INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 129.8 MILLION
(US$ 200 MILLION EQUIVALENT)

TO THE

DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

FOR A

SECOND HEALTH SECTOR DEVELOPMENT PROJECT

February 28, 2013

Human Development Unit
South Asia Region

This document is being made publicly available prior to Board consideration. This does not imply a presumed outcome. This document may be updated following Board consideration and the updated document will be made publicly available in accordance with the Bank’s policy on Access to Information.
CURRENCY EQUIVALENTS
(Exchange Rate Effective January 31, 2013)

Currency Unit = Sri Lankan Rupee (LKR)
LKR 126.35 = US$1
US$1.54 = SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

CEMOC Comprehensive Emergency Maternal and Obstetric Care
CIGAS Comprehensive Integrated Government Accounting Software
MOH Ministry of Health
CPS Country Partnership Strategy
DA Designated Accounts
DDG Deputy Director General
DGHS Director General Health Services
DLI Disbursement Linked Indicators
DP Development partner
eIMMR Electronic Indoor Morbidity and Mortality Returns
EEP Eligible Expenditure Program
EMF Environment Management Framework
EOHD Environment and Occupational Health Division
EPL Environmental Protection License
ERD Economic Relations Department
ETU Emergency Treatment Unit
FAO Food and Agricultural Organization
FBS Fixed Budget Selection
FC Finance Commission
FCTC Framework Convention for Tobacco Control
FHB Family Health Bureau
FM Financial Management
FR Financial Regulations
GDP Gross Domestic Product
GOSL Government of Sri Lanka
HCWM(F) Health Care Waste Management (Framework)
HMIS Health Management Information System
HRD Human Resource Development
HSDP Health Sector Development Project
HWL Hazardous Waste License
ICB International Competitive Bidding
ICD International Classification of Diseases
ICU Intensive Care Unit
IDA International Development Association
IMMR  Indoor Morbidity and Mortality Return
IUFR  Interim Unaudited Financial Report
JICA  Japan International Cooperation Agency
MCH  Maternal and Child Health
MDG  Millennium Development Goal
MLGPC  Ministry of Local Government and Provincial Councils
MOFP  Ministry of Finance and Planning
MRI  Medical Research Institute
NCB  National Competitive Bidding
NCD  Non-Communicable Diseases
NGO  Non-Governmental Organization(s)
NHA  National Health Accounts
NHDP  National Health Development Plan
NS  National Surveillance
ORAF  Operational Risk Assessment Framework
PDHS  Provincial Director of Health Services
PDO  Project Development Objectives
PFM  Public Finance Management
PMM  Department of Project Management and Monitoring in MOFP
PMOH  Provincial Ministry of Health
PSC  Project Steering Committee
QBS  Quality Based Selection
QCBS  Quality and Cost Based Selection
QMU  Quality Management Unit
RBF  Results-Based Financing
RDHS  Regional Director of Health Services
SAS MS  Senior Assistant Secretary Medical Services
SHSDP  Second Health Sector Development Program
THE  Total Health Expenditure
UNAIDS  United Nations Joint Program on HIV/AIDS
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
WFP  World Food Program
WHO  World Health Organization

Regional Vice President:  Isabel Guerrero
Country Director:  Diarietou Gaye
Sector Director:  Jesko Hentschel
Sector Manager:  Julie McLaughlin
Task Team Leader:  Kumari Vinodhani Navaratne
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## Basic Information

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Lending Instrument</th>
<th>EA Category</th>
<th>Team Leader</th>
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</thead>
<tbody>
<tr>
<td>P118806</td>
<td>Sector Investment and Maintenance Loan</td>
<td>B - Partial Assessment</td>
<td>Kumari Vinodhani Navaratne</td>
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</table>

<table>
<thead>
<tr>
<th>Project Implementation Start Date</th>
<th>Project Implementation End Date</th>
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<td>01-Jul-2013</td>
<td>30-Sep-2018</td>
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<table>
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<th>Expected Effectiveness Date</th>
<th>Expected Closing Date</th>
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<td>01-Jul-2013</td>
<td>30-Sep-2018</td>
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<table>
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<tr>
<th>Joint IFC</th>
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<table>
<thead>
<tr>
<th>Sector Manager</th>
<th>Sector Director</th>
<th>Country Director</th>
<th>Regional Vice President</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie McLaughlin</td>
<td>Jesko S. Hentschel</td>
<td>Diarietou Gaye</td>
<td>Isabel M. Guerrero</td>
</tr>
</tbody>
</table>

**Borrower:** Ministry of Finance and Planning

**Responsible Agency:** Ministry of Health

- **Contact:** Dr. Y.D.N. Jayathilaka
- **Telephone:** 94112698511
- **Email:** secretary@health.gov.lk

**Responsible Agency:** Ministry of Local Government and Provincial Councils

- **Contact:** Mr. R.A.A.K. Ranawake
- **Telephone:** 94112305326
- **Email:** a_ranawaka@yahoo.com

## Project Financing Data (US$M)

- [ ] Loan
- [X] Credit
- [ ] Grant
- [ ] Guarantee

The credit would be a Specific Investment Credit repayable under Standard IDA Blend Term with 25 years maturity.
Total Project Cost (US$M): 5170.00
Total Bank Financing (US$M): 200.00

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<th>Financing Source</th>
<th>Amount(US$M)</th>
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<td>BORROWER/RECIPIENT</td>
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<tr>
<td>International Development Association (IDA)</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>5170.00</strong></td>
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**Expected Disbursements (in USD Million)**

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<tr>
<th>Fiscal Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td><strong>Annual</strong></td>
<td>24.19</td>
<td>16.69</td>
<td>45.75</td>
<td>45.75</td>
<td>34.81</td>
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<tr>
<td><strong>Cumulative</strong></td>
<td>24.19</td>
<td>40.88</td>
<td>86.63</td>
<td>132.38</td>
<td>167.19</td>
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**Project Development Objective(s)**

To upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases.

**Components**

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<th>Component Name</th>
<th>Cost (USD Millions)</th>
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<tbody>
<tr>
<td>Support to priority areas under the National Health Development Plan</td>
<td>190.00</td>
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<tr>
<td>Innovation, results monitoring and capacity building fund</td>
<td>10.00</td>
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**Compliance**

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<th>Policy</th>
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<tr>
<td>Does the project depart from the CAS in content or in other significant respects?</td>
</tr>
<tr>
<td>Does the project require any waivers of Bank policies?</td>
</tr>
<tr>
<td>Have these been approved by Bank management?</td>
</tr>
<tr>
<td>Is approval for any policy waiver sought from the Board?</td>
</tr>
<tr>
<td>Does the project meet the Regional criteria for readiness for implementation?</td>
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**Safeguard Policies Triggered by the Project**

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<th>Safeguard Policies Triggered by the Project</th>
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<th>No</th>
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<tr>
<td>Natural Habitats OP/BP 4.04</td>
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<td>Forests OP/BP 4.36</td>
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<td>Pest Management OP 4.09</td>
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<tr>
<td>Name</td>
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<td>Due Date</td>
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<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
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<td>Indigenous Peoples OP/BP 4.10</td>
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<td>Involuntary Resettlement OP/BP 4.12</td>
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<td>Safety of Dams OP/BP 4.37</td>
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<td>Projects on International Waterways OP/BP 7.50</td>
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<td>Projects in Disputed Areas OP/BP 7.60</td>
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**Legal Covenants**

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<tr>
<th>Name</th>
<th>Recurrent</th>
<th>Due Date</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Financial Management and Reporting</td>
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<td></td>
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</tr>
</tbody>
</table>

**Description of Covenant**

GOSL will ensure that financial records are maintained and prepare and furnish as part of the Project Report not later than forty-five (45) days after the end of each calendar quarter, interim unaudited financial reports for the Project covering such quarter period.

<table>
<thead>
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<th>Name</th>
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<th>Frequency</th>
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<tr>
<td>Environment Safeguards</td>
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<td>Yearly</td>
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**Description of Covenant**

GOSL shall (a) by no later than February 28 each year, until the completion of the Project, commencing February 28, 2015, carry out an environmental assessment and prepare a report assessing the performance of the Environment Management Framework (b) review by March 30 of such year, or such later date as requested, the environmental assessment report.

<table>
<thead>
<tr>
<th>Name</th>
<th>Recurrent</th>
<th>Due Date</th>
<th>Frequency</th>
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<tr>
<td>Reporting on Disbursement Linked Indicators</td>
<td>X</td>
<td></td>
<td>Yearly</td>
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</table>

**Description of Covenant**

GOSL will no later than March 31 each year, commencing March 31, 2014, prepare and furnish a report integrating the results of the DLIs and the monitoring and evaluation activities performed on the progress achieved in the carrying out of the Project and in meeting the targets for DLIs during the preceding calendar year.

<table>
<thead>
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<th>Name</th>
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<th>Due Date</th>
<th>Frequency</th>
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<tr>
<td>Project Steering Committee</td>
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**Description of Covenant**

GOSL will constitute for monitoring and coordination of the project, a Project Steering Committee chaired by the Secretary of MOH, and including Senior Management of MOH, FC, and MLGPC, all nine Health Secretaries, all nine PDHSs, and appropriate representatives from MOFP.

**Conditions**

<table>
<thead>
<tr>
<th>Name</th>
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### Description of Condition

#### Team Composition

<table>
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<tr>
<th>Bank Staff</th>
<th>Name</th>
<th>Title</th>
<th>Specialization</th>
<th>Unit</th>
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<tbody>
<tr>
<td></td>
<td>Kerima C. Thilakasena</td>
<td>Program Assistant</td>
<td>Program Assistant</td>
<td>SASHD</td>
</tr>
<tr>
<td></td>
<td>Kumari Vinodhani Navaratne</td>
<td>Senior Health Specialist</td>
<td>Team Leader</td>
<td>SASHN</td>
</tr>
<tr>
<td></td>
<td>Kishor Uprety</td>
<td>Senior Counsel</td>
<td>Senior Counsel</td>
<td>LEGES</td>
</tr>
<tr>
<td></td>
<td>Henri A. Aka</td>
<td>Operations Officer</td>
<td>Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td></td>
<td>Alejandro Welch</td>
<td>Information Assistant</td>
<td>Information Assistant</td>
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<td></td>
<td>Chau-Ching Shen</td>
<td>Senior Finance Officer</td>
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<td></td>
<td>Cornelis P. Kostermans</td>
<td>Lead Public Health Specialist</td>
<td>Lead Public Health Special</td>
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<td></td>
<td>Nkosinathi Vusizihlobo Mbuya</td>
<td>Senior Nutrition Spec.</td>
<td>Senior Nutrition Spec.</td>
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<td></td>
<td>Jiwanka B. Wickramasinghe</td>
<td>Senior Financial Management Specialist</td>
<td>Senior Financial Management Specialist</td>
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<td>Mohamed Ghani Razaak</td>
<td>Senior Social Development Specialist</td>
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<td>Sangeeta Carol Pinto</td>
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<td>Darshani De Silva</td>
<td>Environmental Specialist</td>
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<td>Sunethra Chandrika Samarakoon</td>
<td>Procurement Specialist</td>
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<td>SARPS</td>
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<td>Bernadeen Enoka Wijegunawardene</td>
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<td>Rabia Ali</td>
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<th>Locations</th>
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### Institutional Data

#### Sector Board
Health, Nutrition and Population

#### Sectors / Climate Change
 Sector (Maximum 5 and total % must equal 100)

<table>
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<tr>
<th>Major Sector</th>
<th>Sector</th>
<th>%</th>
<th>Adaptation Co-benefits %</th>
<th>Mitigation Co-benefits %</th>
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<td>Public Administration, Law, and Justice</td>
<td>Public administration-Health</td>
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<tr>
<td>Health and other social services</td>
<td>Health</td>
<td>70</td>
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</table>

Total 100

☑️ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

#### Themes
 Theme (Maximum 5 and total % must equal 100)

<table>
<thead>
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<th>Major theme</th>
<th>Theme</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>Human development</td>
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<tr>
<td>Human development</td>
<td>Nutrition and food security</td>
<td>25</td>
</tr>
<tr>
<td>Human development</td>
<td>Injuries and non-communicable diseases</td>
<td>25</td>
</tr>
<tr>
<td>Human development</td>
<td>Other human development</td>
<td>25</td>
</tr>
</tbody>
</table>

Total 100
I. STRATEGIC CONTEXT

A. COUNTRY CONTEXT

1. Sri Lanka is a lower middle income country with a per capita income of US$ 2,864 (2011). Poverty rates have fallen from 15% of the population in 2006-7 to 9% in 2009-10, most dramatically in the estate sector\(^1\) (from 32-11%) following a major wage increase at the beginning of 2010. Inequality of consumption declined between 2006-7 and 2009-10, with the Gini index falling from 0.40 to 0.36.\(^2\) However, geographic differentials in poverty rates are significant, e.g., poverty rates in Colombo District are under 4% contrasting with 20% in Batticaloa District.

2. The Government has traditionally prioritized social services, endeavoring to provide universal health and education coverage and promote gender equality, and it has succeeded to a large degree. The country’s human development index ranked it 97 among 187 countries in 2011\(^3\) and it is also on track to achieving most of the targets of the Millennium Development Goals (MDG) according to a review conducted in 2008\(^4\).

3. With a population of 20.5 million in 2011\(^5\), Sri Lanka is going through a rapid demographic and epidemiologic transition owing in part to the successes in the health sector, that is, increased life expectancy (74.9 years in 2011) and decreased fertility (latest data - 2006: 2.3 children per woman)\(^6\). The management of the rapid aging of the population (9.2% of the population being over 60 years in 2000; expected to reach 28.5% by 2050\(^7\)), constitutes a key contextual factor in the country’s development outlook.

B. SECTORAL AND INSTITUTIONAL CONTEXT

4. The Government of Sri Lanka’s (GOSL) health programs are guided by the *Mahinda Chintana: Vision for the Future—Sri Lanka, The emerging wonder of Asia* (2010-16), the national policy and strategic framework for development and growth in Sri Lanka, and by the national health policy of 1996, a health master plan for the period 2007-16, and a detailed five-year National Health Development Plan (NHDP) which includes as a priority area the systems strengthening plan for the sector for 2013-17.

*Health status*

5. Sri Lanka has better health indicators than most developing countries and many lower-middle-income countries. The remarkable success in reducing maternal and infant mortality to very low levels, i.e., 36 per 100,000 and 12.2 per 1,000 live births respectively (2006-latest

---

\(^1\) In the Sri Lankan context “estate sector” refers to the population who live and work in plantations called “tea estates” or “rubber estates”


\(^3\) Human Development Report, the United Nations Development Program, 2011

\(^4\) MDG Indicators of Sri Lanka Mid-Term Review, Department of Census and Statistics (2008)


\(^6\) Demographic and Health Survey, 2006-07

\(^7\) Addressing the needs of an Ageing Population in Sri Lanka, World Bank, 2009
reported Registrar General data)\textsuperscript{8}, is partially the result of the extended availability of effective and integrated maternal and child health (MCH) services for the last half century. Services for the prevention and control of communicable diseases are widely accessible, with key interventions such as childhood immunizations, antenatal care and institutional deliveries, at nearly 100% coverage. Barring under-nutrition and some persisting communicable diseases, such as tuberculosis, dengue, rabies and leptospirosis, Sri Lanka has successfully dealt with most of the typical health problems of low-income countries. However, maintaining and enhancing these achievements will require continued efforts. It remains with the challenge of malnutrition and is now encountering a new burden of non-communicable diseases.

6. The World Bank has supported the Sri Lankan health sector through analytical work and International Development Association (IDA) credits/grants since the late 1980s with the most recent being the Health Sector Development Project (HSDP) from 2004 to 2010. That project contributed to improving service delivery and building system capacity at the central, provincial and district levels.

\textit{Nutrition}

7. Against the backdrop of the impressive achievements in most health indicators, malnutrition among mothers and children less than five years continues to be a challenge in Sri Lanka. Over a fifth (21\%) of children under-five years of age are underweight, about 18\% stunted and 14.7\% wasted. Over 40\% of pregnant and lactating mothers have been found to have anemia. Furthermore, these national aggregates mask the inequalities between regions and much worse outcomes among the poor, the conflict-affected populations and workers in the estates sector\textsuperscript{9}.

8. Sri Lanka is also in the midst of a nutrition transition whereby both over-nutrition and under-nutrition coexist, sometimes even in the same family. The transition is characterized by a shift from traditional diets based on indigenous staples, legumes, and fruits and vegetables, to a pattern of increased consumption of processed and imported animal foods and of sugar, fats, and salt. A more sedentary lifestyle is another aspect of this transition.

9. Decades of extensive but predominantly supply-driven nutrition programming have yielded less than expected results compared to the economic and other social indicators in Sri Lanka. Hence, there needs to be a fundamentally different approach to malnutrition prevention and control which shift focus to demand creation and community based interventions. While poverty, food insecurity and non-health sector interventions such as safe water and sanitation continue to be important contributors, interventions for improving the eating, feeding and caring practices among pregnant and lactating women and children under-two are most important.

10. The National Nutrition Policy, establishment of the National Nutrition Secretariat at the Presidential Secretariat and the development of a multi-sectoral national nutrition implementation plan are expected to provide the direction required to address malnutrition in the next 5-10 years in Sri Lanka. A key strategy under this policy is to reduce maternal and child under-nutrition, by a special focus on the first 1000 days of life (from conception to 24 months).

\textsuperscript{8} Registrar-General’s Department, Government of Sri Lanka
Non-Communicable Diseases

11. An increasing proportion of the population is suffering from NCDs and this increase is associated with a rapidly changing age distribution, economic development, urbanization, increased motorization and lifestyle changes (low levels of physical activity, less healthy eating, and tobacco and alcohol and substance abuse).

12. During the past half-century, the proportion of deaths due to cardiovascular diseases has increased from 3 to 24% while that due to infectious diseases has decreased from 42 to 20%. While chronic NCDs are often perceived to be associated with affluent lifestyles, they are also a significant burden on the poorer segments of the population. Selected risk factors and NCD’s such as hypertension do not show a significant difference between the lowest and highest wealth quintiles, while diseases like asthma show a significant difference in deaths per 100,000 populations for different socio-economic groups. As publicly provided health care services do not yet provide comprehensive coverage for these diseases, the poor also face a financial burden to treat such chronic illnesses, and in the absence of disability insurance, they will also suffer from a loss of income.

13. Mental health related illness rates are also high and the suicide rate was estimated at 0.33 per 1000 population in 2000. The highest rates of cancers for women are cancer of the breast and cervix, and of the oral cavity for men. The burden of injuries due to traffic accidents, natural disasters, industrial faults, burns, drowning, falls and violence are also substantial. Injuries affect mainly the young male population and account for 15% of all registered deaths and for approximately 18% of all public hospital admissions annually.

Health service delivery and administration

14. The health sector was devolved in 1987. The Ministry of Health (MOH) is responsible for stewardship functions such as policymaking, development of guidelines, program monitoring and technical oversight, the purchase and distribution of drugs and consumables, human resource training and deployment (for provinces as well as the center), and the operation of tertiary and a few other selected hospitals. Nine Provincial Ministries of Health (PMOHs), each with a department headed by a Provincial Director of Health Services (PDHS) and 26 health districts.

