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Report No: PADHI00450

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

ON SHORTER TERM MATURITY LOAN TERMS

IN THE AMOUNT OF SDR 75,900,000 (US\$100 MILLION EQUIVALENT)

AND

A PROPOSED CREDIT

IN THE AMOUNT OF SDR 38,000,000 (US\$50 MILLION EQUIVALENT)

TO THE

DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

FOR A

SRI LANKA: PRIMARY HEALTHCARE SYSTEM ENHANCING PROJECT (PHSEP)
(P181564)

MAY 29, 2024

Health, Nutrition & Population
South Asia

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CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2024)

Currency Unit = SRI LANKAN RUPEE (LKR)

LKR 297.75 = US\$1

FISCAL YEAR

January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AM	Accountability Mechanism
ANC	Antenatal Care
BCR	Benefit Cost Ratio
CERC	Contingent Emergency Response Component
CPD	Continuous Professional Development
CPF	Country Partnership Framework
DA	Designated Account
DALY	Disability-Adjusted Life Year
DDG	Deputy Director General
DP	Development Partner
DPMM	Department of Project Management and Monitoring
EDGE	Excellence in Design for Greater Efficiencies
ERHSP	Emergency Response and Health Systems Preparedness
ESCP	Environment and Social Commitment Plan
ESCOP	Environment and Social Code of Practice
ESMF	Environment and Social Management Framework
ETU	Emergency Treatment Unit
FA	Financing Agreement
FFC	Friends of Facility Committee
FM	Financial Management
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHG	Greenhouse Gas
GoSL	Government of Sri Lanka
GRM	Grievance Redress Mechanism
GRS	Grievance Redress System
HCW	Health Care Waste
HMIS	Health Management Information System
HR	Human Resources
HRH	Human Resources for Health
IA	Implementing Agency
IDA	International Development Association
IPF	Investment Project Financing
ISM	Implementation Support Mission
IT	Information Technology
IUFR	Interim Unaudited Financial Reports
LKR	Sri Lankan Rupee
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
ML	Management Letter
MoF	Ministry of Finance
MoH	Ministry of Health
MOH	Medical Officer of Health
MSD	Medical Supplies Division

NAOSL	National Audit Office of Sri Lanka
NAP	National Adaptation Plan
NCD	Noncommunicable Disease
NDC	Nationally Determined Contribution
NSC	National Steering Committee
PBC	Performance Based Condition
PCMU	Project Coordination and Management Unit
PDHS	Provincial Department Of Health Service
PDO	Project Development Objective
PFM	Public Financial Management
PHC	Primary Health Care
PHR	Personal Health Records
PHSEP	Primary Healthcare Strengthening Enhancing Project
PMCI	Primary Medical Care Institutions
POM	Project Operations Manual
PP	Procurement Plan
PPA	Performance and Policy Actions
PPSD	Project Procurement Strategy for Development
PPWC	Project Provincial Working Committee
PSSP	Primary Health Care System Strengthening Project
RDHS	Regional Director of Health Services
SBCC	Social and Behavioral Change Communication
SDG	Sustainable Development Goal
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SML	Shorter Maturity Loan
SOP	Standard Operating Procedure
SPD	Standard Procurement Document
STEP	Systematic Tracking of Expenditure in Procurement
TA	Technical Assistance
TOR	Terms of Reference
WFP	World Food Program
WHO	World Health Organization



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**DATASHEET****BASIC INFORMATION**

Project Beneficiary(ies)	Operation Name		
Sri Lanka	Sri Lanka: Primary Healthcare System Enhancing Project (PHSEP)		
Operation ID	Financing Instrument	Environmental and Social Risk Classification	
P181564	Investment Project Financing (IPF)	Moderate	

Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input checked="" type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input type="checkbox"/> Fragile State(s)
<input checked="" type="checkbox"/> Performance-Based Conditions (PBCs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternative Procurement Arrangements (APA)	<input type="checkbox"/> Hands-on Expanded Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
21-Jun-2024	31-Dec-2028
Bank/IFC Collaboration	
No	

Proposed Development Objective(s)

To improve access and quality of primary health care services across all districts of Sri Lanka.

