I. Project Context
   Country Context
   As a lower middle income country Sri Lanka has to manage a rapid demographic and epidemiologic transition.

II. Sectoral and Institutional Context
   The Government of Sri Lanka’s (GOSL) health programs are guided by the Mahinda Chintana Vision for the future (2005 to 2016)- the national policy and strategic framework for development and growth in Sri Lanka; the national health policy of 1996; a health master plan for the period 2007-2016; and a five-year detailed national health development plan (NHDP) which also includes a priority area strengthening plan for the health sector for 2013-2017.

   Health status

   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 in 2006, is partially the result of the extended availability of effective and integrated maternal and child health (MCH) services. However, the challenges of malnutrition and non-communicable diseases require enhanced efforts. To effectively respond to this health burden, Sri Lanka will need to consider modernizing its approaches to service delivery; better organizing its health care system and its financing.

Health financing
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 was 3.5% with government financing of health expenditure at approximately 47.3%, private sector at 51.8% and donor contribution being 0.8%. The 51.8% of total health expenditure (private health expenditure) only accounts for about 10% of inpatient care and 50% of ambulatory care, an unknown proportion of drugs and investigative 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 total public health spending by Provincial Councils declined from 41% in 1991 to 33% in 2008 and 25% in 2011. The preventive expenditure, most of which is from the public sector, decreased from 9% to 5% during the period 1990 to 2008. Despite devolution, public expenditures on health remains increasingly centralized.

III. Project Development Objectives
To improve the public sector health system so as to respond to the challenges facing it, especially regarding nutrition and non-communicable diseases (NCDs).

IV. Project Description

Component Name
Program support to health sector modernization
Innovation, Capacity Building and Results Monitoring

V. Financing (in USD Million)

<table>
<thead>
<tr>
<th>For Loans/Credits/Others</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>BORROWER/RECIPIENT</td>
<td>4970.00</td>
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<tr>
<td>International Development Association (IDA)</td>
<td>200.00</td>
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<tr>
<td>Total</td>
<td>5170.00</td>
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</table>

VI. Implementation
The project has two components:

Component 1: Program support to health sector modernization (IDA USD 190 million): will contribute to NHDP. The IDA funds will be comingled with GOSL funds, while the Bank’s technical engagement and monitoring will focus on specific thematic areas: (i) malnutrition, (ii) prevention and control of non-communicable diseases, (iii) maternal and child health and communicable diseases and (iv) health system improvement measures.

Component 2: Innovation, Capacity Building and results Monitoring (IDA 10 million): will support 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 from this component, as well as training, workshops, the demographic and health survey, baseline and end-line surveys and other evaluative studies, including the annual Disbursement Linked Indicators (DLIs) report by Ministry of Finance and Planning (MOFP), baseline and gap analysis for Health Care Waste Management (HCWM) and annual environmental audits.

The section below summarizes health sector implementation arrangements in Sri Lanka, which would apply equally to SHSDP.

Central Ministry of Health (CMOH) 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 Provincial Ministries of Health (PMOHs) are responsible for primary and secondary levels of service delivery and all preventive services. Ministry of Local Government and Provincial Councils (MLGPC) provides program oversight and central level representation for provincial level activities. The Finance Commission (FC) 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. Provincial Management and Monitoring groups chaired by the Health Secretary of each province will be established at the level of the provinces.

Monitoring
The Department of Project Management and Monitoring of the MOFP will prepare annually DLI Results Reports for the previous year and share this with the World Bank each year. The World Bank team will verify the results reported by the GOSL through an independent firm or consultant and will provide its recommendations related to the achievements of the DLI. The verification report will be discussed with the GOSL and a final agreement on DLI performance and rating will be agreed with GOSL. The amounts of IDA disbursements will depend on the level of achievement of the DLI targets.

Evaluation
Baseline 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 CMOH. Additionally, impact evaluations will be designed and conducted for all innovative and new initiatives.

Sustainability
SHSDP adopts a program approach and essentially contributes to the financing of a five-year timeslice of the regular health sector program as reflected in the National Health Development Plan (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 sector budget is less than 5%, therefore, the risk to financial sustainability post IDA support 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.
VII. Safeguard Policies (including public consultation)

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
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<th>No</th>
</tr>
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<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
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<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
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</table>

VIII. Contact point

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