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9 The term Non-Communicable Diseases (NCDs) is used in this document to include both chronic and acute NCDs, e.g., cardio-vascular diseases, all cancers, endocrine disorders such as diabetes mellitus, degenerative diseases, mental illnesses, asthma, renal disease of unknown etiology and injuries from all causes. Chronic NCDs is used when referring to Diabetes, Hypertension, Asthma, Cancers, renal diseases, cerebrovascular and circulatory diseases.

10 Prevention and Control of selected Non Communicable Diseases in Sri Lanka, 2011. HNP Discussion Series, World Bank


12 Cancer incidence in Sri Lanka 2006, Ministry of Health, Rates given as age standardized rates per 100,000 world population men or women.

each led by a Regional Director of Health Services (RDHS), are responsible for secondary and primary levels of curative care and all preventive services. Annex 3 includes a diagram depicting the organization of the public sector health services in Sri Lanka.

15. The public sector provides about 90-95% of all inpatient admissions (approximately 70,000 hospital beds), 50-60% of all outpatient consultations, and almost all preventive health care while the remainder is provided by the private sector.

16. The network of publicly managed facilities includes about 650 hospitals (50 under MOH + 600 under PMOHS), about 500 outpatient facilities (provincially managed) and 325 Medical Officer of Health (MOH) area offices providing preventive health care (provincially managed).

A clear separation between preventive and curative service provision at the local level is a unique feature of the Sri Lankan health system, which has also contributed to its remarkable health status results. Approximately 120,000 staff are employed by the government’s health system (about 40% under the MOH and 60% under the PMOHS).

17. The PMOHS receive their funds through the Chief Secretary of their respective province. The capital funds are received by the province as a direct transfer from the Treasury in the Ministry of Finance and Planning (MOFP) and the recurrent grants to the provinces are allocated to the Ministry of Local Government and Provincial Councils (MLGPC) and directly released as a block grant to the Chief Secretaries accounts at the provinces based on recommendations given by the Finance Commission (FC). The MLGPC serves as the central ministry representing provincial and local government bodies.

18. Even though budgeting is input based, the FC has recently introduced for the provinces a planning process which shifted from input to output focus and regular monitoring emphasizes results more than expenditures. MOFP is also interested in enhancing the focus on results, and as such, NHDP is designed with a results-based approach.

19. Still, the MOH and PMOHS continue to allocate the budget for operational costs to each hospital largely on the basis of that hospital’s historical budget, which is closely related to the number of beds and staffing of the hospital rather than on its demand, disease burden, or productivity. Decisions regarding human resources, services provided or adjustments of bed numbers or other hospital services to meet the health needs are generally made by the MOH. The exception to this is the only board-managed Sri Jayawardenapura Teaching Hospital, which functions as an experimental model of a publicly owned facility which attempts to be financially self-sufficient.

**Curative health services**

20. Outpatient physician contacts at four visits per capita per annum, are lower than levels observed in more advanced Asian economies, whereas in-patient admissions at 0.20 per capita in 2008 are among the highest in the world. This high utilization of in-patient services is the result of various factors, including a largely educated population demanding specialized services and care, relatively easy access to tertiary and secondary care hospitals (in the absence of a referral system), physician behaviors, and non-availability of out-patient services in most government
hospitals after 4 PM (now extended to 8 PM in some facilities), however it may be a far less efficient approach to addressing many health needs.

21. Standards and norms for service delivery are set centrally, but no hospital accreditation system has been established. The absence of an accreditation system has resulted in limited effective regulation of curative care quality in both the public and private sector. Hospital quality enhancement systems were initiated under the Bank-financed HSDP. However, mechanisms and systems for reporting on regular clinical audits, mortality analysis, drug utilization and availability trends, infection rates in surgical and Intensive Care Unit (ICU) patients, use of guidelines for patient management, laboratory management, medical equipment introduction and management guidelines, utilization of antibiotics, estimation of drugs requirements based on patient load, and following up of patient outcomes are not yet in place across all hospitals.

22. The hospital information system has expanded over the years but it is still paper-based and not timely. The hospital Indoor Morbidity and Mortality Return (IMMR) is utilized to report on all in-patients (approximately 4.5 million patient episodes) using a grouped version of the International Classification of Diseases (10th revision). Out-patient and long term out-patient (clinic patient) information (approximately 50 million and 16 million patient episodes per annum respectively) is reported only as numbers of visits, without age, sex or clinical information. The drug availability and usage data are reported upon but information is not analyzed so as to plan for future requirements. Maternity information, mortuary statistics and police records are maintained in hospitals, and all reports maintained in hospitals are sent to the Medical Statistics Unit on an annual basis for the compilation of the Annual Health Bulletin published by MOH. As in many developing countries, the publication of this report is generally late by several years - the latest one is for 2008.

Preventive health services

23. Preventive health care services are provided through a well laid out network of facilities across the country, each of which is led by a Medical Officer of Health. Each Medical Officer of Health covers a well-defined geographic area with a population ranging from 50,000 to 100,000. The Medical Officer of Health also coordinates the smaller curative care institutions and other local bodies in the area. Medical Officer of Health teams includes Public Health Nursing Sisters (PHNS), Public Health Inspectors (PHIs), and Public Health Midwives (PHMs). Comprehensive antenatal, natal and post natal care, family planning, Well Women services, immunization, nutrition services, communicable disease prevention, school health and environmental and occupational preventive services are all provided free of charge. While pilot interventions to expand the services for mental health and other NCDs are in place, the package of preventive health services are yet to include NCD prevention and promotion services in a systematic and comprehensive manner.

24. The preventive health information system (communicable diseases and MCH services) is also paper-based but is reported on time to the MOH on a regular basis. The data on MCH and communicable diseases are managed by the Family Health Bureau (FHB) and the Epidemiology Unit of MOH, respectively.
Health care waste management

25. Sri Lanka took many positive steps towards regularizing and standardizing health care waste management (HCWM), with significant support from the two previous World Bank funded projects. The MOH developed a National Policy for HCWM, carried out a situation analysis of HCWM practices in the sector and then produced the National Guidelines and a National Action Plan in 2001. In addition, specific HCWM regulations were introduced under the National Environmental Act (NEA) mandating every health care facility in the country to obtain an Environmental Protection License (EPL) from the Central Environmental Authority. Notwithstanding these efforts, HCWM remains a significant environmental issue. Apart from implementing the HCWM plan for 10 hospitals in the Colombo municipal area (which was commissioned in 2010) with support from HSDP, the government’s HCWM regulations are yet to be complied with. Only seven teaching hospitals currently have an EPL.

Health financing\textsuperscript{14}

26. Per capita health expenditure in Sri Lanka was approximately US$70 in 2008 (the most recent year for which data exists). Total health expenditure as a share of Gross Domestic Product (GDP) was 3.5% with government financing of health expenditure at approximately 48.2%, private sector at 51.8%. The 51.8% of total health expenditure which is private only accounts for about 5-10% of inpatient care and 50% of ambulatory care, with the larger share on drugs, self-treatment and investigative/diagnostic services. The share of total government spending has remained relatively stable as a share of the total health expenditure (THE) over the last decade. Over 82% of the private financing has been out-of-pocket expenses. The share of private health insurance has increased from less than 1% in 1990 to about 5% in 2008, while health expenditure financed by employers has remained constant in the range of 8% over the period 1990-2008. The World Bank in consultation with the Ministry of Health is currently conducting a private health sector review to better understand the private health sector, and thus support the government in creating a basis for dialogue and potential collaboration.

27. Public expenditures on health are increasingly centralized with a large and increasing share of public funds (as much as 65% in 2008 and 75% in 2012 budget as compared with 57% in 1998) being channeled through the MOH (though this includes the drugs and pharmaceuticals centrally procured for the provincially managed hospitals as well). The share of total public health spending by Provincial Councils declined from 41% in 1991 to 33% in 2008 and 25% in 2011. The preventive expenditures, most of which are from the public sector, have decreased from 9 to 5% of THE during the period 1990-2008.

System Challenges

28. In summary, the current health system is not fully well-positioned to deal effectively with health problems of emerging middle-income countries. Developing a modern health management information system, establishment of a quality assurance system, strengthening the capacity for results based planning and management and strengthening the coordination between institutions

\textsuperscript{14} Sri Lanka Health Accounts, National Health Expenditure 1990 to 2008, Institute for Health Policy Health Expenditure Series No 2 July 2011.
and agencies for coordinated development and continuing human resource development are essential to improve the health system and better address the changing health needs of Sri Lanka.

C. **Higher Level Objectives to which the Project Contributes**

29. Investing in further improvement of the health system will be a critical pre-requisite for Sri Lanka’s vision as reflected in the *Mahinda Chintana: Vision for the Future, Sri Lanka—The emerging wonder of Asia (2010-16)*. A more modernized and efficient health system employing more international standards will not only help achieve the objective of improving living standards and social inclusion, but it will also contribute to the broader objectives set out in the vision document, including sustained economic growth, and a move towards a knowledge-based and competitive economy.

30. The World Bank’s Country Partnership Strategy (CPS) seeks to deepen the World Bank Group’s support to Sri Lanka in addressing its emerging middle-income country agenda. The CPS includes support to the Mahinda Chintana’s three goals, i.e., (i) doubling per capita income, (ii) shifting the structure of the economy, and (iii) improving living standards and social inclusion. The Second Health Sector Development Project (SHSDP) is an important contributor to the CPS, most directly to the goal of improving living standards and social inclusion, and indirectly to the first two goals as well.

II. **Project Development Objectives**

A. PDO

31. The project development objective (PDO) is to upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases.

**Project Beneficiaries**

32. The project is expected to benefit the whole population of the country, especially the poorer and more vulnerable population groups who depend more on public health services. The project will benefit directly those who are vulnerable to under-nutrition; MCH problems; continuing, emerging and re-emerging communicable diseases (tuberculosis, dengue, leptospirosis, HIV/AIDS; rabies and other zoonotic diseases); and NCDs. Children under five years of age, pregnant and lactating women and adolescent girls are being targeted for nutrition interventions, while young, working aged and elderly women and men are expected to benefit more from NCD interventions. Because of the disproportionate financial burden created by NCDs for the poor, enabling the public sector to upgrade standards of performance will be of particular benefit to this population.

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PDO Level Results Indicators

33. The following results indicators will be used to measure progress towards achievement of the PDO:
   (i) Percentage of persons (over 40 years) screened for selected NCD (diabetes, hypertension, cancer breast and oral) at healthy lifestyle centers;
   (ii) Percentage of pregnant women who are anemic after the second trimester;
   (iii) Percentage of centrally managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 1);
   (iv) Percentage of provincially managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 2);
   (v) Percentage of MOH managed health facilities sending indoor morbidity data through e-IMMR (DLI 3);
   (vi) Percentage of provincially managed health facilities sending indoor morbidity data through e-IMMR (DLI 4).

III. PROJECT DESCRIPTION

A. PROJECT COMPONENTS

34. The project includes two Components, as follows:

Component I: Support to priority areas under the National Health Development Plan (GOSL US$ 5,165 million, of which IDA contribution will be US$ 190 million for 5 years)

35. Component I will contribute to the goals of the NHDP, supporting the overall program. The IDA funds will complement GOSL funds; while the Bank’s technical engagement and monitoring will focus on specific thematic areas: (i) addressing maternal and child health and nutrition and communicable diseases, (ii) prevention and control of non-communicable diseases, and (iii) health system improvement measures.

Thematic area 1: Addressing maternal and child health and nutrition

36. Implementation of those interventions targeted at the first “1000 days” (as malnutrition from conception through age two causes the most irreversible damage) with a focus on the under-served areas will be further strengthened. The nutrition interventions will be specifically targeted at (i) pregnant and lactating women and (ii) children up to two years of age. NHDP also ensures improved targeting of these interventions to underserved areas, such as the estate communities and the urban poor. The use of community groups/mobilizers will be piloted and encouraged for the implementation of community-based nutrition activities.

37. The program will also improve the capacity of health service providers through various forms of training, mentoring and supervision to deliver nutrition interventions at facility and community level. Enhancing the capacity and empowering community organizations to plan, implement and monitor relevant nutrition interventions will also be supported.
38. The program will establish a national monitoring and evaluation and nutrition surveillance system. The system will monitor the (i) implementation of the key nutrition “1000 days” interventions; (ii) strengthen the utilization of national surveillance reports for decision making at national and divisional levels; and (iii) link the surveillance data to the national nutrition information system and to existing tools and systems of the GOSL.

39. The NHDP further plans to strengthen services provided for MCH and integrate the above nutrition interventions in the program wherever possible.

40. The release of IDA credit funds will be linked to the achievement of the following disbursement linked indicator (DLI) for this thematic area:

- Percentage of MCH clinics with an agreed package of equipment and supplies for the provision of care for pregnant women and children under 5 years (DLI 5).

41. In addition the following indicators relevant to this thematic area will be monitored during the project period:

- Percentage of Medical Officer of Health areas with at least three health and nutrition community support groups;
- Percentage of pregnant women with anemia after the second trimester (PDO indicator);
- Percentage of comprehensive emergency maternal and obstetric care (CEMOC) facilities providing 24x7 CEMOC services.

**Thematic area 2: Improving the prevention and control of non-communicable diseases**

42. The program will further improve the implementation of the framework convention for tobacco control (FCTC), the Tobacco Control Act and support the introduction of legislation for the control of indoor air pollution, pesticides and excessive alcohol, salt, sugar and trans fat usage. Further, mechanisms for increasing safety awareness and supporting the establishment of safe communities will be encouraged. These activities will be supported with the development of communication strategies for prevention and control of chronic and acute NCD.

43. Acute NCDs will be managed more effectively with the availability of fully-functioning 24-hour emergency treatment units (ETUs) at all levels of hospitals, according to accident and emergency policy, standards and guidelines that will be finalized in the first year of the project’s implementation. The ETUs will manage acute NCDs, acute complications of chronic NCDs and any other emergency medical/surgical situations, thus improving the quality of services. The ETUs will improve the efficiency of hospital performance. In addition, under this thematic area the GOSL will explore options for providing pre-hospital services which are essential to improve outcomes of acute health situations.

44. The program will establish at least two healthy lifestyle centers in each of the Medical Officer of Health areas to prevent/delay the onset and reduce the burden of chronic NCDs (especially heart diseases, diabetes) and early detection of selected cancers (breast and oral cavity). Promotion of healthy lifestyles, early screening of higher risk individuals, referral of
patients for care and regular follow-up will be practiced in these centers, based on the national guidelines for the screening, diagnosis and management of chronic NCDs.

45. The program will expand screening services at various levels and strengthen the hospitals services to improve the quality of care for NCDs. Mobile health services for screening at workplaces (informal and formal) will be put in place. The program will further strengthen the screening of out-patients attending all primary and secondary care level hospitals and in Medical Officer of Health area clinics. In addition, quality improvement of the services provided at hospital or clinics (long term hospice care) for the management of the increasing number of diagnosed NCD patients will be strengthened. Within hospitals, following a needs assessment, expansion of services including strengthening the laboratory and other investigative services, ICU services, clinic facilities, and other ancillary services will be supported with the development of master plans for larger facilities along with the development of referral networks. As NCD drugs are required at all levels of care for improving prevention and control of NCD, drug quality assurance, logistics and distribution systems related to NCD drugs will be improved as required at each level of health facility.

46. The program will establish at least one comprehensive rehabilitation unit in the most advanced health facility in every province to strengthen the tertiary care services in Sri Lanka. These units will be linked with a two-way referral arrangement for follow-up care along with appropriate facility strengthening of the lower level facility for providing long-term care. Furthermore, appropriate human resource development for these centers will be supported.

47. The release of IDA funds will be linked to the achievement of the following DLIs for this thematic area:

- Percentage of centrally managed health facilities with ETUs for that level of facility based on standard guidelines (PDO indicator, DLI 1);
- Percentage of provincially managed health facilities with ETUs for that level of facility based on standard guidelines (PDO indicator, DLI 2);
- Percentage of Medical Officer of Health areas with at least two healthy lifestyle center (DLI 6).

48. In addition, the following indicators will be used to monitor progress in addressing NCD:

- Percentage of persons (over 40 years) screened for selected NCD at healthy lifestyle centers (PDO indicator);
- Number of provinces with at least one health facility providing rehabilitation services;
- Percentage of primary health care institutions having one month’s buffer stock for 16 selected NCD drugs.

**Thematic area 3: Health systems improvement**

49. NHDP plans to modernize the Health Management Information System (HMIS), in line with the country’s overall vision of promoting e-governance, information and communication technologies and turning Sri Lanka into a “knowledge economy”. Program resources will be
utilized to scale up relevant and useful on-going pilot e-initiatives based on the draft Health Information Policy and Strategic Plan for Health Information in Sri Lanka. In addition, resources will be utilized in converting the IMMR which reports all in-patient information using a modified International Classification of Diseases 10 (ICD 10) coding system to an eIMMR using the complete ICD 10 coding in secondary and tertiary hospitals managed by central and provincial health teams.

50. HSDP supported several interventions aimed at improving health services quality in Sri Lanka. The project will assist establishing national standards for laboratory accreditation and other relevant accreditation standards, guidelines and policies. It will also help establish Quality Management Units (QMUs) in each of the centrally or provincially managed hospitals. The role of the QMU is to help institutionalize the use of clinical care guidelines and standards including arrangements for sample death audits, morbidity and mortality analysis, premature death analysis, within 48 hour death analysis, HCWM practices, and pilots for a responsive grievance mechanism.

51. In addition to QMUs, further strengthening of the drug quality assurance is envisioned for laboratories to expand testing facilities for assessing quality of drugs. Strengthened drug logistics and storage systems are planned for buffer stocks of selected drugs and supplies at all health facilities.

52. HCWM practices with regard to the following will be addressed: (i) development of annual HCWM plans of larger hospitals and consolidated district HCWM plans; (ii) prioritizing a few of the larger hospitals in the country for further improving their HSWM practices; (iii) capacity building of the Environment and Occupational Health Division (EOHD) at the MOH to take forward the overall planning and management of HCWM in the country; and (iv) formalization of the draft national HCWM policy, by obtaining the required approvals for it.

53. Basic in-service and continuing medical education programs for all levels of staff will be established. Expenditure management and internal controls in the sector will be supported by institutionalizing Financial Management (FM) and procurement training. Comprehensive capacity building program for health sector staff for management at the central, provincial and sub-provincial levels will be developed and implemented.

54. The NHDP further plans to strengthen services for the priority communicable diseases. Some of these interventions include prevention and control of Tuberculosis, Dengue, Rabies, Leptospirosis, other zoonotic diseases and HIV/AIDS.

55. IDA funds release will be linked to the achievement of the following DLIs for this thematic area:

- Percentage of fully-functioning quality management units (QMUs) in MOH managed base hospitals and above (DLI 7);
- Percentage of fully-functioning quality management units (QMUs) in provincially managed base hospitals and above (DLI 8);
- Percentage of MOH managed health facilities sending indoor morbidity data through e-IMMR (PDO indicator, DLI 3);
- Percentage of provincially managed health facilities sending indoor morbidity data through e-IMMR (PDO indicator, DLI 4);
- Percentage of the six-monthly cash forecast (for non-salary recurring and capital expenditures) released (DLI 9).