Components

Component Name	Cost (US\$)
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Increase availability of comprehensive PHC services at PMCIs and Medical Officer of Health offices	90.00
Strengthen the quality of clinical and person-centered care at PMCIs	50.00
Strengthen health promotion, community empowerment and citizen engagement	4.00
Project management and monitoring and evaluation	6.00
Contingent emergency response component (CERC)	0.00

Organizations

Borrower: Democratic Socialist Republic of Sri Lanka
Implementing Agency: Ministry of Health

PROJECT FINANCING DATA (US\$, Millions)**Maximizing Finance for Development**

Is this an MFD-Enabling Project (MFD-EP)? No

Is this project Private Capital Enabling (PCE)? No

SUMMARY

Total Operation Cost	150.00
Total Financing	150.00
of which IBRD/IDA	150.00
Financing Gap	0.00

DETAILS**World Bank Group Financing**

International Development Association (IDA)	150.00
IDA Credit	50.00
IDA Shorter Maturity Loan (SML)	100.00

IDA Resources (US\$, Millions)



	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	50.00	0.00	0.00	0.00	50.00
Scale-Up Window (SUW)	0.00	0.00	100.00	0.00	100.00
Total	50.00	0.00	100.00	0.00	150.00

Expected Disbursements (US\$, Millions)

WB Fiscal Year	2024	2025	2026	2027	2028	2029
Annual	0.00	10.00	25.00	50.00	50.00	15.00
Cumulative	0.00	10.00	35.00	85.00	135.00	150.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● Substantial
2. Macroeconomic	● High



3. Sector Strategies and Policies	● Substantial
4. Technical Design of Project or Program	● Moderate
5. Institutional Capacity for Implementation and Sustainability	● Moderate
6. Fiduciary	● Substantial
7. Environment and Social	● Moderate
8. Stakeholders	● Moderate
9. Overall	● Substantial

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

☐ Yes ☒ No

Does the project require any waivers of Bank policies?

☐ Yes ☒ No

ENVIRONMENTAL AND SOCIAL

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4: Community Health and Safety	Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
ESS 8: Cultural Heritage	Not Currently Relevant



ESS 9: Financial Intermediaries

Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

LEGAL

Legal Covenants

Sections and Description

Institutional Arrangements Financing Agreement (FA), Schedule 2, Section I.A.2: (a) The Recipient shall establish within thirty (30) days after the Effective Date and maintain throughout Project implementation the National Steering Committee to provide oversight, monitor implementation progress and provide overall guidance. (b) The National Steering Committee shall meet at least once every three (3) months during Project implementation to review implementation progress, discuss emerging challenges, identify mitigating measures and introduce course correction.

Institutional Arrangements FA, Schedule 2, Section I.A.3: (a) The Recipient shall establish within sixty (60) days after the Effective Date and maintain, throughout the implementation of the Project, a separate dedicated team within MoH responsible for coordinating, managing, implementing, monitoring and supervising operational aspects of the Project (PCMU), with adequate resources and professional and administrative staff in numbers and with qualification and experience and under terms of reference satisfactory to the Association, including (i) a Project director, (ii) a deputy Project director, (iii) a finance specialist and two financial management support staff, (iv) a procurement specialist and two procurement support staff, (v) a monitoring and evaluation specialist, (vi) an environmental and social specialist, (vii) a program administrative assistant, and (viii) such other specialists performing such functions as may be further detailed in the POM. (c) Within one (1) year of the Effective Date, the Recipient shall adopt an internal audit mechanism for the Project and shall commence internal audit, in a manner satisfactory to the Association, and thereafter throughout the implementation of the Project shall maintain the internal audit mechanism and carry out internal audits.

