preventive care services are managed by the medical officers of health with the support of public health nursing sisters, public health inspectors and public health midwives while curative primary care human resources are provided by general medical officers, nurses, dispensers, pharmacists, medical lab technologists, radiographers, etc. via the 955 PMCUs or DHs located across the country. All HRH service categories attached to the DHs, PMCUs and MOH offices are considered as HRH PHC staff.

[34] Private Medical Institutions (Registration) Act, 2006.

[35] Private Health Services Regulatory Council (PHSRC) is an independent statutory body established by the Private Medical Institutions (Registration) Act of 2006.

[36] S. Perera. 2015. Center for Global Health Histories. Chapter 10: *PHC Reforms in Sri Lanka: Aiming at Preserving Universal Access to Health (Health for All: The Journey of Universal Health Coverage).* The University of York. United Kingdom.

10. Based on 2016 data, there are approximately 140,000 staff attached to the central MOHNIM and the nine provinces. Among them 82000 are skilled staff. It is seen that the PHC services are provided by 18% of all skilled staff in the health sector. From all medical officers (approximately 18,000) serving in Sri Lanka, 13% are serving in PHC facilities.[37]

11. The report highlights a maldistribution of staff across the three levels of care with as much as 80% of the public sector HRH workforce engaged in managing and providing secondary and tertiary care services.

12. In addition, there are large proportion of vacancies of staff in the PHC level. While no standards exist to identify the ideal no of required PHC staff or required PHC level medical officers at an international level, in the Sri Lanka context, it is mandated to at least provide all existing PMCUs and DHs with adequate staff numbers and have standards for providing the field-based health staff in MOH areas.[38] For medical officers, approximately 2,375 medical officers are currently providing PHC services but there is a shortfall of 23% (700 medical officers) in the PHC level and if two medical officers are to be posted to each of the 473 PMCUs (currently only one medical officer is available, and this is a recently approved reform)[39] then the short fall is as much 33% (1,180 medical officers) in the medical officer requirement in the PHCs. In addition, there are vacancies of essential staff needed to run laboratories with only 7% (103) of medical laboratory technologists (total 1,550) are attached to divisional hospitals. The report notes that as much as 70% of the medical laboratory technicians' posts are vacant in Ratnapura district, a target district under the HSEP.

13. Furthermore, the report highlights recruitment variations in various human resource categories with only the medical officers having an annual recruitment system. This has created gaps and career development challenges in staff categories other than medical officers. Gaps in making available opportunities for continuous professional development are noted. In addition, staff accreditation and quality enhancement opportunities are limited.

C. Recommendations

14. The foremost need is to fill the gaps in terms of availability and distribution of the health PHC workforce in the provinces. This needs to be addressed via two ways; (i) as there is a severe shortfall of HRH in the PHC settings, it will be necessary to review the maldistribution in each of the districts and in discussion with all relevant officials and trade unions there should be a road map developed to address the maldistribution of staff across different levels of care, different districts and between curative and preventive sectors. (ii) other than medical officers, there is also an urgent need to streamline the training intake of all categories of staff so that training occurs on a regular, annual basis at the training schools managed by the MOHNIM.

15. In addition, given the changing disease and demographic burdens and the reforms related to establishing a more people centered health system, there is a need to carry out a workload analysis, develop staffing projections for all categories of PHC staff. This will need to consider the current workload and the changes in the expected workload at the PHC level following the

[37] All skilled staff (excludes attendants and laborers) amount sot 82015. All skilled staff attached to PHCs (PMCUs, DH As, DH Bs, DH Cs, MOH offices) are 15,458. Among all medical officers (18,243 in the public sector), only 1,723 (13%) are medical officers engaged to provide PHC services.

[38] Government of Sri Lanka, Ministry of Health. 2012. *Circular on 'Criteria for deciding cadres of health staff for public health services in Sri Lanka' dated 28 March 2012*. Colombo.

[39] Government of Sri Lanka. MOHNIM, MDPU, 2018. *New policy on rational health care delivery in Sri Lanka.* Colombo. http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/2018/Batch231.pdf

finalization of the essential services package and the piloting of the shared care clusters system in selected areas. Therefore, the cadre and norms need to be revised according to standard criteria such as service demand, work load, demographic, geographical and territorial factors, international standards etc.

16. There is also a need to develop new competency-based job descriptions for all categories of HRH especially at the PHC level. In addition, a new country wide performance appraisal system should be established for increasing staff satisfaction and motivation. Given the non- availability of a continuous professional development opportunities, gaps in capacity is observed. As modern technology is now in place for easy access to continuous professional development, it is recommended to utilize information technology and distance learning modalities for this purpose.

D. Areas proposed to be supported under the HSEP

17. It is proposed that the HSEP resources be used to recruit an HRH consultant to work with the other partners, trade unions, MOHNIM and the provinces to carry out a work load analysis and in the drafting of a road map for HRH development in PHC in Sri Lanka. In addition, the project supports the establishment of a distance learning center at the National Institute of Health Sciences to further improve the quality and to introduce continuous professional development in the PHC sector in Sri Lanka. The training gaps in the PHC sector is also identified for providing training opportunities on various relevant areas under the HSEP.