56. In addition to the DLIs for health system improvement the following indicator/s relevant to health systems improvement will also monitor progress in improving the health system:

- Percentage of laboratories in health facilities participating in external quality assurance program for selected tests conducted by Medical Research Institute;
- Tuberculosis case detection rate;
- No. of hospitals (base hospitals and above) that have obtained EPL and Hazardous Waste License (HWL);
- Percentage of training institutes managed by the Ministry of Health meeting national standards;
- Percentage of National Competitive Bidding (NCB) contracts awarded within the first nine months of the previous calendar year from 2014 onwards.

**Component II: Innovation, results monitoring and capacity-building (US$ 10 million)**

57. This Component supports the implementation of innovations within the NHDP, operational research and opportunities for capacity building. Technical assistance (including a support team for project implementation and monitoring) will be financed. In addition, training, workshops, the Demographic and Health Survey, or the National Health Survey, surveys and end-line evaluations and other evaluative studies, including the annual review of DLIs by the MOFP, baseline and gap analysis on HCWM and annual environmental assessment will be supported.

58. IDA resources will be available to all key stakeholders involved in the implementation of NHDP and which include MOH, PMOH, MLGPC, MOFP and FC. The proposals/activities financed under this Component will be reviewed, approved and monitored on a regular basis by a Committee. The Committee will be appointed by the Secretary Health in consultation with the World Bank. Criteria for selection and approval of proposals will be cleared by IDA. This Component will not employ DLIs but use normal investment procedures. An Operational Manual, describing the criteria, the terms and conditions and procedures applicable to such activities, has been prepared and will be observed during implementation of this Component.

**B. PROJECT FINANCING**

59. For the implementation of the NHDP, GOSL is allocating an increasing amount from approximately US$ 850 million to 1.2 billion to health per year during the project period (based on the three-year rolling budget for 2012-14, released by the MOFP in January 2012). These resources will be supplemented by the IDA credit of US$ 200 million equivalent over a five-year period. In parallel to IDA support, the sector is receiving a Japanese credit of US$ 50 million
equivalent, spread over a few years. Grant funds of US$ 96 million have been provided from the Global Fund to fight AIDS, Tuberculosis and Malaria over the past nine years. Technical support from UN agencies and programs (the WHO, UNICEF, UNFPA, UNAIDS, the WFP, and FAO) also contribute to the program objectives. Although, in view of the different programming cycles of the UN agencies, it is impossible to indicate the precise amount of resources brought in by these agencies during the project.

60. IDA resources for Component I will be disbursed to the MOH and the provinces dependent on achievement of the DLI targets. Partial achievement of a specific DLI (for DLI 1-8) target will lead to a corresponding proportionate disbursement for that specific DLI. The inter-provincial allocations will be finalized by the MOFP in consultation with MLGPC, MOH and the provinces.

61. IDA funds for Component I will be provided as support to the general budget of the MOH and the nine PMOHs. Table 3 in Annex 3 provides the IDA fund allocations for each year if the agreed targets for each DLI are fully achieved for that corresponding year. While the project will disburse contingent upon the achievement of DLI targets, the expenditures for this Component I will be against an Eligible Expenditure Program (EEP) which means collectively the expenditures related to non-procureable items identified in the national health budget and pertaining to personal emoluments, travel expenses, fuel, transportation, communication, utilities, office rental and local taxes. IDA disbursements for Component I will be upon DLI target achievement and the submission of Interim Unaudited Financial Report (IUFR) containing the eligible expenditures.

62. Funds for Component I will be provided as an advance amount [up to a maximum of 75% (including retroactive financing) of the annual allocation for the first year] soon after the SHSDP is declared effective for the financing of activities in the first year of the project. Retroactive financing will be made available for payments made prior to the date of the Financing Agreement but on or after January 1, 2013 for Eligible Expenditures under Category I up to an aggregate amount not to exceed $7,500,000. For the second year (2014), an advance of 50% of the 2014 allocation will be released in February 2014 based on the forecasted eligible expenditures for 2014 and the submission of IUFR to account for previous undocumented advances. The final report on DLI results for first year’s performance (2013) will be available by May 2014 (detailed steps in Annex 3). The second year (2014), second fund release of the remaining 25% of the allocation for the first year will be in May 2014 on reimbursement basis, after adjusting for 2013 year’s performance based on DLIs and the submission of IUFR to account for previous undocumented advances. The same cycle of fund release will be in place for the succeeding years with 50% advance in February and 50% reimbursement of previous year’s EEP in May. Delayed achievement of a DLI will lead to delayed disbursement of the corresponding funds. The only exception will be the DLI with regard to cash flow ("percentage of the six-monthly cash forecast for non-salary recurring and capital expenditures released") where there cannot be delayed achievement and thus also no delayed disbursement. DLI proceeds of the Credit, upon disbursement, will not be tracked separately as an expenditure category of the project. Further details are in Annex 3.
63. IDA funds under Component II will be based on a regularly updated proposed plan of activities, which will be reviewed by the World Bank. An appropriate procurement plan will be prepared for the approved plan of activities and shared for review to the World Bank every quarter. Expenditures will be reported against eligible expenses which will include goods, minor works, training, research, workshops and incremental operating costs. Advance based on forecast of two quarters of the annual planned budget will be provided under this Component II. In addition, an amount not to exceed 20% of the allocation for Component II, or USD 2 million, will be provided for retroactive financing against eligible expenditures after January 31, 2013.

Fund Flow arrangements

64. IDA funds will follow the same pathways applicable to the GOSL’s own funds. IDA funds for Component I will be provided as support to budget of the MOH and the provinces, while the funds for Component II will be provided through earmarked financing managed by the MOH. Credit funds will be reflected in the MOH and PMOH budgets. The funds for Component I will be merged with the budgetary allocations to MOH and PMOHs, while Component II will be separately tracked as project funds. There will be two separate Designated Accounts (DA) managed by MOH for the central level and by MLGPC for the provincial level. Component II will be managed by the MOH through a third DA. More details are provided in Annex 3.

Lending Instrument

65. SHSDP will use a Specific Investment Lending instrument. IDA financing will contribute to the country’s five-year NHDP (2013-17) using DLI for Component I and traditional disbursement approaches for Component II.

Project Cost and Financing

66. The program cost (total health sector) in US$ is estimated based on the current budget estimates for 2012-2014, converted at the current exchange rate and extrapolated to five years. The figures are presented in the table below.

<table>
<thead>
<tr>
<th>Components</th>
<th>NHDP Program Cost</th>
<th>IDA Financing</th>
<th>Percent Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Support to priority health areas under NHDP (includes GOSL support to RBF)</td>
<td>5160</td>
<td>190</td>
<td>3.7</td>
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<tr>
<td>II. Innovation, Results Monitoring and Capacity Building Fund</td>
<td>10</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Total Program Costs</td>
<td>5,170</td>
<td>200</td>
<td>3.8</td>
</tr>
</tbody>
</table>
C. LESSONS LEARNED AND REFLECTED IN THE PROJECT DESIGN

67. Previous IDA supported operations experienced implementation challenges primarily due to inadequate ownership, poor management and low management capacity for projects with investment components with complex Bank procurement requirements. In response to these challenges, SHSDP supports NHDP, which was fully developed by GOSL itself, and uses GOSL systems for implementation for the major portion (Component I) of the IDA credit.

68. Decentralized health services work best when roles and responsibilities are clear, the central level fulfills its stewardship functions, and the decentralized levels are provided with adequate resources. SHSDP will follow GOSL’s rules of business regarding the roles and responsibilities of MOH and those of PMOHs. The NHDP also puts in place specific coordination and steering committees to ensure that MOH and PMOHs function in a more coherent manner.

69. In order to avoid disbursement delays, where there are many implementing agencies, DA reimbursements should not depend on consolidation of IUFR from all agencies, as this will penalize agencies whose accounts were submitted early on, as was witnessed under one component of HSDP. Under SHSDP disbursements will be made on the basis of DLI achievements and IUFRs with simplified formats which are fully aligned with the government system.

IV. IMPLEMENTATION

A. INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

70. As per GOSL arrangements, MOH is responsible for supporting the implementation of the national health policy, stewardship functions, service delivery at the tertiary level, procurement of medical supplies including pharmaceuticals, human resource training and deployment, and disaster management. PMOHs are responsible for primary and secondary levels of service delivery and all preventive services. MLGPC provides program oversight and central level representation for provincial level activities, while the FC makes policy recommendations.

71. The focal person for the management of the IDA credit will be the Senior Assistant Secretary Medical Services (SAS MS) at the Ministry of Health. Project offices will not be created for project implementation at central or at provincial levels. A support team consisting of a financial management specialist, procurement specialist, monitoring and evaluation specialist, communications specialist, and relevant assistant administrative and technical staff will be formed under the leadership of the SAS MS. These positions will be filled through open competitive process. A FM specialist and a procurement specialist will provide fiduciary implementation support to the MLGPC and will report to the Secretary MLGPC.

72. The support team will assist the central and provincial teams on project implementation and monitoring of the NHDP and in developing and reviewing of the annual activity plans for achievement of the results agreed with IDA. In addition, the support team will be responsible for the management of Component II implementation.
73. At the national level, a Project Steering Committee (PSC), chaired by the Secretary Health, will be established to (i) monitor the sector results, (ii) review progress of the priority activities supported under the NHDP and (iii) review implementation progress of Component II of the IDA credit. The PSC will meet every six months. The PSC will receive input from the provincial and central management and monitoring Committees that meets on a quarterly basis. The Secretary MLGPC, Secretary of the FC and the nine Provincial Health Secretaries will be members of the Committee. Other members will be high level representatives from the FC, MLGPC and the MOFP, and MOH.

74. The Management and Monitoring Committee of the MOH with membership from the DGHS, relevant DDGs and Directors will review and support project implementation based on the annual results implementation plan prepared and finalized by the respective Directorates (in close coordination with the Management and Development Unit) on a quarterly basis. This Committee will be chaired by Secretary Health.

75. All nine provinces will also be part of a Province Level Monitoring Committee which would be chaired by the Secretary MLGPC on a bi-annual basis. The membership of this committee will include the focal person for the project SAS MS, FC, MOH, DGHS, relevant DDGs and Directors of the MOH, nine Health Secretaries, nine PDHS, 26 RDHS and other required province and district level officers. This committee will review the implementation of the NHDP at the provincial level.

76. At each of the provinces, Provincial Management and Monitoring Committees will be established and chaired by the Health Secretary of each province. These Committees on a quarterly basis will review and support project implementation based on the annual results implementation plan prepared and finalized by the Provincial Planning units.

B. RESULTS MONITORING AND EVALUATION

Monitoring

77. Based on the NHDP, the MOH and the respective PMOHs will develop annual implementation plans for Component 2 in consultation with all stakeholders. The annual implementation plans will be shared with the World Bank by December 31 of the preceding year.

78. The NHDP has a large set of indicators to measure outcomes, outputs, processes and inputs at the sector level. Recognizing the selected number of areas in which the World Bank’s engagement is focused, a results framework with a sub-set of these indicators is presented in Annex 1 which will monitor progress against those thematic areas which will impact upon the PDO.

79. Apart from regular monthly monitoring of relevant indicators by the managers at various levels (central and provincial levels); quarterly reviews will be carried by the MOH and PMOH Management and Monitoring Committees. Semi-annual reviews of sector performance with joint involvement of the MOH and PMOHs will be at the PSC level.
DLI Verification

80. The PMM of the MOFP will prepare annually a DLI Results Report (format of the DLI results report to be agreed with the World Bank) for the previous year and share this with the World Bank for its review by end March of each year of implementation. The World Bank team will verify the results reported by the GOSL using an independent firm or consultant and will provide its recommendations related to the achievements of the DLI targets by end April. The verification report will be discussed with the GOSL and final agreement on DLI performance and rating will be agreed by both parties by May of each year. The total due allocation for the preceding year will be confirmed and the funds released by end May of each year, after adjusting for the earlier corresponding advance for the preceding year provided (details in Annex 3).

Evaluation

81. Surveys and end-line evaluations will be carried out on sector performance and its determinants, with a focus on the indicators contained in the Results Framework. Such evaluations will be conducted by firms contracted by MOH. Additionally, impact evaluations will be designed and conducted for all innovative and new initiatives, as needed.

C. Sustainability

82. SHSDP adopts a program approach and essentially contributes to the financing of a five-year time-slice of the regular health sector program as reflected in the NHDP, thus enhancing its sustainability as compared with a traditional project approach. As everything financed by the project is part of the NHDP, there is a high level of GOSL ownership and commitment, which increases the likelihood that the interventions will be sustained beyond the five year period. IDA’s contribution to the health sector budget is less than 5%; therefore the risk to financial sustainability when IDA supports ends is minimal. The SHSDP uses the country’s own systems and processes, rather than introducing parallel mechanisms. By improving efficiency and effectiveness of health service delivery, the system will be able to make significant financial savings, again making program sustainability more likely.

V. KEY RISKS AND MITIGATION MEASURES

Risk Ratings Summary Table

83. A detailed list of risks and risk management measures is provided in Annex 4. Table 2 below summarizes the risk ratings for the proposed project.

<table>
<thead>
<tr>
<th>Stakeholder Risk</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementing Agency Risk</td>
<td></td>
</tr>
<tr>
<td>- Capacity</td>
<td>Moderate</td>
</tr>
<tr>
<td>- Governance</td>
<td>Moderate</td>
</tr>
<tr>
<td>Project Risk</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>- Design</td>
<td>Moderate</td>
</tr>
<tr>
<td>- Social and Environmental</td>
<td>Moderate</td>
</tr>
<tr>
<td>- Program and Donor</td>
<td>Low</td>
</tr>
<tr>
<td>- Delivery Monitoring and Sustainability</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>Overall Implementation Risk</strong></td>
<td><strong>Moderate</strong></td>
</tr>
</tbody>
</table>

**Overall Risk Rating Explanation**

84. The overall risk is rated as Moderate. Sri Lanka has a good track record and strong commitment for improving health care services by modernizing the system and paying special attention to both the newer challenges of non-communicable diseases and the unfinished agenda of malnutrition. However, the capacity to initiate, implement and go through with sector reforms needed to face these new challenges might be a constraining factor.

VI. APPRAISAL SUMMARY

A. ECONOMIC AND FINANCIAL ANALYSES

85. Benefit incidence analyses show that public expenditure in health in Sri Lanka is generally pro-poor.\(^\text{16}\) This suggests that continuing to invest and improve the public health system should benefit the poor and vulnerable, especially since special emphasis is being placed on results related to under-nutrition, NCDs, and some key systemic issues that will increase the efficiency of the system as a whole. These three sets of interventions all warrant public action because of market failures, externalities, and asymmetry of information as well as redistribution.

86. Nutritional interventions are found to be among the most cost-effective interventions to enhance welfare. The Copenhagen Consensus 2008\(^\text{17}\) ranked five nutritional interventions among the top ten proposals presented as the best way to advance global welfare. In addition, addressing under-nutrition will contribute to reducing maternal and child mortality and poverty by enhancing productivity, cognitive development, and school performance.

87. Investments in NCD prevention and treatment, as well as modernization of the health system are likely to have an impact on poverty reduction and economic development in Sri Lanka. Some studies have shown that in Sri Lanka high mortality rates from NCDs appear to be the result not primarily of high levels of risk factors, but the systematic under-treatment of most major NCDs. In the absence of financial protection mechanisms which cover the costs of treating common NCDs, the risks to households increase with this epidemiological transition.


Unaddressed NCDs also have an effect on the working-age population, disabling workers and potentially undermining productivity.

88. In terms of fiscal sustainability and government commitment, the Government budget is divided between central level functions (about 65%) and provincial and district level functions (about 35%). For fiscal year 2013, the budget is US$ 815 million, excluding external funding. Based on Government projections, the annual health budget at central and provincial level is expected to increase at an average annual growth of 9.6% from 2013-17. Assuming that GOSL’s health budget and spending remain approximately the same over the next five years Government will have a large enough budget to sustain the recurrent costs generated by NHDP.

B. TECHNICAL

89. Sri Lanka is well on track to reaching most MDG targets. The NHDP builds on these achievements and also addresses new challenges posed by the increasing burden of acute and chronic NCD by improving infrastructure and the development of new lines of programs and services for prevention and treatment, while promoting a healthy lifestyle. This prioritization of the program is technically sound and IDA will support key systems innovations to address these new challenges.

90. Malnutrition rates have remained stubbornly high and rightfully these are a thematic area of attention for World Bank support. The nutrition program will be targeted to vulnerable populations, especially the estate populations. Beneficiaries of various programs will be women of reproductive age, pregnant women and children under the age of two (the “1000 days” approach). Such programs, largely community-based, have shown internationally to have the greatest impact when addressing malnutrition.

91. Unless cross-cutting systemic issues such as infrastructure planning and management, human resource development and deployment, health management information systems, and quality assurance of health care services are addressed, the health system in Sri Lanka may not be capable of addressing NCD, and the new challenges faced by a lower middle income country that aspires to double its per capita income and join the upper middle income ranks. NHDP does just that.

C. FINANCIAL MANAGEMENT

92. The FM for IDA funds will essentially be the same as that which is used for the Government resources, following the Government’s own rules and regulations laid down for the purpose. IDA Disbursement has been described under the section on Lending Instrument (See Annex 3 for details).

93. The proposed overall FM procedures and practices for SHSDP are satisfactory to meet GOSL’s and IDA’s fiduciary requirements as per OP/BP 10.02. SHSDP has a “Moderate” FM risk rating. The overall responsibilities for FM for the activities at the central level will rest with the MOH. The FM work for the activities under the PMOHs will be monitored primarily by the MLGPC, including the compliance with the financial covenants of the legal agreement. The
MOH, MLGPC, FC and other relevant health sector institutions including hospitals, will be strengthened to carry out the program related FM arrangements. The MLGPC will have a financial management specialist satisfactory to IDA.

94. The internal audit of SHSDP will be carried out by the Government internal auditors attached to the MOH and the provincial councils. The external audit will be performed by the Auditor General of Sri Lanka. The Auditor General will issue two consolidated audit reports including an audit opinion and management letters on the two consolidated financial reports prepared for the program, one reflecting health sector expenditure incurred by central level institutions and the other reflecting the provincial level expenditures. The audit reports are required to be submitted to the Bank within 10 months of the end of the financial year in the first year and a gradually reduced to 9, 7, 6 and 6 months for the following years. There are no overdue audit reports or ineligible expenditures for previous projects in the sector. According to the Bank’s Access to Information Policy, the audit reports received by the Bank for the program will be accessible to the public on the World Bank website.

D. PROCUREMENT

95. The fiduciary assessment identified a few drawbacks in the country’s procurement system: (i) lack of capacity of some staff to handle procurement; (ii) delays in procurement process including preparation of designs and specifications and delays in awarding of contract; and (iii) lack of knowledge on packaging contracts. The overall procurement risk is rated as Substantial. The main source of risk is gaps in procurement capacity, which needs to be upgraded for improved procurement performance. Therefore, the system for procurement performance and compliance monitoring needs strengthening. SHSDP will support the development of a strengthened system for procurement and compliance monitoring, both at central and provincial level.