Institutional Arrangements FA, Schedule 2, Section I.B.1.: To facilitate the carrying out of the provincial level Project activities, the Recipient, shall ensure that: (a) each PC and each Provincial Department of Health works closely with the MoH in the implementation of the Project, including designating provincial staff to the PCMU, coordinating, monitoring, evaluating and reporting on Project implementation, all as further detailed in the POM. (b) each PC allocates sufficient and appropriately qualified staff with adequate resources to enable the Recipient, the MoH, the PCMU and the respective Provincial Department of Health to carry out the provincial level Project activities within their Province. (c) each PC establishes within thirty (30) days after the Effective Date and maintains throughout Project implementation a Project Provincial Working Committee to provide oversight, monitor implementation progress and provide overall guidance on the provincial level Project activities.

Project Document FA, Schedule 2, Section I.C.1.: The recipient shall within one (1) month of the Effective Date, prepare, approve, and adopt a Project Operating Manual (POM) in a manner and substance satisfactory to the Association. The POM shall set out detailed guidelines, methods and procedures for the implementation of the Project.

Environmental and Social Standards FA, Schedule 2, Section I.D.1.: The Recipient shall ensure that the Project is carried out in accordance with the Environmental and Social Standards, in a manner acceptable to the Association.

Project Monitoring, Reporting and Evaluation FA, Schedule 2, Section II: The Recipient shall furnish to the Association each Project Report not later than three months after the end of each calendar year, covering the calendar year.



Other Undertakings FA, Schedule 2, Section IV: The Recipient shall: (a) ensure that the collection, use and processing (including transfers to third parties) of any Personal Data collected under this Project shall be done in accordance with applicable national law and the best international practice, ensuring legitimate, appropriate, and proportionate treatment of such data; (b) in the event that, during the implementation of the Project, the approval of any new legislation regarding Personal Data protection may have an impact on the activities financed by the Project, ensure that a technical analysis of said impact is conducted, and that the necessary recommendations and adjustments, are implemented, as appropriate; and (c) except as may otherwise be explicitly required or permitted under this Agreement, or as may be explicitly requested by the Association, in sharing any information, report or document related to the Project, ensure that such information, report or document does not include Personal Data.

Conditions

Type	Citation	Description	Financing Source
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I. STRATEGIC CONTEXT

A. Country Context

1. **Sri Lanka experienced a deep economic crisis in 2022, as longstanding structural weaknesses were exacerbated by exogenous shocks and policy mistakes.** After losing access to international financial markets in 2020, official reserves dropped precipitously, and the foreign exchange liquidity constraint led to severe shortages of essential goods. The country announced an external debt service suspension in April 2022, pending debt restructuring. The economy contracted by 10.5 percent during 2022 and 2023 amid high inflation (46.4 percent, annual average in 2022) and a sharp currency depreciation (81.2 percent, year-on-year in 2022). Public and publicly guaranteed debt ballooned to 118.7 percent of the gross domestic product (GDP) in 2022.
2. **The economy showed initial signs of stabilization in 2023, as external and fiscal balances improved.** The economic contraction slowed to 2.3 percent in 2023, following the sharp contraction in 2022, due to robust performances in tourism and agriculture. From a high base, inflation trended downwards faster than expected, as the Sri Lankan Rupee (LKR) appreciated, and demand remained weak. Usable official foreign exchange reserves increased to about eight – nine weeks of imports (compared to one – two weeks in December 2022) due to the recovery of tourism and remittances and increased inflows from development partners (DPs). As a result of new revenue measures and curtailed expenditures, the primary balance of the government budget was in surplus, although the overall deficit remained high.¹
3. **The implementation of recent structural reforms, including cost-reflective utility pricing and new revenue measures, helped macroeconomic stability but contributed to increased stress on household budgets.** Since 2022, 60.5 percent of households have faced declining incomes from reduced working hours or job losses.² Food insecurity and malnutrition increased, poverty doubled, and inequality widened. The government concluded the domestic debt restructuring in September 2023, while negotiations with the International Monetary Fund successfully completed the first review of the Extended Fund Facility program. Key reforms related to debt, public financial management (PFM), trade, investment, and state-owned enterprises continue to advance.
4. **Growth prospects depend on progress with debt restructuring and the continued implementation of structural reforms.** The primarily revenue-based fiscal adjustment is, however, likely to further reduce disposable incomes, weaken demand, and weigh down growth in the short-term. As a result, the modest recovery will be insufficient to reverse welfare losses experienced during the crisis, and poverty is estimated to remain around 23 percent until 2026. Inflation is likely to rise moderately in the near future due to new revenue measures and the waning of favorable base effects and remain benign in the medium term as demand continues to be subdued. Although the primary deficit is expected to decline further, the overall fiscal balance will remain high in 2024 due to the large interest bill. Debt restructuring and continued fiscal consolidation are projected to reduce the overall fiscal balance in the medium term.
5. **While the recent macroeconomic performance has been better than expected, downside risks remain high, given a narrow path to recovery and limited buffers.** These risks include a protracted or insufficiently deep debt restructuring, reform fatigue or reversal linked to elections, and a weaker recovery linked to scarring effects of the crisis. With declining household expenditure on health and education, concerns over the impact on future human capital remain high. Financial sector risks need to be carefully monitored as elevated non-performing loans and significant exposure