96. All procurement for implementation of NHDP will follow the Government procurement guidelines and the Procurement Cell of the MOH will be responsible for procurement at MOH level and the PMOHs are responsible for procurement at the provincial level. IDA will periodically review the performance of the overall procurement systems of the sector to ensure that recommendations arising from the fiduciary review are being addressed.

97. All procurement of goods, works, consulting services and non-consulting services under Component II will be carried out in accordance with World Bank’s Guidelines: Procurement of Goods, Works, and Non-consulting Services under IBRD Loans and IDA Credits and Grants for World Bank Borrowers (dated January 2011), and Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers (dated January 2011).

98. Dedicated full-time staff for procurement will be placed both at MOH and MLGPC throughout the project implementation period. They will be responsible for procurement monitoring and reporting, training and guidance. The Procurement Specialist will build provincial capacity and develop a procurement performance and compliance monitoring system during the first six months of SHSDP. Moreover, the procurement staff will be responsible for
strengthening the procurement systems and delivering training programs to enhance the procurement capacity of the staff responsible of procurement at central and provincial levels. In order to enhance the monitoring system of procurement, both internal and external auditors will be provided with additional training on procurement.

99. The Procurement Specialist of the support team attached to MOH will maintain a consolidated procurement plan throughout the project implementation period for activities relevant to Component II. The MOH has developed the initial procurement plan for Component II and agreed with IDA on the procurement methods on by February 26, 2013. This Procurement Plan will be updated at least annually, or as required, to reflect the actual needs vis-à-vis project implementation and institutional capacity.

E. SOCIAL (INCLUDING SAFEGUARDS)

100. SHSDP does not trigger any World Bank social safeguard policies. Infrastructure development that may be supported under the Component II will not finance land acquisition and all such development will take place within existing premises of health care facilities/institutions. The existing premises of health care facilities proposed for new constructions should be freely available and not be under temporary occupancy by any individual. The expected social development outcome of SHSDP is deemed to be substantial with positive social impacts across the population. These positive impacts will be enhanced by the project’s focus on promoting equity, social inclusion and contributing to poverty reduction goals of the country, which are also key themes of the Mahinda Chinthana and the World Bank’s CPS. The equity impacts of SHSDP will be assessed through data on health outcomes and behavioral changes disaggregated by geographical area and socio-economic groups where ever possible.

101. SHSDP will address regional inequalities associated with health and nutrition outcomes and develop quality health services in the conflict affected and disadvantaged areas and for vulnerable groups. Further, SHSDP is expected to address: (i) social protection aspects through health development interventions; (ii) quality of care for rural populations; and (iii) gender-specific issues as they relate to health care.

102. Furthermore, SHSDP was prepared through extensive consultations and participation of stakeholders, including government, private health care providers, NGOs and health insurance agencies, the public, civic organization representatives, and professional associations, to ensure greater ownership to SHSDP. The predecessor operation, HSDP, engaged at the grass-root levels and provided good insights into population needs and ground realities about system needs.

F. ENVIRONMENT (INCLUDING SAFEGUARDS)

103. SHSDP is categorized as Environment Category B and triggers the safeguard policy on Environmental Assessment (OP/BP 4.01). Environmental safeguards requirements focus primarily on HCWM and at a small scale on infrastructure development as part of Component II.

104. The draft national policy and guidelines for HCWM, situation analysis and national action plan provide adequate basis for taking forward and scaling up HCWM in the country. As
part of SHSDP preparation, the MOH carried out a rapid evaluation of current HCWM practices in 40 larger hospitals. Based on its findings, past experiences and best practices of other countries an Environmental Management Framework (EMF) for HCWM and Infrastructure Development has been prepared. The EMF was disclosed to the public on November 20, 2012 and shared with IDA. The EMF focuses on (i) evaluation of the HCWM strategy, implementation under the Bank-funded HSDP, and key lessons learnt that can be incorporated in future HCWM activities; (ii) status of enforcement of national regulations, types of infrastructure, treatment technologies and practices currently in place in the major healthcare facilities; (iii) best practices and lessons learned on healthcare waste management that can be adopted locally; (iv) a road map for scaling up HCWM nationally; and (e) process to follow-up infrastructure development activities under Component II of the SHSDP.

105. SHSDP will contribute towards the safe management of healthcare waste by focusing on key priority areas in line with the strategies proposed in the NHDP and the EMF for the HCWM Framework. These priority areas include the following: (i) the consolidation of the HCWM system for public hospitals in the Colombo Municipal Council area by addressing operational issues; (ii) scaling-up HCWM planning to all centrally managed hospitals where comprehensive HCWM plans will be set up and annually revised; (iii) scaling-up HCWM planning to all Provinces where the PDHS will gather and synthesize the HCWM plans of each district under its jurisdiction to develop a Provincial HCWM plan and monitor and report on its implementation; (iv) prioritizing selected larger hospitals in the country for further improvement of HCWM practices through the allocation of necessary financial and human resources and to obtain EPL; (v) capacity building of the EOHD at the MOH to take forward the overall planning and management of HCWM in the country and other environment, health and safety issues; and (vi) adoption of the draft National HCWM policy, by obtaining Cabinet approval. Status of implementation of the targets agreed for the above priority areas of the EMF for HCWM and infrastructure development will be monitored through annual environmental assessments conducted by the MOH, as part of safeguards compliance and sustainability of project investments.

G. OTHER SAFEGUARDS POLICIES TRIGGERED

106. None applicable.
**Annex 1: Results Framework and Monitoring**

**SRI LANKA: Second Health Sector Development Project**

**Project Development Objective (PDO):** To upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Core</th>
<th>Unit of Measure</th>
<th>Baseline (2012/2013)</th>
<th>Cumulative Target Values**</th>
<th>Frequence</th>
<th>Data Source / Methodology</th>
<th>Responsibility for Data Collection</th>
<th>Description (indicator definition etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of persons (over 40 years) screened for selected NCDs' at healthy lifestyle centers</td>
<td>%</td>
<td>3%</td>
<td>4%</td>
<td>6%</td>
<td>8%</td>
<td>10%</td>
<td>12%</td>
<td>annual</td>
</tr>
<tr>
<td>% of pregnant women with anemia after the second trimester</td>
<td>%</td>
<td>34%</td>
<td>34%</td>
<td>31%</td>
<td>28%</td>
<td>24%</td>
<td>20%</td>
<td>annual</td>
</tr>
<tr>
<td>% of centrally managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 1)</td>
<td>% (at Primary Secondary Tertiary levels)</td>
<td>0</td>
<td>Develop and finalize the policy and guidelines for Accident and Emergency services</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>annual</td>
</tr>
<tr>
<td>% of provincially managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 2)</td>
<td>% (at Primary Secondary Tertiary levels)</td>
<td>0</td>
<td>Develop, finalize and make available the policy and guidelines</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
<td>annual</td>
</tr>
<tr>
<td>Indicators</td>
<td>Core</td>
<td>Unit of Measure</td>
<td>Baseline (2012/2013)</td>
<td>Cumulative Target Values**</td>
<td>Frequency</td>
<td>Data Source / Methodology</td>
<td>Responsibility for Data Collection</td>
<td>Description (indicator definition etc.)</td>
</tr>
<tr>
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</tr>
<tr>
<td>% of MOH managed health facilities sending indoor morbidity data through e-IMMR (DLI 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E-IMMR</td>
<td>Medical Statistics Unit</td>
<td>No. of central Medical Officer of Health managed health facilities sending indoor morbidity data through e-IMMR/Total No. of central Medical Officer of Health managed health facilities</td>
</tr>
<tr>
<td>% of provincially managed health facilities sending indoor morbidity data through e-IMMR (DLI 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E-IMMR</td>
<td>Medical Statistics Unit</td>
<td>No. of provincial health facilities sending indoor morbidity data through e-IMMR/Total no. of provincial health facilities</td>
</tr>
</tbody>
</table>

**INTERMEDIATE RESULTS (Outputs)**

Intermediate Results Thematic Area 1: Addressing Mother and Child Health and Nutrition

<p>| % of MCH clinics with an agreed package of equipment and supplies for the provision of care for pregnant women and children under five years. (DLI 5) | | | | | | Admin data | FHB, PDHS, RDHS | No. of MCH clinics with a complete set of equipment and supplies (to test Hb, Height, weight and availability of micro nutrients and deworming drugs)/Total no of MCH clinics |
| % of Medical Officer of Health areas with at least three health and nutrition community support groups | | | | | | Admin data | HEB, PDHS, RDHS | No. of community health and nutrition support groups (established and functioning) in each Medical Officer of Health area/Total no. of Medical Officer of Health areas in a given year |
| % of CEMOC facilities providing 24x7 CEMOC services. | | | | | | Admin data | FHB, PDHS | No. of centrally and provincially managed health facilities providing 24x7 Comprehensive Emergency Maternal and Obstetric Care (CEMOC) /70 selected hospitals |</p>
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Core</th>
<th>Unit of Measure</th>
<th>Baseline (2012/2013)</th>
<th>Cumulative Target Values**</th>
<th>Frequency</th>
<th>Data Source / Methodology</th>
<th>Responsibility for Data Collection</th>
<th>Description (indicator definition etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Medical Officer of health areas with at least two healthy lifestyle centers* (DL1 6)</td>
<td></td>
<td>%</td>
<td>10%</td>
<td>10%</td>
<td>25%</td>
<td>50%</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>No. of provinces with at least one health facility providing rehabilitation services</td>
<td></td>
<td>No.</td>
<td>1</td>
<td>Develop and finalize the guidelines for rehabilitation services and disability.</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>% of primary health care institutions having one month’s buffer stock for 16 selected NCD drugs</td>
<td></td>
<td>% (to be presented by MSD and at province levels)</td>
<td>2%</td>
<td>Develop capacities for drug logistics system to be improved.</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>% of training institutes managed by the Ministry of Health meeting national standards</td>
<td></td>
<td>%</td>
<td>N.A.</td>
<td>National Standards to be developed for accreditation</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>% of laboratories in health facilities (base hospitals and above) participating in external quality assurance program for selected tests conducted by MRI.</td>
<td></td>
<td>%</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td>Case detection rate for Tuberculosis</td>
<td></td>
<td>rate</td>
<td>69%</td>
<td>72%</td>
<td>74%</td>
<td>76%</td>
<td>77%</td>
<td>78%</td>
</tr>
<tr>
<td>Indicators</td>
<td>Core</td>
<td>Unit of Measure</td>
<td>Baseline (2012/2013)</td>
<td>Cumulative Target Values**</td>
<td>Frequency</td>
<td>Data Source / Methodology</td>
<td>Responsibility for Data Collection</td>
<td>Description (indicator definition etc.)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>% of hospitals (base hospitals and above) that have obtained EPL and HWL</td>
<td>%</td>
<td>&lt;5%</td>
<td>Review existing situation based on the HCWM guidelines/framework</td>
<td>10% 20% 30% 40%</td>
<td>annual</td>
<td>Admin data</td>
<td>Director Env and Occ Health</td>
<td>No of hospitals that have met standard waste management practices</td>
</tr>
<tr>
<td>% of fully functioning** quality management Units (QMUs) in MOH managed base hospitals and above (DL1 7)</td>
<td>%</td>
<td>9%</td>
<td>Guideline/protocols for a fully functioning QMU developed, appropriate training carried out</td>
<td>15% 40% 70% 95%</td>
<td>Annual</td>
<td>Admin data</td>
<td>Director QA and Safety</td>
<td>No of fully functioning quality management Units (QMUs) in MOH managed secondary and tertiary level (Base hospital and above) hospitals/Total no of MOH managed hospitals</td>
</tr>
<tr>
<td>% of fully functioning** quality management Units (QMUs) in provincially managed base hospitals and above (DL1 8)</td>
<td>%</td>
<td>6%</td>
<td>15% 40% 70% 90%</td>
<td>Annual Admin data</td>
<td>Director QA and Safety</td>
<td>No of fully functioning quality management Units (QMUs) in provincially managed secondary and tertiary level (Base hospital and above) hospitals/Total no of MOH managed hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of NCB contracts awarded within the first nine months of the previous calendar year from 2014 onwards</td>
<td>% (to be presented by province s and the MOH)</td>
<td>N.A.</td>
<td>Prepare list of NCB contracts awarded for previous year and identify the training required and finalize internal controls</td>
<td>40% 50% 60% 80%</td>
<td>annual</td>
<td>Admin data</td>
<td>PDHS</td>
<td>No of NCB contracts awarded within the first nine months of the previous calendar year /Total No of NCB contracts awarded in the previous year</td>
</tr>
<tr>
<td>% of the six monthly cash forecast (for non-salary recurring and capital expenditures) released</td>
<td>%</td>
<td>81%</td>
<td>Equal to or more than 83%</td>
<td>6 monthly Admin data DDG Finance and Provincial</td>
<td>Amount of funds released by the treasury every 6 months/total value of forecast amount. The</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators</td>
<td>Core</td>
<td>Unit of Measure</td>
<td>Baseline (2012/2013)</td>
<td>Cumulative Target Values**</td>
<td>Frequency</td>
<td>Data Source / Methodology</td>
<td>Responsibility for Data Collection</td>
<td>Description (indicator definition etc.)</td>
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<td>(DLI 9)</td>
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<td>Department Health Accountants</td>
<td>data for this indicator are not cumulative. The data will be presented by the MOH and by Provinces</td>
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</tbody>
</table>
Annex 2: Detailed Project Description

SRI LANKA: Second Health Sector Development Project

Introduction

1. Sri Lanka’s national health strategies are reflected in “Mahinda Chintana: Vision for Future, Sri Lanka—The emerging wonder of Asia (2010 to 2016)”, the National Health Policy of 1996, the Health Master Plan of 2007-16, and the Strategic Framework for Health of 2007-2016. These strategies have been translated into a Medium Term (three-year) rolling Budgetary Framework for the health sector and a five-year National Health Development Plan (NHDP) for 2013-17 and a Priority Area Interventions Action Plan for the same period. These documents have highlighted initiatives to improve the health system to better address the changing health needs of the Sri Lankan population.

2. The NHDP focuses on all aspects of health sector development especially the 23 strategies in the thematic areas of health systems improvement, maternal and child health, communicable diseases and non-communicable diseases. The strategies include the following: (i) providing basic healthcare free of cost to all individuals in an equitable manner at the point of delivery in state healthcare institutions, (ii) working towards a country free from major communicable diseases by strengthening disease control programs, (iii) improving existing preventive health programs by further strengthening maternal and child health, environment and occupational health and dental services, as well as health promotion and community empowerment for reducing disease and disability burdens, (iv) developing a network of modern hospitals in all districts with a special focus on tertiary and secondary care services, (v) introducing effective and affordable new technologies and innovations to state health services (vi) developing and maintaining centers of excellence in cardiology, oncology, maternal and child care and oral health, (vii) strengthening and reorganizing laboratory services in government and private sectors, (viii) increasing the efficiency and cost effectiveness of medical equipment utilization and management in government health care institutions, (ix) ensuring quality, safety and cost effectiveness of blood transfusion services, (x) strengthening human resource development to meet emerging needs of the health sector, (xi) reducing the burden of non-communicable diseases with better preventive and curative services (xii) introducing special care services for youth, elderly, and the disabled, (xiii) providing more effective and comprehensive mental health services, (xiv) improving the nutrition status of the targeted population, (xv) improving the health care services for vulnerable populations, (xvi) improving managerial efficiency, productivity, quality and safety of all levels of health care services, (xvii) strengthening the health information system for better management with e-health solutions, (xviii) promoting and regulating the private health sector to deliver affordable and quality health services, (xix) improving private public partnerships in providing health care, (xx) strengthening integrated approaches with other government and non-government sectors to improve health services, (xxi) strengthening the implementation of a national drug policy to better manage medical supplies, (xxii) promoting medical research, and (xxiii) promoting medical tourism.

3. Based on the NHDP, a ‘Priority Area Interventions Action Plan’ for the same period (2013 to 2017) was also developed by the Ministry of Health. This action plan identifies the detailed activities and results to be achieved during 2013 to 2017. The main thematic areas of
focus in this plan are; (i) health systems improvement, (ii) maternal and child health, (iii) prevention and control of communicable diseases, (iv) prevention and control of non-communicable diseases.

4. The NHDP provides strategic direction to MOH and the nine PMOHs, to prepare their annual activity plans to be finalized by December each year. These annual sector plans and the respective budgets are prepared through a collaborative process of consultation and joint work between the MOH, the nine PMOHs and the districts under them, the FC and MLGPC.

5. The Second Health Sector Development Project is supporting the interventions identified in the National Health Development Plan under three thematic areas of (i) addressing maternal and child health and nutrition and communicable diseases, (ii) prevention and control of non-communicable diseases, and (iii) health system improvement measures.

6. The Project Development Objective is to upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases.

7. An improved health system will result in improved service delivery, to better address Sri Lanka’s new health problems (acute and chronic NCDs). Furthermore, it will also address the remaining challenge of under-nutrition and communicable diseases like tuberculosis, and continue interventions that would help sustain the past gains on MCH services.

Results Indicators

8. The achievement of the PDO will be measured by specific outcome indicators. Additionally, many intermediate results have also been identified, nine of which have been selected as DLI, with targets spread over the five year project (See Annex 1). In cases where systems need to be established or guidelines need to be developed, required ground-work would be completed in the first year, and the number of health facilities meeting the set standard would gradually reach the targeted value (with intermediate annual targets also established). DLIs are being separated into Central Level and Provincial Level, in view of the decentralized system of service delivery, which involves fund-flow and accountability to the nine PMOHs separate from that to the MOH.

PDO Level Results Indicators

- Percentage of persons (over 40 years) screened for selected NCDs (DM, hypertension, cancer breast and oral) at healthy lifestyle centers;
- Percentage of pregnant women with anemia after the second trimester;
- Percentage of centrally managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 1);
- Percentage of provincially managed health facilities with ETUs for that level of facility based on standard guidelines (DLI 2);
- Percentage of MOH managed health facilities sending indoor morbidity data through e-IMMR (DLI 3);
- Percentage of provincially managed health facilities sending indoor morbidity data through e-IMMR (DLI 4).

**Intermediate Results Indicators**

- Percentage of MCH clinics with an agreed package of equipment and supplies for the provision of care for pregnant women and children under 5 years (DLI 5);
- Percentage of Medical Officer of Health areas with at least three health and nutrition community support groups;
- Percentage of CEMOC facilities providing 24x7 eCEMOC services;
- Percentage of Medical Officer of Health areas with at least two healthy lifestyle centers (DLI 6);
- Number of provinces with at least one health facility providing rehabilitation services;
- Percentage of primary health care institutions having one month’s buffer stock for 16 selected NCD drugs;
- Percentage of fully-functioning quality management units (QMUs) in MOH managed base hospitals and above (DLI 7);
- Percentage of fully-functioning quality management units (QMUs) in provincially managed base hospitals and above (DLI 8);
- Percentage of the six-monthly cash forecast (for non-salary recurring and capital expenditures) released (DLI 9);
- Percentage of laboratories in health facilities participating in external quality assurance program for selected tests conducted by Medical Research Institute;
- Tuberculosis case detection rate;
- Percentage of hospitals (base hospitals and above) that have obtained EPL and HWL;
- Percentage of training institutes managed by the Ministry of Health meeting national standards;
- Percentage of National Competitive Bidding (NCB) contracts awarded within the first nine months of the previous calendar year from 2014 onwards.

9. The results which are not linked to IDA disbursement (non-DLIs) are also important to monitor, as the sector is complex and there are many results of interest, though it is not practical or realistic to link all of them to IDA disbursement.

**Component I: Support to Priority areas under the National Health Development Plan (GOSL US$ 5,165 million, of which IDA contribution would be US$ 190 million for 5 years)**

10. Component I of IDA financing will contribute to the GOSL’s NHDP. The IDA funds will be combined with GOSL funds, while the Bank’s technical engagement and monitoring would focus on specific thematic areas: (i) addressing maternal and child health and nutrition and communicable diseases, (ii) prevention and control of non-communicable diseases, and (iii) health system improvement measures. The initiatives that would be supported under each of these thematic areas are further described in the main body of the PAD on pages 18 to 24.

**Component II: Innovation, Results monitoring and Capacity-Building Fund (US$ 10 million)**
11. This Component is meant to support the implementation of innovations within the NHDP with funds earmarked for technical assistance (includes the salaries and maintenance of a support team for project implementation and monitoring), training, workshops, testing innovative ideas, operational research, the demographic and health survey, surveys and end line surveys and other evaluative studies. This fund provides opportunities to health system implementers at all levels of care or management in the administrative, curative, preventive and rehabilitation areas to plan and implement pilot projects on new ideas that may include projects with regard to improvement of inpatient safety initiatives, quality enhancement measures, private-public partnerships, inter-sectoral partnerships, e-health projects, introduction of cost effective new interventions, human resource development measures through innovative approaches within the respective health institutions.

12. The fund would be accessible to all implementing teams which include the MOH, PMOH, MLGPC, MOFP and FC. The proposals to be financed under this Component will be reviewed and approved by a Review Committee appointed by the Secretary Health in consultation with the World Bank. Criteria for selection and approval will be defined before approving proposals for funding under this Component. An operations manual has been prepared for this Component which includes implementation details.
Annex 3: Implementation Arrangements

SRI LANKA: Second Health Sector Development Project

Overall coordination and oversight:

1. As per the GOSL’s implementation arrangements, the MOH is responsible for supporting the implementation of the national health policy, stewardship functions, service delivery at the tertiary level, procurement of medical supplies including pharmaceuticals, human resource training and deployment, and disaster management while PMOHs are responsible for primary and secondary levels of service delivery and all preventive services according to the health policy. The MLGPC provides program oversight and central level representation for provincial level activities. The Finance Commission addresses equitable regional development and recommends to the Treasury the amounts of funds to be allocated to the Provincial Councils, and ensures that the utilization of these funds is in accordance with the agreed plans and programs.

2. The SHSDP will be monitored by establishing a national level Project Steering Committee and three other committees called the Management and Monitoring Committees that will review progress of all provinces, at all of the provincial level and also at the MOH levels.

3. A PSC will be established to: (i) monitor the sector results; (ii) review progress of the priority activities supported under the NHDP using GOSL/IDA resources; and (iii) review implementation progress of Component II of the project. This Committee which will meet biannually will be chaired by the Secretary Health. The Committee will receive input from the provincial and central management and monitoring committees that meet on a quarterly basis. The Secretary MLGPC, Secretary Finance Commission and the 9 Provincial Health Secretaries will be members of the committee. The other members will be representatives from the Finance Commission, MLGPC and the MOFP – includes the DGHS National Planning, ERD, PMM, Budget and Treasury operations and relevant officials, Provincial Directors and Regional Directors of Health, central ministerial and provincial level accountants and other relevant officers, MOH, DGHS, Deputy Directors Generals (DDGs) and Directors and other relevant officers. As the need arises, the PSC will organize review meetings with the relevant program managers, representatives of concerned provinces and districts to resolve operational issues on various topics, including financial management, procurement or monitoring and evaluation for instance. MOH and PMOH officers will ensure that the PSC recommendations are satisfactorily implemented.

4. The Management and Monitoring Committee of the MOH with membership from the DGHS, relevant DDGs, will review and support project implementation based on the annual results implementation plan prepared and finalized by the respective directorates (in close coordination with the Management and Development Unit) on a quarterly basis. This Committee will be chaired by Secretary Health/DGHS or the SAS MS.

5. All nine provinces will also be part of a Province Level Monitoring Committee which would be chaired by the Secretary MLGPC on a bi-annual basis. The membership of this committee will include the focal person for the project SAS MS, MOH, DGHS, relevant DDGs and Directors of the MOH, nine Health Secretaries, nine PDHS, 26 RDHS and other required
province and district level officers. This committee will review the implementation of the NHDP at the provincial level.

6. At each of the provinces, a Provincial Management and Monitoring Committee will be established and chaired by the Health Secretary. The members of this Committee will include the PDHS, Province Planning Unit, Consultant Community Physicians attached to the Province and or district, District Planning Units, Regional Epidemiologists, Medical Officers Maternal and Child Health, Medical Officer Non Communicable Diseases, Regional Dental Surgeon, Medical Officers for Tuberculosis Control, Hospital Directors, Medical Superintendents and Medical Officers–in-charge of smaller hospitals etc. These Committees on a quarterly basis will review and support project implementation based on the annual results implementation plan prepared and finalized by the Provincial Planning units.

Program administration mechanisms

7. The focal person for the IDA credit will be the Senior Assistant Secretary Medical Services (SAS MS) in MOH. Project offices will not be created for project implementation at central or at provincial levels. However, a support team consisting of a FM specialist, procurement specialist, monitoring and evaluation specialist, communications specialist, and relevant assistant administrative and technical staff will be set up under the leadership of the SAS MS. These positions will be filled through open competitive process among internal and/or external candidates. A FM Specialist and a Procurement specialist will provide fiduciary implementation support to the MLGPC and report to the Secretary MLGPC.

8. The support team will provide support to the central and provincial teams for project implementation and monitoring of the NHDP and in development and reviewing of the annual activity plans for achievement of the agreed results under the IDA credit. In addition, the support team will be responsible to manage the implementation of Component II of the project. Funds for maintaining the support team and implementation support of the project will be provided from the Component II of the project.

9. The functions of such a support team will include the following:

- Operating SHSDP Account(s);
- Reviewing the annual activity plans for central and provinces and budgets for approval by the PSC;
- Coordinating the development and finalization of operational documents, including TORs and contracts for technical assistance (e.g. capacity building of PMUs, Health Forum organization, annual audits, DHS surveys etc.);
- Consolidating reports necessary for documenting use of IDA funds and implementation progress and results;
- Coordinate the external audit arrangements to meet the audit covenants of the project.
- Monitoring and advising procurement staff at the central and provincial level on procurement conducted under Component I;
- Responsible for procurement carried out under Component II if required;
- Conduct sample procurement audit either by the staff themselves or through internal and external auditors;
- Reporting on procurement documents for large items;
- Managing capacity building activities. In particular, it will develop training programs in planning/monitoring and procurement/financial reporting for the districts/province and central teams;
- Coordinating monitoring and evaluation activities and updating of the Results framework including the DLIs;
- Communicating to key stakeholders the nature, progress and outcome of SHSDP;
- Liaising with international partner agencies such as World Bank, Japan International Cooperation Agency (JICA), WHO, UNICEF, UNFPA, to ensure that all project activities are well coordinated.

**Table 1: Project oversight responsibilities**

<table>
<thead>
<tr>
<th>Program</th>
<th>Management Oversight</th>
<th>Team</th>
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<tbody>
<tr>
<td>Province level programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provincial Programs</td>
<td>Provincial Councils, PMOHs &amp; PDHS</td>
<td>Provincial health team led by Planning units under PMOH/PDHS</td>
</tr>
<tr>
<td>District Programs</td>
<td>Provincial Councils, PMOHs, PDHS through RDHS</td>
<td>District health teams led by district planning units under RDHS</td>
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<td>Central level programs</td>
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<tr>
<td>Family Health</td>
<td>DDG Public Health Services</td>
<td>FHB</td>
</tr>
<tr>
<td>Nutrition</td>
<td>DDG Public Health Services and Additional Secretary Public Health, MOH</td>
<td>Nutrition Coordination Unit, FHB, Nutrition division, MRI, HEB</td>
</tr>
<tr>
<td>Communicable diseases includes Vaccine Preventable Diseases</td>
<td>DDG Public Health Services</td>
<td>Epidemiology Unit</td>
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<td>DDG Medical Services 1</td>
<td>Mental Health Services Directorate</td>
</tr>
<tr>
<td>NCD</td>
<td>DDG Medical Services 1</td>
<td>NCD, Medical Services and Cancer Directorates</td>
</tr>
<tr>
<td>Hospital Efficiency &amp; Quality</td>
<td>DDG Medical Services 1</td>
<td>Directorates of Health Care Quality, Medical Services and Tertiary Care</td>
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<tr>
<td>Bio Medical Services</td>
<td>DDG Bio Medical Engineering Services</td>
<td>Hospital Directors and other relevant Directorates</td>
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<td>DDG Laboratory Services</td>
<td>Hospital Directors, Director Laboratory Services</td>
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Drugs and supplies | DDG Medical Services | Director Medical Supplies Division
---|---|---
Public Expenditure | DDG Planning and DDG Finance | Organizational Development, Policy Analysis and Finance Directorates
Monitoring and Evaluation, e-Health initiatives | DDG Planning | Health Information Directorate and Medical Statistics Unit
Health Waste Management | DDG Medical Services 1 | Environmental and Occupational Health Directorate
Project Management | Additional Secretary (Senior Assistant or above) | DGHS/DDG Planning and Director Planning

**Financial Management, Disbursements and Procurement**

**Financial Management**

10. The responsibility for the health system in Sri Lanka is shared between the Central Government and the Provincial Councils. The Ministry of Health (MOH) is responsible for the country’s health policy as embodied in the NHDP and the Health Development Master Plan. The main objective of NHDP and Master Plan is to improve health status and reduce inequalities. Administratively, the MOH is responsible for the 23 national hospital and teaching hospitals and 27 other specialized and secondary hospitals while the Provincial Councils (PCs) are responsible for the 3 provincial general hospitals, 18 district general hospitals, 68 base hospitals, 455 divisional hospitals and 473 primary medical care units. These hospitals are part of free health services provided by GOSL.

11. The annual health budget in Sri Lanka is approximately 4.5% of the national budget. The World Bank provided approximately US$75 million equivalent in support of health projects under Health Sector Development Project (2004 to 2010) and the HIV Prevention Project (2003 to 2008). These funds were used for procurement of goods required in the health sector, civil works advisory/technical services, training programs, etc., and also to finance incremental operating costs. FM takes place at all levels of government, including the MOH and other decentralized agencies at the center, provincial and district levels and at national and provincial hospitals.

**Fiduciary Assessment of the Health Sector**

12. The FM team of the Bank together with the procurement team conducted a joint fiduciary review of the health sector in 2010/2011 with the primary objective of identifying opportunities for greater use of the country’s FM and Procurement systems in SHSDP. In the FM assessment the following were identified: (i) gaps in the design and practice of the country’s/sectors FM systems; (ii) aspects of the country systems that can be used as part of SHSDPs FM arrangements and the areas that need further improvement before they can be adopted; and (iii) actions that can be taken at the sector level to improve the systems.
Summary findings of the assessment

13. **Budgeting:** A structured, participatory budget preparation process is in place at the sector level. The budget calendar of the country ensures that the budget is passed before the start of the fiscal year. There is a notable shift in focus both at the Center and Provinces to a more performance base culture by establishing clear linkages between the action plans and budgets in the budget preparation process and moving towards results based budgeting. The World Bank-funded health sector development project contributed to this success given its focus on enhancing the planning and budget preparation process. The proposed project will further strengthen these practices. There is one budget head under the MOH at the center and separate budget heads for the PMOH and the Provincial Department of Health Services at the provincial level. The Central Health budget has a block allocation for central level hospitals where the allocations for each hospital are not separately identified. Sub allocations to hospital are not identified and approved upfront at the start of the year by the central level institutions such as the MOH, Bio-Medical Unit and the Medical Supplies Unit. Instead sub allocations are given throughout the year on a need basis. The budget classification allows the tracking of expenditures by the following dimensions: administrative unit, program, project, economic and financing. Program classification is confined to two programs - 01 for operational activities and 02 for development activities. The areas that can be further strengthened include; (i) indicative budget ceilings to be made available at the start of the budget preparation process; (ii) approval processes of the provincial level procurement plans and action plans for timely implementation of the capital budget and approval processes for sub allocations to hospitals; (iii) budget execution by increasing the predictability of funding to the sector.

14. **The accounting system:** The accounting system at all levels of Government is called Comprehensive Integrated Government Accounting and Reporting Software (CIGAS) used in all sectors including Health. The system follows the same classification as the budget allowing the tracking of expenditures and monitoring of expenditures according to the budget. Reporting practices can be further enhanced: (i) by using the CIGAS code structure to further classify expenditures by geographic, or by service delivery unit (e.g., hospital), and the resulting analysis can be tracked back to the standard classification; and (ii) greater use of commitment accounting for high quality forecasting and improved cash and budget management.

15. **Internal Control Framework:** Some features of a sound internal control framework exist in the sector such as comprehensive financial rules and regulations, an accounting system with internal controls, comprehensive health forms for expenditure approvals of laundry, diet, etc. and source documents and registers of fairly high standards. There are internal audit units at the MOH and in each Province. The Chief internal auditor at the MOH has a direct reporting line to the Secretary MOH and the Chief Internal Auditor in a province reports to the Chief Secretary. This arrangement ensures the functional independence of internal auditors. To ensure compliance with the existing rules and regulations both in salary and non-salary expenditures, a few key prerequisites were identified; (i) adequate risk based oversight by internal and external auditors; (ii) active audit and management committees at the sector level to follow-up on the implementation of audit recommendations; (iii) institutionalize the knowledge and skill maintenance and development for all staff involved in FM related aspects in the sector both at the center and provinces; (iv) the center and provincial leadership to continue their dialogue with the Management Services Department to fill the existing cadre vacancies.
16. **Fixed asset and inventory management** including drugs: The sector will benefit by having a fixed asset management strategy, comprehensive reporting of fixed assets and inventories and timely verification of the availability and usage of assets and inventories. Both fixed asset management and inventory management could be enhanced by having automated systems that are adequately networked between the center and provinces.

17. **Annual Financial Statements and External Audit:** At the end of the year annual appropriation accounts are prepared for each budget head both at the MOH and the PMOHs and explanations for variances between budgeted and actual expenditure are included.

18. **Appropriation accounts/budget execution reports** at all levels are audited and certified by the Auditor General. This process is done in a timely manner. Additionally the Auditor Generals detailed observations for each budget head are tabled in the Parliament, in the form of Audit Paragraphs. Some delays are noted in tabling these reports primarily due to the delay in translating the reports into 2 languages.

19. **Legislative Oversight:** The MOH comes under the legislative scrutiny of the Parliamentary Committee on Public Accounts (COPA) and the PMOH and department under the scrutiny of the Provincial Committee on Public Accounts.

20. As the fiduciary arrangements of the provinces are closely aligned with those of the MOH most of the sector strengths and weaknesses in public finance management (PFM) are cross-cutting across the center and provinces.

**Financial Management Arrangements for SHSDP**

21. The proposed overall FM procedures and practices for SHSDP are satisfactory to meet GOSL’s and IDA’s fiduciary requirements as per OP/BP 10.02. SHSDP has a “Moderate” FM residual risk rating. The overall responsibilities for FM for the activities under the central health agencies will rest with the MOH. The FM work for the activities under the provincial health agencies will be coordinated by the MLGPC with support from the Finance Commission, which will have similar responsibilities as the MOH in terms of implementing the financial covenants of the legal agreement. This entails managing funds in an efficient, effective and transparent manner, obtaining funds from the World Bank and releasing to other implementing agencies, furnishing financial reports, forwarding all audit reports, monitoring and reporting on FM related results indicators and any other requests relating to FM made by the World Bank team.

22. The MOH has a full-fledged accounting unit and the assessment concludes that there is adequate FM capacity in the FM unit. The Chief Accountant will allocate responsibility accordingly among the FM staff for a smooth operation and assign a focal person to liaise with the Bank on FM related activities. The FMS hired/seconded to the support team will support the FM tasks related to the project.
23. The MLGPC has a finance team headed by the Chief Accountant of the Ministry. One of their support functions is to collect and consolidate monthly financial statements of all 9 provinces and share the information with other parts of Government has needed. The project will rely heavily on this function and the unit to meet the reporting requirements of the project. This unit along with the FC will be further strengthened to carry out the additional coordination with the provinces required by hiring/seconding a FMS to the support team. The FMS will work closely with the MLGPC, FC and all 9 provinces and will report to the Secretary MLGPC.

24. The proposed project in an effort to strengthen the FM systems in the sector will institutionalize the knowledge and skill maintenance and development for all staff involved in FM related aspects in the sector both at the center and the provinces. A broad framework for the training of FM staff should be jointly designed by the MOH, PCs and MLGPC and the elements of this framework should include: (i) HRD plans capturing the training needs of sector FM staff; (ii) training a pool of trainers; and (iii) working with training institutions such as the Management Development Training Units (MDTU), to include sector specific FM training in the training calendars; and (iv) Designating a staff member as a training coordinator with a clear list of duties at the center and working closely with the existing training coordinators in each of the provinces. These activities will be supported throughout this project and the progress will be monitored. With the strengthened capacity, the proposed project will explore ways of improving management reporting practices of the sector for more informed decision making such as generating reports by service delivery units.

25. The project will support a fixed asset management strategy to be designed and formed as part of the HMIS for the health sector which also includes the scheduling of asset maintenance activities and the physical asset/inventory verification. The MOH with support from the Bio Medical Engineering unit, MLGPC and other relevant agencies will be held responsible for the implementation of this. The internal audit of the program will be carried out by the Government internal auditors attached to the MOH and the provincial councils. As personal emoluments are part of the EEP, the health sector as a whole is expected to adhere fully to the financial rules and regulations relating the payroll including the Establishment units maintaining complete cadre control records and carrying out a monthly reconciliation between the number of officers paid under each position or category, and the numbers appearing in the cadre control records to ensure that the number of officers paid is correct. The internal auditors are expected to carry out a detailed payroll audit on an annual basis. A legal covenant will be introduced to ensure that acceptable internal audit arrangements will be maintained for the sector as a whole. The capacity of internal auditors will be enhanced to carry out risk based high impact audits even in small numbers given the staff constraints. The MOH and MLGPC will jointly design a framework for training the internal auditors involved in the health sector, under SHSDP. The training will be based on the Government internal audit guidelines which are in line with international internal audit guidelines and standards. A monitoring mechanism by the MOH and the MLGPC will be introduced as part of the proposed project’s focus to enhance institutional practices to ensure adequacy of internal audit coverage and to ensure that the audit and management committees meet frequently.