¹ The country is assessed to be eligible for SUW-SML per the IDA20 Scale-up Window guidelines. Sri Lanka re-gained access to IDA concessional resources in December 2022 and is required to implement Performance and Policy Actions (PPAs) for the first time in FY24 under the Sustainable Development Finance Policy. The Bank and GoSL reached an agreement on the FY24 PPAs and the achievement against the PPAs is under review. To date, Sri Lanka has not exceeded the Non-Concessional Borrowing ceiling set out under PPA3. Use of the SUW-SML resources is within the acceptable range under the Debt Sustainability Analysis.

² Ministry of Finance, Economics Stabilization and National Policies, Department of Census and Statistics, *Household Survey on Impact of Economic Crisis 2023*. http://www.statistics.gov.lk/WebReleases/HECS_Bulletin_Final



to the sovereign continue to hinder financial sector stability and impede credit intermediation. On the upside, a strong and sustained implementation of the structural reform program, could boost confidence and attract fresh capital inflows.

B. Sectoral and Institutional Context

6. **With a strong public sector health care delivery system, Sri Lanka has been a positive outlier in South Asia on health outcomes, particularly for maternal and child health (MCH).** It surpassed the 2030 Sustainable Development Goal (SDG) targets for maternal mortality ratio (29 per 100,000 live births, 2020), under-five mortality rate (6.7 per 1,000 live births, 2021) and infant mortality rate (5.8 per 1,000 live births, 2021). Total fertility rate is below the replacement level (2.0 births per woman, 2021), and annual population growth was 0.1 percent in 2022.³ Sri Lanka has been a leader in prioritizing services related to reproductive, maternal and child health, along with a concomitant improvement in social determinants of health (female education and labor force participation). For example, 95 percent of expectant women are registered for antenatal care (ANC) by 12 weeks of pregnancy, over 90 percent of women receive key components of comprehensive ANC, and there is near universal coverage of facility-based births.⁴ However, MCH indicators have been stagnant during last few years and further improvements will require significant strengthening of services from primary and beyond.
7. **Sri Lanka faces growing challenges of non-communicable diseases (NCDs).**⁵ Eight of the top 10 causes of death in the country are attributable to NCDs; and gender-based violence (GBV) is also prevalent. In terms of risk factors, tobacco use affects 48.9 percent of males and 6.5 percent of females aged 18-69 years, while alcohol consumption stands at 43.3 percent for males and 1.2 percent for females. Data indicate a gender gap with women suffering from higher rates of key NCD risk factors, including insufficient physical activity, overweight, and raised total cholesterol.⁶ The gender pattern persists in some metrics of service utilization and quality of care as well. While high blood pressure affects similar proportions of men and women (35.8 percent of males and 34.0 percent of females), the prevalence of diagnosis differs significantly by gender with 41.1 percent of men reporting ever having their blood sugar measured, compared to 24.4 percent of women. Among those patients diagnosed with hypertension and on medication, 81.2 percent of male patients have their blood pressure under control, whereas this treatment success rate is only to 74.4 percent for female patients. Screening rates for cancers remain low.