26. The proposed project’s external audit will be performed by the Auditor General of Sri Lanka. AGD will use a tracking system to monitor the various steps in the audit process to
mitigate the risk of delayed audit reports. There are no overdue audit reports or ineligible expenditures for the health sector. For the proposed project the AGD will issue two consolidated audit reports including an audit opinion and management letters on the two consolidated financial reports prepared for the program, one reflecting health sector expenditure incurred by central level institutions and the other reflecting the provincial level expenditures. The reports will reflect the entire health sector expenditures for all sources of funds. The Final Year’s (2018) audit report, however, will cover only Component 2 activities. The activities of Component 1 will have concluded by December 2017 and the disbursements for 2018 for this Component will be on reimbursement basis for EEPs of 2017. In a programmatic approach, the Bank funds are considered fungible. As the Bank funds are indistinguishable from GOSL funds the financial reports submitted to the Bank will include all sector expenditures from all sources of funds.

27. The objective of the two consolidated audit reports is for the Bank to obtain assurances that they present a true and fair view of the health sector expenditures and free from material misstatements. The basis of the two consolidated audit reports and management letters will be the audit findings and audit opinions on the individual appropriation accounts of the health sector. The consolidated audit reports are required to be submitted to the Bank within 10 months of the end of the financial year in the first two years and a gradually reduction in the due to 9, 7 6 and 6 months from the end of the financial year in the ensuing years.

**Disbursement arrangements for SHSDP**

28. Given the programmatic approach in SHSDP, the budgeting and IDA fund flow arrangements will be fully aligned with the existing systems of government. SHSDP will have three Designated Accounts (DAs): (i) two DAs for Component I, one for the activities managed by MOH (DA administered by MOH) and the other for the activities managed by PMOHs (DA administered by MLGPC); (ii) one DA for Component II activities (DA administered by MOH). Disbursements will be report-based. Replenishment of the DAs will be based on the IUFRs and fulfillment of agreed DLIs. Three sets of IUFRs will be prepared one for each DA by the entities responsible for administering the DA. The quarterly IUFRs will be due within 45 days of the end of each calendar quarter. The Governments guidelines for operating designated accounts will be followed by the MOH and MLGPC. No funds from the DAs will be withdrawn without instructions from MOH and MLGPC and the proceeds of the withdrawals will go directly to bank accounts specified below. This will be closely monitored and information regarding the release of funds will form part of the reporting to the Bank. For Component I: (i) The Central DA - the proceeds in the Central DA can be obtained by the MOH directly and will be deposited in the MOH’s general bank account; and (ii) The proceeds from the Provincial DA will be directly advanced to the each of the nine provincial treasuries general bank accounts. For Component II, proceeds of the Component II DA will be advanced to a project specific local bank account operated by MOH. The provincial treasuries, following the regular fund flow mechanism of the Government, will release the funds to the provincial ministry and department of health based on the budget allocations.

29. The IDA financing will contribute to the country’s five-year health sector program (2013-2017), as reflected in the NHDP. IDA funds for Component I will be provided as sector budget support and divided between the budget allocation to MOH and the nine PMOHs per formula.
30. IDA funds for Component I will be disbursed only against non-procurable items, i.e., salaries and wages (object code 1001), overtime and holiday payment (object code 1002), other allowances (object code 1003), domestic travelling (object code 1101), foreign travelling (object code 1102), transport (object code 1401), postal communication (object code 1402), and electricity and water (object code 1403). The above non-procurable items constitute the Eligible Expenditure Program (EEP) to be financed by IDA under this project. IDA funds for component I will be provided as Sector Budget Support, utilized by the MOH and the nine PMOHs. The Table below provides the IDA fund allocations for each year if the agreed targets of each DLI are achieved completely for that corresponding year. While the project will monitor results with the use of DLIs for Component I, the expenditures for this Component will be against an EEP. IDA disbursements for Component I will be upon achievement of the DLI targets and the submission of eligible expenditure reports (see table below).

Table 2: Component I: Allocation amounts for each DLI in US$ million (Physical targets for each DLI are presented in Annex 1)

<table>
<thead>
<tr>
<th>DLI</th>
<th>Implementing authority</th>
<th>Yr 1 2013</th>
<th>Yr 2 2014</th>
<th>Yr 3 2015</th>
<th>Yr 4 2016</th>
<th>Yr 5 2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Child Health and Nutrition related DLI</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>1. % of MCH clinics with an agreed package of equipment and supplies for provision of care for pregnant women and children under 5 years. (DLI 5)</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>NCD related DLIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. % of Medical Officer of Health areas with at least two healthy lifestyle centers. (DLI 6)</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>3. % of centrally managed health facilities with ETUs for that level of facility based on standard guidelines (NCD). (DLI 1)</td>
<td>MOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>4. % of provincially managed health facilities with ETUs for that level of facility based on standard guidelines (NCD). (DLI 2)</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>System improvement DLIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. % of fully functioning quality management Units (QMU) in MOH managed base hospitals and above. (DLI 7)</td>
<td>MOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>6. % of fully functioning quality management Units (QMU) in provincially managed base hospitals and above. (DLI 8)</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>7. % of MOH managed health facilities sending indoor morbidity data through e-IMMR. (DLI 3)</td>
<td>MOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
<tr>
<td>8. % of provincially managed health facilities sending indoor morbidity data through e-IMMR. (DLI 4)</td>
<td>PMOH</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
</tr>
</tbody>
</table>
9. % of the 6 monthly cash forecast (for non-salary recurring and capital expenditures) released. (DLI 9)

<table>
<thead>
<tr>
<th></th>
<th>Treasury, FC, MLGPC</th>
<th>1.67</th>
<th>4.86</th>
<th>4.86</th>
<th>4.86</th>
<th>21.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td>15.00</td>
<td>43.75</td>
<td>43.75</td>
<td>43.75</td>
<td>190.00</td>
</tr>
<tr>
<td>Total funds available to the MOFP, MLGPC, FG, MOH, PMOHs</td>
<td>1.67</td>
<td>4.86</td>
<td>4.86</td>
<td>4.86</td>
<td>21.11</td>
<td></td>
</tr>
<tr>
<td>Total funds available to the MOH</td>
<td>5.00</td>
<td>14.58</td>
<td>14.58</td>
<td>14.58</td>
<td>14.58</td>
<td>63.33</td>
</tr>
<tr>
<td>Total funds available to GOSL</td>
<td>8.35</td>
<td>24.30</td>
<td>24.30</td>
<td>24.30</td>
<td>24.30</td>
<td>105.55</td>
</tr>
</tbody>
</table>

31. In a programmatic approach (Component I), the Bank funds are merged with GOSL funds. The financial reports submitted to the Bank will include the total expenditure of the government health sector in a given reporting period. A DLI on the flow of funds have been incorporated to ensure that the health sector as a whole will receive adequate and timely funding to achieve sector results.

32. The arrangements for fund-flow and reporting are complex. However a key strength in the reporting environment of government is that the expenditure reports are collected from all spending units and consolidated by budget head at a central point once a month both at the center and provinces. At the end of every month, the cumulative consolidated expenditure is also captured. It is strongly encouraged that the two implementing units i.e. the MOH and the MLGPC use these consolidated reports of the Government to prepare the IUFR for the World Bank. The World Bank reporting formats will be simplified to the extent possible and fully aligned with the Government reports.

33. Actual expenditures incurred under Component II will be tracked and recorded in a separate IUFR.

34. As the aforesaid reports only capture the expenditure, a separate statement on the release of Bank funds to the relevant implementing agencies will be forwarded by the MOH and the MLGPC to the World Bank. This statement will form part of the IUFRs.

35. Disbursements will be report-based. Replenishment of the DA’s will be based on the IUFRs of the EEP, and fulfillment of agreed DLIs. Three sets of IUFRs will be prepared one for each DA by the entity which is assigned to administer the DA. The quarterly IUFRs will be due within 45 days of the end of each calendar quarter.

**Methodology for pro-rating disbursements as per DLI performance**

36. Of the total IDA credit of US$ 200 million equivalent, $10 million are for the Innovation, Results Monitoring and Capacity-Building Fund (Component II), leaving US$ 190 million for the DLIs.

37. The DLIs are equally weighted, and thus each DLI is worth US$ 21.11 million divided over five years. This amount of $21.1 million per DLI will be divided as: US$ 1.67 million for
the first year, and US$ 4.86 million for each of the following 4 years. Therefore, the first year’s maximum IDA contribution to the EEP will total US$ 15 million equivalent, plus any expenses incurred for Component II. For the subsequent 4 years, the disbursement is expected to be $43.75 million for the DLIs plus expenses incurred for Component II.

38. IDA funds for Component I will be provided as an advance amount (up to a maximum of 75% of the allocation for the first year including retroactive financing) soon after the SHSDP is declared effective for the financing of activities in the first year of the project. Retroactive financing will be made available for payments made prior to the date of the Financing Agreement but on or after January 1, 2013 for Eligible Expenditures under Component I up to an aggregate amount not to exceed US$ 7.5 million and under Component II up to an aggregate amount not to exceed US$ 2 million.

39. For the second year (2014) an advance of 50% of the 2014 allocation will be released in February 2014 based on the forecasted EEPs for 2014 and the submission of IUFR to account for previous undocumented advances. The final report on results for first year performance (2013) will be available by May 2014. The second year (2014), second fund release of the remaining 25% of the allocation for the first year will be in May 2014 on reimbursement basis, after adjusting for 2013 year’s performance based on DLIs and the submission of IUFR to account for previous undocumented advances. The same cycle of fund release will be in place for the succeeding years. Delayed achievement of a DLI will lead to delayed disbursement of the corresponding funds. Partial achievement of a specific DLI (for DLI 1-8) target will lead to a corresponding proportionate disbursement for that specific DLI. Credit proceeds upon disbursement will not be tracked separately as an expenditure category for the Component I of the project.

40. IDA funds under Component II will be used following approval of proposed activities reviewed by the World Bank every quarter. The expenditure will be reported against eligible expenses which will include goods, works, consultants, training, workshops, research and incremental operating costs (“Incremental Operating Costs” means the incremental expenditures incurred on account of the management of Part B of the Project, including for per diems, office supplies, vehicle rental charges (including passenger insurance), government motorcycle and vehicle operating charges (fuel, maintenance, and insurance), utilities, maintenance of office equipment, telephone and other communications charges, office rent, advertising costs for procuring goods, works and services, bank charges for the operation of the designated account, salaries of contractual staff, salary top-up and Project related allowances of officials of the Recipient’s civil and public service, but excluding their salaries). Advance based on forecast of two quarters of the annual planned budget will be provided under this Component II. In addition, an amount not to exceed 20% of the allocation for Component II, or USD 2 million, will be provided for retroactive financing against eligible expenditures after January 31, 2013.

41. The DLI approach is expected to improve the development impact of resources due to: (i) greater focus on results through the link between the flow of funds and the achievement of results; (ii) open policy dialogue for the entire program and a strong partnership between GOSL and IDA; (iii) scaling-up and sustainability of benefits by focusing on the entire program; and (iv) strengthening the country’s capacity, systems and institutions at a feasible pace and phasing.
The funds under the SHSDP will be integrated into the budgets of the MOH and the health budgets of the Provincial Councils, and use the public sector format for reporting expenditures.

**Table 3: Illustrative Disbursement Schedule for Component I**

(At 100% achievement of DLI targets)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Disbursements based on achievement of DLIs</th>
</tr>
</thead>
</table>
| On Effectiveness (mid 2013) | 1. Initial advance of 75% of US$15 million equivalent or US$11.25 million (including retroactive financing not to exceed US$ 7.5 million).  
2. Initial advance will be against forecasted EEPs from signing date to December 31, 2013.  
3. Retroactive financing will be for EEPs from January 31, 2013 up to signing date. |
| February 2014        | 1. Advance of 50% of year-2 allocation against forecasted EEPs of 2014, and if actual EEPs up to December 31, 2013 exceed the advance amount released in the previous tranche.  
2. Document against advance amount released upon effectiveness against actual EEPs up to December 31, 2013. |
| May 2014             | 1. Reimbursement of the remaining 25% of the year-1 allocation or US$ 3.75 million, against actual EEPs from signing to December 31, 2013, if (i) actual EEPs up to December 31, 2013 exceed year-1 allocation; and (ii) all DLIs are fully met (based on DLI performance verification report for 2013). Actual amount will depend on the DLI performance.  
2. Document against 50% advance amount released in Feb 2014 against actual EEPs from Jan-March 2014. |
| February 2015        | 1. Advance of 50% of year-3 allocation against forecasted EEPs of 2015.                                                                                                                                                                                          |
| May 2015             | 1. Reimbursement of the remaining 50% of year-2 allocation against actual EEPs from April-December 2014, if (i) actual EEPs of 2014 exceed year-2 allocation; and (ii) all DLIs are fully met (based on DLI performance verification report for 2014). Actual amount will depend on the DLI performance.  
2. Document against 50% advance amount released in Feb 2015 against actual EEPs from Jan-March 2015. |
| February 2016        | 1. Advance of 50% of year-4 against forecasted EEPs of 2016.                                                                                                                                                                                                   |
| May 2016             | 1. Reimbursement of the remaining 50% of year-3 allocation against actual EEPs from April-December 2015, if (i) actual EEPs of 2015 exceed year-3 allocation; and (ii) all DLIs are fully met (based on DLI performance verification report for 2015). Actual amount will depend on the DLI performance.  
2. Document against 50% advance amount released in Feb 2016 against actual EEPs from Jan-March 2016. |
| February 2017        | 1. Advance of 50% of year-5 allocation against forecasted EEPs of 2017.                                                                                                                                                                                           |
| May 2017             | 1. Reimbursement of the remaining 50% of year-4 allocation against actual EEPs from April-December 2016, if (i) actual EEPs of 2016 exceed year-4 allocation and (ii) all DLIs are fully met (based on DLI performance verification report for 2016). Actual amount will depend on the DLI performance.  
2. Document against 50% advance amount released in Feb 2017 against actual EEPs from Jan-March 2017. |
| May 2018             | 1. Reimbursement of the remaining 50% of year-5 allocation against actual EEPs from April-December 2017, if (i) actual EEPs of 2017 exceed year-5 allocation, and (ii) all DLIs are fully met (based on DLI performance verification report for 2017). Actual amount will depend on the DLI performance. |
42. **Fund flow** arrangements for SHSDP are depicted in the figure below.

**Figure 1: Fund flow arrangements for SHSDP**

- The World Bank
- Three Designated USD Accounts in the name of DST MoF at Central Bank
  - MOH dedicated local bank a/c – component II
  - MOH general local bank a/c – Component I
  - 9 PCs general local bank a/c – Component I
- MOH Directorates
- MOH Hospitals
- MOH Institutions
- 9 PMOHs (PDHS)
- 26 RDHS
- PDHS managed Hospitals
- RDHS managed hospitals

Procurement

**Country Procurement Environment**

43. Public procurement in Sri Lanka is governed by the Procurement Guidelines of 2006 (with amendments), supplemented by a procurement manual and standard bidding documents. Procurement of consultancy services is regulated by the Guidelines on the Selection and Employment of Consultants dated August 2007. The Guidelines, manuals and standard bidding documents constitute the public procurement regulatory framework and are comprehensive. These include a menu of procurement methods, provide for the contents of bidding documents, evaluation criteria, and adequately respond to procurement needs of different procuring entities. These Guidelines apply to all procuring entities at national and provincial levels using national budget funds. Procurement is decentralized to procuring entities both at the central and provincial levels.

**Assessment of the Agencies’ Capacities to Implement Procurement**

44. As mentioned earlier, the fiduciary team of the World Bank carried out a comprehensive review of the health sector including three selected provinces out of the nine. PMOH, PDHS, RDHS and Hospital Directors are the responsible executing agencies at the provincial level. In addition, the Engineering Department of each Province is responsible for civil works contracts in the province.
45. The review revealed that the contracts carried out at the provincial level are smaller in magnitude and hence the capacity of handling large value contracts may be a limited. It was revealed in some cases that the procurement process and the evaluations were done by deviating from the guidelines and principles of procurement mainly due to the lack of exposure and the knowledge of the staff who handle procurement.

46. The key issues and risks concerning procurement for implementation of SHSDP have been identified and include (i) limited experience and lack of knowledge of the staff handling procurement, (ii) limited experience in selection of consultants, (iii) absence of a system for systematic procurement performance and compliance monitoring, (iv) limited experience in dealing with complaints, fraud and corruption issues. The suggested action plan for improving these issues include; (i) implementing an effective capacity building program within SHSDP; (ii) producing an operation manual for Component II; (iii) assigning dedicated procurement staff at the MLGPC and the MOH, (iv) introduce an effective and independent complaint handling system; (v) establish a procurement monitoring and evaluation system at all levels; (vi) develop standard functional specifications for commonly used goods; (vii) introduce a procurement compliance audit system; and (viii) strengthening of the contract administration system at central and provincial levels.

47. Procurement Risks and Mitigation Measures: The overall procurement risk is rated “substantial” based on an assessment of procurement capacities during the fiduciary review carried out for the health sector. The main risk is the limited procurement capacity, which needs to be upgraded for improved procurement performance. The procurement specialists in the MOH and the MLGPC will support this work for the MOH and Provincial Councils.

Procurement Arrangements for Component I

48. Funds under this Component will be provided as Sector Budget Support, utilized by the MOH and the nine PMOHs. While the project will monitor results with the use of DLIs for Component I, the funds will be disbursed against reimbursement of expenditure under EEPs. EEP is defined to include non-procurable items only. All procurement under this Component will follow Government procurement guidelines and procedures. IDA will periodically review the overall procurement system in the sector ensure that recommendations arising from the fiduciary review are being addressed. The implementing units of the MOH and the Provincial councils will develop and maintain procurement plans for activities under Component I as required under the paragraph 4.2 of the National Procurement Guidelines 2006.

Procurement Arrangements for Component II

50. The following methods will be applicable for Goods, Works and Non-consulting Services to be procured under this Component, consistent with the relevant sections of the Bank’s Procurement Guidelines:

   a. National Competitive Bidding (NCB);
   b. Shopping (S);
   c. Direct Contracting; and
   d. Procurement from United Nations Agencies

51. Procurement conducted under National Competitive Bidding (NCB): In order to ensure economy, efficiency, transparency and broad consistency with the provisions of the Procurement Guidelines, goods, works, and non-consultant services procured under the National Competitive Bidding (NCB) method shall be subject to the following requirements:

   a. Only the model bidding documents for NCB agreed with the Bank shall be used for bidding;
   b. Invitations for bids will be advertised in at least one widely circulated national daily newspaper, and bidding documents will be made available at least 21 days before, and issued up to, the deadline for submission of bids;
   c. Qualification criteria will be stated in the bidding documents, and if a registration process is required, a foreign firm declared as the lowest evaluated responsive bidder shall be given a reasonable time for registering, without let or hindrance;
   d. Bids will be opened in public in one location, immediately after the deadline for the submission of bids, as stipulated in the bidding document (the bidding document will indicate the date, time and place of bid opening);
   e. Except in cases of force majeure or exceptional situations beyond the control of the implementing agency, the extension of bid validity will not be allowed;
   f. Bids will not be rejected merely on the basis of a comparison with an official estimate;
   g. Except with the prior concurrence of the Bank, there will be no negotiation of price with bidders, even with the lowest evaluated bidder;
   h. A bidder’s bid security will apply only to the specific bid, and a contractor’s performance security will apply only to the specific contract under which they are furnished; and
   i. Bids will not be invited on the basis of percentage premium or discount over the estimated cost, unless agreed with the Bank.