⁷ These health challenges are compounded by food insecurity stemming from the economic downturn, with 86 percent of families unable to afford nutritious food, likely contributing to poor dietary intake and rising rates of weight-related and metabolic risk factors.⁸ Notably, the suicide rate in Sri Lanka, the highest in Southeast Asia Region, is skewed by gender, with profound disparities (22.3 per 100,000 for males and 6.2 per 100,000 for females)⁹, potentially exacerbated by economic crises and rising unemployment rates. The COVID-19 pandemic has heightened vulnerabilities, particularly for women, affecting employment, personal safety, maternal health, and nutrition. Furthermore, challenges persist for marginalized groups, compounded by underreported cases of domestic violence amidst the ongoing economic crisis.
8. **Sri Lanka has the fastest ageing population in South Asia and the health system needs to be transformed to cater to the healthcare needs of the elderly.** The share of people over 65 years of age is projected to double by 2045.¹⁰

³ World Bank. "Sri Lanka." Retrieved from <https://data.worldbank.org/country/sri-lanka>

⁴ Sri Lanka Demographic and Health Survey 2016. <http://www.statistics.gov.lk/Resource/en/Health/DemographicAndHealthSurveyReport-2016-Contents.pdf>

⁵ Sri Lanka: Health System Review. 2021. Health Systems in Transition. <https://iris.who.int/bitstream/handle/10665/342323/9789290228530-eng.pdf?sequence=1>

⁶ 43.9% of women do not engage in WHO-recommended levels of physical activity per week, in contrast to 24.2% of men; 47.6% of women are overweight versus 30.0% of men; and 21.8% of women have high cholesterol or are on medication for hypercholesterolemia versus 15.6% of men.

⁷ Non-Communicable Diseases Risk Factor Survey (STEPS Survey) Sri Lanka 2021.

https://ncd.health.gov.lk/images/pdf/20230817_STEPS_Survey_new_1_compressed.pdf

⁸ Wijerathna-Yapa A, Henry RJ, Dunn M, Beveridge CA. Science and opinion in decision making: a case study of the food security collapse in Sri Lanka. *Modern Agriculture*. 2023; 1(2): 142–51.

⁹ WHO. Addressing mental health in Sri Lanka. 2022. <https://iris.who.int/bitstream/handle/10665/364902/9789290210221-eng.pdf?sequence=1>

¹⁰ Asian Development Bank. 2019. Growing Old Before Becoming Rich. <https://www.adb.org/sites/default/files/publication/557446/aging-population-sri-lanka.pdf>



Responding to the requirements of an ageing population will involve changes in the healthcare service delivery system. Dedicated geriatric care units with specialized medical and nursing staff will be necessary to cater to the physical and mental conditions, and long-term care of older people. Healthcare personnel, including medical officers, nurses, and caregivers will need to be trained to ensure adequate human resources (HR) in the geriatric sector. Though public health institutions do not cater specifically to elderly patients, several initiatives including the introduction of elderly wards, daycare centers, stroke units and health clinics for the elderly have been introduced at certain hospitals to provide better services for elderly patients. Such efforts are yet to be institutionalized and streamlined in the Sri Lanka health system. Furthermore, efficient elderly health care requires better integration and linkage between primary health care (PHC) services, secondary care apex hospitals for palliative, rehabilitative and geriatric health care services, and community domiciliary care services to fulfill the life course approach.

9. **The health system is under-prepared to tackle emerging challenges and weaknesses in the quality of care provided at PHC facilities hamper promoting comprehensive care, adherence to treatment, and patient-centeredness.** Structural quality deficiencies coupled with limited laboratory facilities, long wait times, inconvenient opening hours and low public awareness about screening contribute to suboptimal screening, diagnosis, and treatment outcomes. Poor process quality is also prevalent, with only 70 percent of hypertensive patients reported having their blood pressure measured during the last medical visit, and total cholesterol recorded in just 50 percent of those screened.¹¹ The fragmented data systems, and lack of integrated NCD care contribute to poor outcomes. Only 20 percent of hypertension patients in Sri Lanka have their blood pressure controlled. Weak referral and counter-referral processes, coupled with inadequate patient management systems, lead to bypassing, duplication of services, and losses to follow-up, resulting in service delivery that is not patient-centered.¹² Without an update-to-date evidence-based essential medicine list, some primary care medical institutions (PMCI)s¹³ have stockouts of some important essential medicines. There are also challenges with quality and effective use of medicines, including risk of dispensing errors, and mislabeling.¹⁴ Simultaneously, the increasing significance of mental health, evidenced by high suicide rates, underscores the need to strengthen the diagnostic and treatment capacities of the health workforce.¹⁵
10. **In addition, lack of awareness of service availability, preferences, and poor public perception of PHC service quality leads to underutilization of PHC services.** In Sri Lanka, perception of better quality and “prestige” of accessing services at private, secondary, or tertiary facilities compared to public primary facilities hinder access to and utilization of public sector and primary care, particularly for NCDs.¹⁷ The lack of awareness on the availability and usefulness of primary care services and health promotion services at the PMCI)s, compounded with the absence of referral pathways, results in underutilization of PMCI)s and overcrowding in costly, higher-level facilities, contributing to inefficiencies. This trend is exacerbated by the economic crisis, causing shortages of essential medical supplies, and increasing bypassing behavior.
11. **The dual fiscal impact of the COVID-19 pandemic and the economic crisis has weakened Sri Lanka’s public PHC system and further threatened the loss of Sri Lanka’s human capital achievements.** In 2020, Sri Lanka’s Human Capital Index scored 0.60, ranking top in South Asia (regional average of 0.48). However, the crises have impacted the provision and quality of social and health services, disproportionately affecting the most impoverished and vulnerable segments of the population. Despite the Government of Sri Lanka’s (GoSL) health expenditure standing at 1.9 percent

¹¹ Nair *et al.* 2023.

¹² Ibid.

¹³ Public primary care services are offered through PMCI)s, which comprise divisional hospitals and primary medical care units. PMCI)s deliver comprehensive primary healthcare services, including health promotion, disease prevention, early disease detection, treatment, rehabilitation, and palliative care. They ensure equitable access to healthcare services and reach vulnerable populations, especially during health and climate-related crises.

¹⁴ Dilsha, R. A. N., Kularathne, H. M. I. P., Mujammil, M. T. M., Irshad, S. M. M., & Samaranayake, N. R. (2020). Nature of dispensing errors in selected hospitals providing free healthcare: a multi-center study in Sri Lanka. *BMC Health Services Research*, 20, 1-10.