52. Selection of Consultants: Consultant services required under SHSDP will include: expertise in monitoring and evaluation, financial management, procurement, and specialized fields in health, environmental and social sciences. Short lists of consultants for services estimated to cost less than US$ 300,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

53. The following methods will be applicable for selection of consultants, consistent with the relevant sections of the Bank’s Consultant Guidelines:
a. Quality- and Cost- Based Selection (QCBS)
b. Quality-Based Selection (QBS)
c. Least Cost Selection (LCS)
d. Selected under Fixed Budget (FBS)
e. Selection based on Consultants’ Qualifications (CQS): for services estimated to cost less than US$ 200,000 equivalent per contract, in accordance with the provisions of paragraph 3.7 of the Consultant Guidelines
f. Single Source Selection (SSS) of consulting firms
g. Selection of UN Agencies
h. Procedures set forth in paragraphs 5.2 and 5.3 of the Consultant Guidelines for the Selection of Individual Consultants
i. Sole Source Procedures for the Selection of Individual Consultants

54. The Bank’s standard request for proposal (SRFP) document will be used for all consultant services. This document may be customized, as appropriate, for small value assignments (less than US$300,000).

55. Composition of procurement committees and TECs. The appointment of procurement committees and TECs will follow the GOSL procedures for foreign funded projects.

56. Procurement information and documentation – Filing and database. Procurement information will be recorded and reported as follows: (i) complete procurement documentation for each contract, including bidding documents, advertisements, bids received, bid evaluations, letters of acceptance, contract agreements, securities, related correspondence, etc., will be maintained by the implementing agency in an orderly manner, readily available for audit, (ii) contract award information will be promptly recorded and contract rosters as agreed will be maintained, (iii) comprehensive quarterly reports by implementing authorities indicating: (a) revised cost estimates, where applicable, for each contract; (b) status of on-going procurement, including a comparison of originally planned and actual dates of the procurement actions, preparation of bidding documents, advertising, bidding, evaluation, contract award and completion time for each contract; and (c) updated procurement plans, including revised dates, where applicable, for the procurement actions.

Frequency of Procurement Supervision

57. In addition to the prior reviews to be carried out by the Bank, the capacity assessment of the implementing agencies has recommended semi-annual supervision missions to visit the field to carry out reviews of procurement actions on a sample basis. Moreover, the Bank will also monitor the procurement performance under Component I on a sample basis, in addition to the monitoring mechanism of the Borrower.

58. Dedicated staff member(s)/consultant(s) will be assigned for procurement monitoring and reporting, training and guidance for both the central and the provincial level activities. Bi-annual procurement progress reports to be provided to the World Bank will include status updates, procurement monitoring reports and analysis of agreed intermediate outcome indicators. The
MOH and the Provinces will develop an effective monitoring mechanism during the first six months of SHSDP.

**Table 4: Thresholds for Procurement Methods and Prior Review for the Procurement to be carried out under Component II**

<table>
<thead>
<tr>
<th>Procurement Category</th>
<th>Procurement Method</th>
<th>Method Threshold</th>
<th>Prior Review Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Competitive Bidding (NCB) in accordance with the Bank’s Procurement Guidelines, and subject to the provisions set forth below.</td>
<td>Works estimated to cost not to exceed US$5 million equivalent per contract.</td>
<td>➢ All contracts subject to post review on sample basis.</td>
</tr>
</tbody>
</table>
| Works                | National Shopping in accordance with the Bank’s Procurement Guidelines, and subject to:  
  - receiving not less than three sealed quotations from ICTAD registered contractors;  
  - submission of quotations by a pre disclosed deadline and public opening; and  
    a written invitation for quotation shall be provided, including a detailed description of the works, and evaluation criteria. | Works estimated to cost not to exceed US$50,000 equivalent per contract.           | ➢ All contracts subject to post review on sample basis.                                 |
|                      | ICB in accordance with the Bank’s Procurement Guidelines:  
  * Bank’s standard bidding documents for goods shall be used. | Packages of goods, equipment and NCS estimated to cost exceeding US$600,000 equivalent per contract. | ➢ All contracts.                                                                         |
| Goods, Equipment and Non-consultant services (NCS) | NCB in accordance with the Bank’s Procurement Guidelines, and subject to the provisions set forth below. | Packages of goods, equipment and NCS estimated to cost not to exceed US$600,000 equivalent per contract. | ➢ All contracts exceeding US$300,000 million equivalent;                                 |
|                      | National Shopping in accordance with the Bank’s Procurement Guidelines, subject to:  
  - receiving not less than three sealed quotations;  
  - submission of quotations by a pre disclosed deadline and | Works estimated to cost not to exceed US$50,000 equivalent per contract.           | ➢ All contracts subject to post review on sample basis.                                 |
- a written invitation for quotation shall be provided, including quantity requirements, specifications, delivery schedule, terms of payment, and evaluation criteria.

<table>
<thead>
<tr>
<th>Consultant Services-Firms</th>
<th>Quality and cost based (QCBS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bank’s standard request for proposal shall be used.</strong></td>
<td>Irrespective of the value in accordance with Section II of the Bank’s Guidelines for selection of consultants. Services costing less than US$300,000 equivalent per contract may comprise all nationals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultant Services-Firms</th>
<th>Quality based (QBS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least cost (LCS)</td>
<td>Fixed Budget (FBS)</td>
</tr>
</tbody>
</table>

**Bank’s standard request for proposal shall be used.**

<table>
<thead>
<tr>
<th>Consultant Services-Firms</th>
<th>Selection based on Consultant’s Qualifications (CQS), in accordance with paragraph 3.7 of the Bank’s Consultant Guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services costing less than US$ 100,000 equivalent per contract.</td>
<td></td>
</tr>
</tbody>
</table>

- Direct Contracting

| All contracts estimated to cost exceeding US$ 100,000 equivalent; and |
| All other contracts are subject to post review on sample basis. |

- Goods, equipment, software non consulting services irrespective of the value under the provisions of paragraph 3.6 of the Bank’s Procurement Guidelines.

- All contracts estimated to cost exceeding US$ 300,000 equivalent; and

- All Terms of Reference.

- First contract to be awarded

- All Terms of Reference
Environmental Safeguards

59. As the SHSDP is providing finances to implement the NHDP, the exact activities that will be undertaken as part of IDA finances will not be identified. Therefore, taking forward the initiative taken up by the HSDP to improve healthcare waste management, the MOH has prepared a HCWM framework in line with the NHDP and OP/BP 4.01 – Environmental Assessment. HCWM framework identifies an action plan to be implemented during the project period which will be monitored as part of environmental safeguards requirement of the project.

60. EOHD of MOH will be overall responsible for the implementation of the HCWM framework with the support of PDHSs. With the implementation of the SHSDP commences, the EOHD will prepare a detailed action plan consistent with the plan proposed in the HCWM framework and NHDP. MOH will monitor the implementation of the action plan and report bi-yearly the achievement of targets and provide supporting documents to IDA.

Monitoring

61. Annually, based on the NHDP, the MOH and the respective PMOHs will develop annual implementation plans in consultation with all stakeholders. The annual implementation plans for each year, will be shared with the World Bank by October 31 of the preceding year.
62. As the NHDP has a large set of indicators to measure outcomes, outputs, processes and inputs at the sector level. Recognizing the selected number of areas on which Bank’s engagement is focused, a separate results framework with a limited sub-set of these indicators is in Annex 1.

63. Apart from regular monthly monitoring of relevant indicators by the managers at various levels (central and provincial levels); quarterly reviews will be carried by the MOH and PMOH Management and Monitoring teams. Semi-annual reviews of sector performance with joint involvement of the MOH and PMOHs will be at the PSC level.

**DLI Verification**

64. The MOH and the MOFP PMM will prepare a DLI results report (format of the DLI results report to be agreed with the World Bank and this will be part of the Annual Progress Report of the SHSDP) for each preceding year and submitted to World Bank by end March. The World Bank team will verify the reported DLI results by contracting an independent firm or consultant and the verification report will be shared with the GOSL by end April. Thereafter, based on discussions with the GOSL agreement will be reached for the rating provided to each of the DLIs by May and the total due allocation for the preceding year will be confirmed by end May and the funds will be released after adjusting for the advance given. The same timeline will be followed for all years of project implementation.

**Non DLI results**

65. The MOH and the MOFP PMM will also report on the status of the other Non DLI results using administrative and survey data wherever necessary.

**Evaluation**

66. Surveys and end-line evaluations will be carried out on sector performance and its determinants, with a focus on the indicators contained in the results framework. Such evaluations will be conducted by independent firms contracted by MOH. Additionally, impact evaluation will be designed and conducted for all innovative and new initiatives undertaken by the project, such as the RBF pilot projects that are envisaged under Component II.
Table 5: Levels of monitoring in the health sector

<table>
<thead>
<tr>
<th>Levels of monitoring</th>
<th>Types of indicators</th>
<th>Carried out by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector level performance review</td>
<td>Broad sector results</td>
<td>MOH, with participation of PMOHs, MLGPC, Finance Commission, MOFP and development partners</td>
</tr>
<tr>
<td>Middle level managers’ monitoring</td>
<td>Indicators of inputs, process, outputs and outcomes at the relevant level</td>
<td>Program managers/institutional heads at the relevant levels</td>
</tr>
<tr>
<td>World Bank engagement</td>
<td>Selected indicators included in the results framework – measuring PDO level and intermediate results</td>
<td>World Bank task-team jointly with MOH, MLGPC, PMOHs, Finance Commission and MOFP</td>
</tr>
<tr>
<td>Disbursement level</td>
<td>DLIs</td>
<td>MOFP, PMM and Independent verification report (for review by IDA and MOFP)</td>
</tr>
</tbody>
</table>

Project Performance Reporting

67. The GOSL (MOH, MLGPC supported by the MOFP and FC) will submit an Annual Progress report (format of this report will also be agreed with the World Bank) along with the DLI Verification report by end of February each year.

68. The Progress Performance Report will include the following sections:
   a. Introduction of project – all 2 Components
   b. Progress with regard to each Component
   c. Update of the Results Framework (annex 1)
   d. Report of DLI achievement with sources of information used for reporting achievements for each of the DLIs
   e. Detailed activity plans for the respective years implementation by province and MOH

Role of Partners (if applicable)

External partner agencies

69. In the spirit of the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008), one of the fundamental characteristics of a sector-wide operation is better coordination among all Development Partners. It is important to ensure that every agency that is active in the Sri Lankan health sector contributes to one common country-led strategy and moves
towards harmonizing and aligning its processes and procedures. The main external development partners involved in health other than the World Bank are: JICA, the Global Fund to fight AIDS, Tuberculosis and Malaria, the European Union, GIZ, and the relevant UN agencies and programs, i.e., the World Health Organization, UNICEF, United Nations Population Fund, UNAIDS, International Labor Organization and World Food Program. It is expected that a mechanism will be established, and evolve into a forum for conducting joint planning exercises, joint reviews of the sector performance and other such coordination activities.

**Other ministries**

70. As health outcomes require multi-sectoral action, SHSDP will foster inter-sectoral collaboration. Some of the key sectors that will need to be engaged are:

a. **Education and Higher Education.** The Ministry of Education and Higher Education will be responsible for introduction of appropriate information on NCD in the primary and secondary and tertiary curricula. This activity will be undertaken by the National Institute of Education.

b. **Transportation/roads and highways/Police:** Very critical in ensuring road safety and preventing accidents, to reduce the proportion of injuries in the disease burden.

c. **Law and justice and Ministry of Industries:** To take forward the legislative actions needed for healthy lifestyle – e.g. on tobacco, alcohol, salt, trans fats, road safety, etc.

d. **Social Services:** To ensure that the disabled people get the necessary health services, including physiotherapy, rehabilitation, assistive devices, etc.; to obtain synergies regarding services provided to the growing population of elderly; and to collaborate on conditional cash transfers and other social protection programs with a health benefit.

e. **Women’s Affairs:** To support activities with regard to domestic violence and other special issues affecting women.

f. **Agriculture, Livestock, and Fisheries:** To take necessary actions in their respective sectors to ensure nutritious food security.

g. **Local Government and Municipalities:** To improve actions with regard to environmental and urban health issues affecting the population.

**NGOs/CBOs and Private sector**

71. The role of the private sector and NGOs in SHSDP will be for (i) providing research, consultancy and services on contractual basis, (ii) exploring partnerships for improved and better coordinated health service delivery.

**Other public and private institutions**

72. Training events, special studies and research activities will be conducted by colleges of health professionals, universities, institutes for research and development, centers of excellence at different levels of government.
Figure 2: Organizational chart of the health sector in Sri Lanka

**CENTRAL LEVEL STAKEHOLDERS**
- Minister of Health
- Secretary, Ministry of Health (MOH)
- Ministry of Finance & Planning (MOFP)
- Ministry of Local Government & Provincial Councils (MLGPC): coordinates and represents provincial councils in the central Cabinet.
- Finance Commission (FC): recommends provincial allocations.

**PROVINCIAL LEVEL**
- 9 Provincial Councils (headed by Governors and Chief Ministers)
  - 9 Provincial Ministers for Health
  - 9 Provincial Secretaries for Health
  - 9 Provincial Directors of Health Services (PDHS) & their teams
  - Technical and policy guidance
  - 26 Regional Directors of Health Services (RDHS) & their teams
  - Directors of provincially managed hospitals
  - Medical Officers of Health (MOH) & their teams
  - Medical Officers in charge of district level hospitals and their teams
  - Approximate 50 Directors of centrally managed hospitals and institutions, and their teams
  - Approximately 65 Program Directors & their teams
  - Curative track (tertiary)
  - Preventive track
  - Curative track (Secondary & Primary)
**Annex 4: Operational Risk Assessment Framework (ORAF)**

**SRI LANKA: Second Health Sector Development Project**

### Project Stakeholder Risks

<table>
<thead>
<tr>
<th>Stakeholder Risk</th>
<th>Rating</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Possible Policy Reversals or weak policy commitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Possible resistance from labor unions and professional associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Possible political influence on the location of health facilities results in a configuration that is not based on coherent planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Management:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High level dialogue and advocacy efforts as necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resp:</strong></td>
<td><strong>Status:</strong></td>
<td><strong>Stage:</strong></td>
</tr>
<tr>
<td>Both</td>
<td>Not Yet Due</td>
<td>Implementation</td>
</tr>
</tbody>
</table>

### Implementing Agency (IA) Risks (including Fiduciary Risks)

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Rating</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Procurement
  (i) High turnover of staff erodes capacity and creates continual need for further training.
  (ii) Dissemination of the GOSL procurement guidelines |       |          |
| **Risk Management:** |        |          |
| Refresher procurement and FM training to be provided to relevant officials on a continuing basis. |        |          |
| **Resp:** | **Status:** | **Stage:** | **Recurrent:** | **Due Date:** | **Frequency:** |
| Bank | Not Yet Due | Preparation | | | |
published in the Year 2006 did not reach adequately to the provincial level. 
Financial Management:
(iii) Specific capacity-building efforts for the Ministry’s move to IUFR-based disbursement.
(iv) Internal audit systems have been established, the latter need further strengthening planning and management.
(v) There is inadequate capacity for planning and management in the sector, and very limited use of available data/evidence.

### Governance

**Description:**
Weak Governance could result in poorer quality of and access to services, and a consequent shortfall in achievement of health outcomes.

### Rating

<table>
<thead>
<tr>
<th>Risk Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modernization of health information systems, capacity-building and technical assistance on the use of information for planning and management.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
<th>Due Date:</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Not Yet Due</td>
<td>Preparation</td>
<td>✓</td>
<td></td>
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</tbody>
</table>

### Risk Management:

#### Rating Moderate

**Description:**
Strongened monitoring and supervision, financial management, inventory management and other systems of accountability.

<table>
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<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
<th>Due Date:</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Not Yet Due</td>
<td>Preparation</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Project Risks

#### Design

**Description:**
4.1.1 New concepts such as sector-wide approach with disbursement linked indicators may not be fully understood by all stakeholders involved in the preparation process. DLI results are not achieved as planned, resulting in under-disbursement of IDA funds.

### Rating

<table>
<thead>
<tr>
<th>Risk Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 Intensive consultation and participation have been conducted to ensure better understanding. Realistic determination of indicators to measure results and targets to achieve; to be reviewed at mid-term and re-adjusted if necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
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<th>Frequency:</th>
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<td>Implementation</td>
<td></td>
<td>31-Dec-2015</td>
<td></td>
</tr>
</tbody>
</table>
4.1.2 DLI Results are achieved, but due to excessive focus on those, other sector results are affected.

4.1.2 All sector results will be monitored continuously, regardless of whether they are DLI or not. If adverse effect on non-DLI results are noticed, appropriate refocusing/restructuring will be carried out.

<table>
<thead>
<tr>
<th>Social and Environmental</th>
<th>Rating</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2.1 Health Care Waste Management. The unsafe disposal of waste generated by the health system is the main environmental risk.</td>
<td></td>
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<tr>
<td>4.2.2 Social risk, i.e., that SHSDP may end up benefiting the better off, rather than the most vulnerable population groups such as the Estate Sector.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Program and Donor</th>
<th>Rating</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncoordinated donor assistance may be sought by the Government for buildings, equipment and other hardware, without adequate attention to maintenance, human resources and other soft inputs.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery Monitoring and Sustainability</th>
<th>Rating</th>
<th>Substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4.1 Access and equity: Difficult geographical accessibility and organizational constraints in the</td>
<td></td>
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</tbody>
</table>

4.4.1 Innovative solutions to estate sector will be found through pilot-testing different models.
Plantation (estate) sector could challenge efforts to improve service delivery for that population group.

4.4.2 Lack of sufficient coordination between the central and provincial levels could impact adversely on health care quality.

4.4.3 Political pressures at the local level could result in decisions which are not in line with national policies and guidelines about health facilities.

<table>
<thead>
<tr>
<th>Risk Management:</th>
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<tbody>
<tr>
<td>4.4.2 Effective center-province dialogue will be continued, and a steering committee with the participation of the Secretary and Additional Secretary, MLGPC and the Finance Commission and all provinces will coordinate provincial level activities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
<th>Due Date:</th>
<th>Frequency:</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Management:</th>
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</thead>
<tbody>
<tr>
<td>4.4.3 Overall program coordination will be overseen by a committee chaired by the Health Secretary, with the participation of the Additional Secretary of MLGPC, various Directors in the Ministry of Health and the Provincial Directors of Health.</td>
</tr>
</tbody>
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<thead>
<tr>
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<table>
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<th>Risk Management:</th>
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<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
<th>Due Date:</th>
<th>Frequency:</th>
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<tr>
<th>Other (Optional)</th>
<th>Rating</th>
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<td>Description:</td>
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<tr>
<th>Risk Management:</th>
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<tr>
<th>Resp:</th>
<th>Status:</th>
<th>Stage:</th>
<th>Recurrent:</th>
<th>Due Date:</th>
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<table>
<thead>
<tr>
<th>Overall Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Risk Rating: Moderate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and equity: Difficult geographical accessibility and organizational constraints in the plantation (estate) sector could challenge efforts to improve service delivery for that population group.</td>
</tr>
</tbody>
</table>
Lack of sufficient coordination between the central and provincial levels could impact adversely on health care quality.

Political pressures at the local level could result in decisions which are not in line with national policies and guidelines about health facilities.
Annex 5: Implementation Support Plan

SRI LANKA: Second Health Sector Development Project

1. The implementation support strategy has been developed based on the structure and contents of the SHSDP and the risk profile. IDA will provide continuous support to the MOH, the MLGPC, the FC and PMOHs to implement the program effectively and smoothly. Implementation support will focus on the public health, malnutrition, non-communicable diseases and health economics content of the NHDP, results monitoring of NHDP and Results Framework of project, the fiduciary and safeguards requirements, and the mitigation of risks identified in the ORAF, especially policy level, governance, design and delivery quality risks.

2. The performance of the NHDP will be reviewed regularly, including through implementation support and supervision visits to the provinces.

3. Technical support. IDA will maintain continuous dialogue and provide technical advice and implementation support to the NHDP. Special attention will be paid to the quality of national assessments of health outcomes re the DLIs and their use in national and provincial sector plans, and on the capacity building of central, provincial and district levels of the system. The Task Team Leader (TTL), public health specialist, nutrition specialist and health economist will provide regular inputs into these activities. Other technical expertise will be brought in as and when required, for instance on health management information systems, quality of care, human resources for health, public-private partnerships, national health accounts, impact evaluation, and so on.

4. Overall program management. The Bank’s Task Team Leader will coordinate the Bank team to ensure that the SHSDP is implemented according to the Bank’s requirements as specified in the Financing Agreement. (S)he will engage in regular dialogue with the senior officials in government to monitor implementation and help resolve issues and relax constraints as and when they arise. (S)he will be assisted by team members, including the operations officer/analyst on the team.

5. Fiduciary requirements and inputs. The financial management and procurement arrangements build on and utilize the capacity developed under a successful previous project, the HSDP at both central and provincial level. The Bank financial management and procurement specialists based in the country office will support program implementation through regular and timely training and capacity building of officials. Supervision of fiduciary processes and procedures will be conducted semi-annually. The operations officer/analyst on the team will work with the financial management and procurement specialists.

6. Safeguards. The Health Care Waste Management Framework (HCWMF) also builds on and utilizes the capacity developed under the HSDP at both central and provincial levels. The environmental specialist on the team will provide training, as needed, to the GOSL officials to strengthen implementation of the HCWMF. The social specialist will focus on the implementation of the social aspects of SHSDP.
7. **Analytical support.** IDA will assist the country by regularly undertaking research and impact evaluations on themes and topics that are considered high priorities for future policy formulation and strategy development in the health sector. These studies and evaluations will build on past analytical work be undertaken collaboratively with the government. The studies might include evaluation of pilot interventions involving RBF approaches or public private partnership (PPP) mechanisms, strategy development for urban health care, better preparation for demographic transition, and development of guidelines and standards as required by the program (on quality of care, human resources, health management information systems, etc.).

8. **Capacity Building support:** IDA will assist in developing capacity in identified areas for a more efficient project implementation. The capacity building needs are expected to be in the areas of using and presenting data for better health planning and monitoring, hospital management training, RBF planning and monitoring skills, FM and Procurement capacity and HCWM capacity development.

9. **Approach for Support and Cooperation by the Development Partners.** IDA and the Development Partners (DPs) will work in support of NHDP. The World Bank and DPs will make every effort to harmonize their work with each other, although it is recognized that funding arrangements and the size and content of their operations differ among DPs, and it is not always possible to agree on one common arrangement. However, through regular information exchange and dialogue (continuing the current system of monthly meetings and enhancing it to a Government-led mechanism), the DPs will avoid duplication and contradictions in how they support the NHDP, and ensure that their support is country-driven. The DPs will also support participatory approaches, transparency, predictability and comprehensive documentation. A joint annual review mission will also be undertaken by the Bank team and DPs in which all the NHDP activities and plans will be reviewed in relation to the expected targets and results.

10. **Resources for implementation support.** The staff skills mix required for implementation support is summarized below. Apart from the specified skills, other technical areas of expertise would need to be procured on short-term basis.

<table>
<thead>
<tr>
<th>Skills Needed</th>
<th>Number of Staff Weeks</th>
<th>Number of Trips</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Team Leader/Public Health Specialist</td>
<td>20 SWs annually</td>
<td>Field trips as required</td>
<td>Preferably Country office based</td>
</tr>
<tr>
<td>Health Economist</td>
<td>16 SWs annually</td>
<td>Field trips as required</td>
<td>Country office based</td>
</tr>
<tr>
<td>Nutrition Specialist</td>
<td>16 SWs annually</td>
<td>field trips as required</td>
<td>Washington Based</td>
</tr>
<tr>
<td>Health economist</td>
<td>8 SWs annually</td>
<td>Two each year and field trips as required</td>
<td>Washington Based</td>
</tr>
<tr>
<td>Operations officer/analyst</td>
<td>8 SWs annually</td>
<td>Two each year and field trips as required</td>
<td>Location to be determined</td>
</tr>
<tr>
<td>Financial management specialist</td>
<td>4 SWs annually</td>
<td>Field trips as required</td>
<td>Country office based</td>
</tr>
<tr>
<td>Procurement specialist</td>
<td>4 SWs annually</td>
<td>Field trips as required</td>
<td>Country office based</td>
</tr>
<tr>
<td>Environment specialist</td>
<td>2 SWs annually</td>
<td>Field trips as required</td>
<td>Country office based</td>
</tr>
<tr>
<td>Social Development Specialist</td>
<td>2 SWs annually</td>
<td>Field trips as required</td>
<td>Country office based</td>
</tr>
</tbody>
</table>
Annex 6: Economic and Financial Analysis

SRI LANKA: Second Health Sector Development Project

1. **Context and Background.** One of the primary reasons behind Sri Lanka’s success has been the impressive performance of its health system. Sri Lanka’s long term commitment to providing universal entitlement to free public service has to date been successful. The success of Sri Lanka has been attributed to early public investments in health services – targeting maternal and child health, communicable diseases, and preventive and population based public health programs, in particular – delivered through a widespread network of public facilities covering all levels of care from rural clinics to tertiary hospitals. It opted early on to prioritize universal access by eliminating user fees and making services accessible to the entire population, even if it meant accepting certain resulting gaps in service provision (for example, in the availability of pharmaceuticals and investigative services in the public sector).

2. Notwithstanding its impressive past achievements in most health indicators at fairly low total expenditures, Sri Lanka faces some challenges associated with: (i) improving the nutrition status, particularly among mothers and children under two years\(^1\); (ii) coping with a rapid aging population and an increasing portion of non-communicable diseases (NCD)\(^2\); and (iii) modernizing the health system in its services provision and in its management (e.g. by developing a robust HMIS for evidence-based planning, policy-making, programming and management, both patient management and facility management). These challenges need to be addressed while maintaining the health gains achieved, and further improving communicable diseases and maternal and child care. The way the health care system is organized in its provision and financing will have a direct impact on the progress of this new agenda.

3. Nowadays, particularly with the increasing NCD burden, not everyone seeks care in the public facilities. Many are clearly seeking care elsewhere or foregoing needed care. However, data on the distribution of out-of-pocket expenditure, and its burden across different socioeconomic groups, is scarce. Some studies\(^3\) using data from 1996-97 found a positive Kakwani index for out-of-pocket health payments, suggesting that the better-off pay more out-of-pocket for health care. However, a closer look at the concentration indices of utilization shows that hospital inpatient care is neither pro-poor nor pro-rich; hospital outpatient care is more pro-poor; and non-hospital care is more pro-rich. The latter may be due to the greater use of private outpatient and diagnostic/laboratory services by the better-off groups. Thus, even if payments are progressive, it is important to assess the gap in services that are essential but are foregone by the poor because they cannot afford them in the private sector.

---

\(^1\) One out of every five children is malnourished and over 30% of pregnant and lactating mothers are found to have anemia.

\(^2\) The term Non-Communicable Diseases (NCD) is used in this document to include both chronic and acute NCDs, e.g., cardio-vascular diseases, all cancers, endocrine disorders such as diabetes mellitus, degenerative diseases, mental illnesses, other NCD such as asthma, renal disease of unknown etiology and injuries from all causes.

4. It is commonly believed that private providers are used for outpatient services by the richer population groups. However, some evidence of the declining use of lower-level outpatient care and increases in out-pocket expenditure by even poorer population groups suggests that Sri Lanka public health sector is not keeping up with the demand for curative services. Particularly, there has been an increase in private expenditure for medicines, notably for NCD, which indicates that public resources for those services are not adequate. If Government is to maintain its record of ensuring universal entitlement of essential services, it will be crucial to increase resources in such areas. This will require creating fiscal space by increasing the overall health budget, reallocating funds between budget lines and/or increasing efficiency of the system to do more with the same resources.

5. **Level of Expenditure.** THE stood at 3.5% of GDP in 2008. In the years 2002-2006 the health to GDP ratio reached its highest levels ever, peaking at slightly above 4%. As we can see in Figure 1, in the last 20 years, private health expenditures were consistently higher than public, particularly between 2000 and 2005.

![Figure 1: Private, Public and Total health expenditure as percentage of GDP](image)

6. Sri Lanka’s per capita health expenditure is higher than its neighboring countries at US$70 compared to US$65 in Bhutan, US$29 in India and US$19 in Afghanistan, and it grew from US$ 20 in the 1990’s. The THE in current prices in US$ steadily grew during the last 20 years. However when looking at constant prices in US$ the THE remained rather constant with a slightly declining tendency.
7. In terms of the composition of THE, around 45% are from public sources while the remaining 55% are from private sources. The share of external resources was 3% of THE in 2010, which is channeled through the Government of Sri Lanka (i.e. is included in the 45% of public spending). Of the private health spending 82% is through out of pocket at the time of service, which represents 45% of the THE. The share of private health insurance has increased from less than 1% of private health care spending in 1990 to more than 5% in 2010 while health expenditure provided by employers has remained constant in the range of 8% of the private spending during the period 1990 to 2008.
The health sector was devolved in 1987 based on the 13th constitutional amendment of Sri Lanka. Based on this amendment, the purchase of drugs and consumables, human resource training and teaching and other selected hospitals management (approximately 50 hospitals) and overall responsibility for the implementation of the national health policy were retained by the MOH while all preventive services and all other approximately 600 hospitals and the 450 outpatient facilities were devolved to the nine Provinces (and through them to the 26 health districts).

Despite the devolution, public expenditures are increasingly centralized with a large and increasing share of public funds (as much as 65% in 2008 as compared to 57% in 1998) being channeled through MOH. For example, the share of total public health spending by Provincial Councils declined from 41% in 1991 to 33% in 2008 and, according to the projections of the MOH, the provincial ration is expected to go down at around 26% in 2014. The central level budget finances the following functions: policy, planning, monitoring and other such stewardship functions, management of tertiary/teaching hospitals, specialized hospitals, and selected secondary level facilities (provincial and district-general and some base hospitals), human resource deployment, and the procurement of pharmaceuticals and high-technology equipment. Provincial financing goes towards service delivery in most secondary level facilities (base hospitals), all primary level facilities (divisional hospitals, primary care units), and all preventive care institutions (managed by Medical Officers of Health and their teams). Provincial financing is allocated based on the recommendations of the Finance Commission, guided by a formula that takes account of health status indicators, other development indicators and vulnerability criteria. The Finance Commission has recently introduced Results-Based Planning and Management (shifting the planning process from input-based to output-based and focusing the monitoring functions on results) for the provincial level functions. The Ministry of Finance is also interested in enhancing the focus on results, and this program financing is thus designed with a results-based approach.
10. Of the government sources, 49% are spent on curative care in hospitals (28% on inpatient care and 21% on outpatient care), 25% on retail purchases of medical goods, 5% on ancillary services to medical care, 6% on preventive care, 11% on capital formation; and 5% on health program administration.

11. Fiscal Sustainability and Government Commitment: The Government budget is divided between the central level functions (about 65%) and provincial and district level functions (about 35%). According to the current budget estimates of MOFP, the health sector budget is estimated to be US$ 855 million for 2013, and US$ 977 million for 2014 (at an exchange rate of 135 LKR to one US$) further growing to well over US$ 1 billion before 2018. Based on Government projections, the annual health budget at Central and Provincial level is expected to increase at an annual average growth of 9.6%. Under such a scenario and taking into account for projections, the Government will have a large enough budget to sustain the recurrent costs generated from SHSDP.

Table 1: Fiscal Impact (in millions of US$)

<table>
<thead>
<tr>
<th>FY</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Program Support from IDA credit grant</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>200</td>
</tr>
<tr>
<td>Public sector annual health budget*</td>
<td>855</td>
<td>977</td>
<td>1060</td>
<td>1113</td>
<td>1165</td>
<td>5170</td>
</tr>
<tr>
<td>% of annual health budget*</td>
<td>5.2%</td>
<td>4.9%</td>
<td>4.5%</td>
<td>4.1%</td>
<td>3.74%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Sri Lanka GDP**</td>
<td>63933</td>
<td>73400</td>
<td>83629</td>
<td>96174</td>
<td>110600</td>
<td></td>
</tr>
<tr>
<td>Health budget as % of</td>
<td>1.31%</td>
<td>1.21%</td>
<td>1.17%</td>
<td>1.11%</td>
<td>1.06%</td>
<td></td>
</tr>
</tbody>
</table>
12. SHSDP is also part of the Country Partnership Strategy, which seeks to deepen the World Bank Group’s support to Sri Lanka in addressing its emerging middle-income country agenda. The SHSDP would be an important contributor to all three sub-areas under the area 3 (Improving Living Standards and Social Inclusion) of the Country Partnership Strategy. Thus, its higher level objective would be to enable the health system to play its critical part in helping Sri Lanka actualize its aspirations of economic growth, overall development and improved quality of life of all Sri Lankans.

13. **Equity:** The program is expected to benefit the whole population of Sri Lanka, and more directly those who use the publicly financed and publicly provided health services, especially the poorer and more vulnerable population groups who are more likely to depend on these services. In particular, the interventions aimed at addressing systems issues would build the system capacity overall and therefore their benefits would accrue to the health sector broadly. However, special emphasis is being placed on results related to under-nutrition and NCD, and interventions aimed at achieving these results would benefit those population groups more at risk of these conditions. Specifically, children under five years of age, pregnant and lactating women and adolescent girls would benefit more from nutrition interventions, while middle-aged and older women and men are expected to benefit more from NCD interventions.

14. The most recent work on benefit incidence of benefit shows that public expenditure in health in Sri Lanka has been generally pro-poor. The share of public expenditure in health that goes to the poorest 20% of individuals is 21%. This compares with 17% for Bangladesh, 13% in India and 7% in Nepal. This shows that continuing to invest and improve the public health system could benefit the pro-poor and vulnerable. Also, as discussed below, the interventions in nutrition, maternal and child health and NCD in the public health sector also have an impact on equity.

15. **Public Rationale.** In SHSDP a special emphasis is being placed on results related to under-nutrition, NCD, and some key systemic issues that will increase the efficiency of the system as a whole. These three set of interventions have the main rationales warranting public action including market failures, externalities, asymmetry of information, redistribution as well as social and political concerns. The interventions aimed at addressing systems issues would build the system capacity overall and therefore their benefits would accrue to the health sector broadly. However, a special emphasis is being placed on results related to under-nutrition and NCD, and interventions aimed at achieving these results would benefit those population groups more at risk of these conditions.

16. Investment in these interventions will contribute to reducing maternal and child mortality and reducing poverty by enhancing productivity, cognitive development, and school performance. There is a large body of evidence showing the link between income/earning and

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nutritional status. At the macroeconomic level, malnutrition could result a significant loss of national income. In countries with high levels of anemia, for instance, it is estimated to cause about a 2% reduction in GDP\textsuperscript{22}. At the household level, malnutrition causes a significant reduction in earning: a study in Brazil found that a percentage decrease in adult height could result in up to 4% reduction in earnings.

17. Besides the impact on poverty reduction, economic development and equity, the public rationale includes information 'asymmetry' and externality: people do not always have full information on feeding practice and food that is best for their children and themselves. Because growth faltering may be the norm, and micronutrient deficiencies are not typically visible enough to be easily recognized, they are often even unaware of the need to invest in improving the nutritional status of their children. The role of information is even more critical because of the limited window of opportunity where the highest impact on nutrition could be made. The benefit of improved nutrition accrues not only to the individual making the investment but to the society at large as improved nutrition reduces the impact of disease and improves productivity. An absence of internalization of all the benefits of one’s investments results in underinvestment in nutrition relative to that which is socially desirable.

18. Nutritional interventions are found to be among the most cost-effective interventions to enhance welfare globally. In the Copenhagen Consensus 2008, a panel of renowned economists, ranked five nutritional interventions among ten of thirty proposals presented to answer the question of the best way to advance global welfare. It ranked micro nutrient supplements for children including vitamin A and zinc supplementation first, micro nutrient fortification including iron and salt iodization third, de-worming and other nutrition programs at school sixth and community based nutrition promotion as ninth. The ranking takes into account the benefit cost ratio, feasibility and sustainability of the interventions. Though under-nutrition is prevalent in all five wealth quintiles, its rates are much higher among the poorer quintiles and among the under-served estate population groups. Thus investments in addressing under-nutrition are pro-poor and pro-vulnerable.

19. Investments in NCD prevention and treatment, as well as modernization of the health system are likely to have an impact on poverty reduction, economic development in Sri Lanka. Higher NCD burden affects productive age-groups, resulting in shortened working life, and thus impacting on overall availability of labor – which compounds the labor shortage being caused by demographic transition. While most NCD may not be entirely preventable, premature mortality from NCD is preventable. In addition to earlier deaths, NCD can cause a great amount of disability, resulting in lower productivity. Some studies have shown that in Sri Lanka high mortality rates from NCD appear to be the result not of mainly of high levels of risk factors, but the systematic under-treatment of most major NCD. This is most marked in the case of asthma, where the mortality rate in Sri Lanka appears to be one of the highest in the world. In the Sri Lankan context, NCD are mostly managed by specialist clinics in the public sector. Primary healthcare facilities are neither equipped nor expected to manage chronic NCD. This concentration of services in higher-level facilities is a major source of dissatisfaction amongst patients, owing to resultant difficulties in access. In addition, the public sector purchases inadequate quantities of the needed medications and medical supplies for chronic NCD care.

\textsuperscript{22} Include reference
Consequently, many patients either incur large financial costs in purchasing needed tests and medicines for their treatment, or they go without. Therefore interventions tackling NCD and making the system more responsive to these new challenges would also be pro-poor, as the marginal benefits will be greatest for those in the poorest households who currently lack access to treatment.

1 NCDs include hypertension, diabetes mellitus, Cancer (Breast and oral)
2 Healthy lifestyle center: with essential facilities for NCD screening at primary care institution level. Detail protocols to be prepared.
3 Functioning QMU will include carrying out (as per standards) death audits, use of safety protocols, guidelines, grievance reporting and redress for grievance mechanisms in place
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