¹⁵ WHO. Addressing mental health in Sri Lanka. 2022



of GDP¹⁶, well below World Health Organization (WHO) recommendations, budget constraints have intensified, notably affecting PHC facilities. The skewed allocation of funds towards secondary and tertiary care exacerbates the strain¹⁷, leaving PHC facilities grappling with chronic shortages and inadequate capacity to deliver people-centric, integrated care, and gaps in pandemic and climate disaster preparedness systems. This situation threatens to increase out-of-pocket expenditures. Additionally, economic hardships have led to forgone treatment, particularly among lower-income groups.¹⁸

12. **The economic crisis has aggravated challenges with pharmaceuticals in Sri Lanka.** A lack of dollar reserves, compounded by the inefficient medical procurement system, has resulted in shortage of many drugs, medical supplies, and laboratory reagents.¹⁹ In addition, the lack of an updated evidence-based essential medicines list for the PMCs led to under-stock of some essential medicines and over-stock of other medicines. Even when drugs are available, the quality and safety of drugs are of concern. While the pharmacovigilance and drug safety management system in Sri Lanka has improved, most medicines in the primary care settings are dispensed in simple loose packaging without clearly labeled instructions for patients, resulting in dispensing errors and suboptimal medicine use.²⁰
13. **Moreover, the economic downturn has exacerbated human resource shortages, halting recruitment to an already strained workforce, contributing to healthcare professional out-migration²¹ and movement towards the private sector.** HR comprise the second largest share of government health budget (29 percent of Ministry of Health [MoH] budget).²² Even prior to the crisis, PMCs struggled to meet staffing requirements, with only 1.2 doctors and 2.4 nurses and midwives per 1,000 population.²³ These shortages have been further exacerbated with brain drain of health workers whose purchasing power has been eroded due to high inflation and currency depreciation.
14. **There is a window of opportunity to enhance PHC in line with GoSL's PHC reorganization initiative to safeguard past achievements, address the growing burden of aging, NCDs, and ensure the system is future-fit for emerging challenges.** The Sri Lankan health system consists of multiple tiers. Primary care is provided by 1,031 PMCs which include Primary Medical Care Units and Divisional Hospitals (Type A, B and C). Secondary care is delivered by Base Hospitals (type A and B). Tertiary care is provided at District General Hospitals, Provincial General Hospitals, Teaching Hospitals and National Hospitals. In addition, the Sri Lankan health system has strong community level presence with Medical Officer of Health (MOH) offices delivering preventive and promotive care. The GoSL's ongoing PHC reorganization is designed as a cluster model, where a network of PMCs and MOH offices are clustered with a Base Hospital, enhancing the linkages between these levels of care. In addition, selected Division Hospitals (two per districts) will convert to Type C Base Hospitals with geriatric care and palliative care capacities. Implementing this cluster model requires capacity building at different levels of care and strong referral and back referral systems between PMCs and secondary care hospitals to ensure continuum of care. Enhancing integrated PHCs is expected to improve patient-centeredness of care, quality, efficiency as well as cost-efficiency of health system.

¹⁶ World Bank, 2023. <https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=LK>

¹⁷ MoH. 2022. National Health Accounts Sri Lanka 2017&2018. <https://www.health.gov.lk/wp-content/uploads/2022/08/National-Health-Accounts-Sri-Lanka-Final-version-23.06.2022.pdf>

¹⁸ Jayawardena, R. et al. 2023. The impact of the Sri Lankan economic crisis on medication adherence: An online cross-sectional survey. <https://doi.org/10.1016/j.dialog.2023.100137>

¹⁹ Koggalage, Prasanna Dinesh, K. M. D. R. Dassanayake, and P. K. S. S. Kulasuriya. "Implementation of e-procurement for pharmaceuticals: perspectives of the staff of the State Pharmaceuticals Corporation of Sri Lanka." International Journal of Procurement Management 15.1 (2022): 113-131.

²⁰ Dilsha, R. A. N., Kularathne, H. M. I. P., Mujammil, M. T. M., Irshad, S. M. M., & Samaranyake, N. R. (2020). Nature of dispensing errors in selected hospitals providing free healthcare: a multi-center study in Sri Lanka. BMC Health Services Research, 20, 1-10.

²¹ Himel 2023. <https://www.himalmag.com/comment/sri-lanka-healthcare-governance-workers-migration-economic-crisis#:~:text=Following%20Sri%20Lanka's%20economic%20crisis,health%20equity%20in%20the%20country>

²² Sri Lanka Government Budget Estimates 2024.

²³ WHO Global Health Workforce Statistics Database. <https://www.who.int/data/gho/data/themes/topics/health-workforce>



15. **The prevalence of GBV and associated risk factors in Sri Lanka require attention.** The Women's Wellbeing Survey²⁴ on violence against women and girls found that: (a) 20.4 percent of ever-partnered women have experienced physical and/or sexual violence by an intimate partner in their lifetime; and (b) women are more than twice as likely to have experienced physical violence by a partner (17.4 percent of all women) than by a non-partner (7.2 percent experienced this since age 15). The prevalence of domestic violence cases remains largely underreported during the current economic crisis.²⁵ Limited funding sources for the temporary safe homes, absence of transport mechanisms to make complaints, lack of interest among the police and authorities to handle GBV amidst multiple forms of civil unrest and constraints in health, psychological and legal services have resulted in compromises in the existing referral mechanism for victims and survivors of GBV.²⁶ In addition, skyrocketing inflation and cost of living have placed tremendous burdens on men as breadwinners and providers, especially for farmers and those working in the informal sector which may lead to depression and increased substance abuse. These are risk factors for perpetration of intimate partner violence. Survivors are often hesitant to seek help and receive care due to shame, embarrassment and fear of being blamed. About half of women who experienced sexual violence by a partner did not seek formal help while 21.6 percent sought help from hospitals and health care centers.²⁷
16. **High temperature and levels of precipitation combined with exposure to extreme weather events make Sri Lanka highly vulnerable to climate-related adverse health conditions.** The 2019 Global Climate Risk Index ranks Sri Lanka as the second most climate change affected country in the world²⁸, while the Notre Dame Global Adaptation Initiative Index ranks the country the 99 most ready out of 192 countries²⁹ underlining the disconnect between the level of exposure and readiness to adapt to climate change. The country experienced a warming of 0.8°C between 1900 and 2017³⁰ and the mean annual temperature increase by 2030 is projected to be in the range of 0.47°C and 1.08°C.³¹ Frequently occurring disaster events in Sri Lanka are floods, droughts, landslides, storm surges, and cyclones.³² Extreme precipitation and flooding occur annually during the monsoon months, resulting in huge economic losses and making the population vulnerable to vector borne diseases. Exposure to extreme or prolonged heat can cause exhaustion and heat stroke which further exacerbates the patient load at the PHC level. Further, climate shocks damage health facilities and limit health facility accessibility, complicating service delivery.^{33,34} Annual average fiscal loss associated with disasters is estimated to be more than US\$380 million, with much higher losses in some cases - damage caused by the 2016 and 2017 floods and landslides amounted to US\$1.2 billion.
17. **The Primary Health Care System Strengthening Project (PSSP; P163721) has supported the reorientation and strengthening of Sri Lanka's primary care system.** PSSP introduced essential service capacities for PMCs to ensure that they are fit for purpose. Of the 1,031 total PMCs nationwide, 550 now meet the minimum criteria for basic capacities, including improved availability of essential medicines and equipment, access to basic testing, and availability of trained staff. Achieving minimum staffing requirements remains challenging. PSSP also introduced laboratory networks and implementation of new human resource strategies to facilitate service availability. These led to: (a) more effective delivery of basic services to communities, especially during COVID-19 pandemic, upgrading pandemic management capacities of health facilities, enabling early detection and follow-up care at the primary level;

²⁴ Ministry of Finance, Department of Census and Statistics, *Women's Wellbeing Survey - 2019: Findings from Sri Lanka's First Dedicated National Survey on Violence against Women and Girls*

²⁵ World Food Programme, 2022. Sri Lanka Joint Rapid Food Assessment.

²⁶ UNFPA, 2022. Upholding the Dignity and Building Resilience of Women and Girls.

²⁷ World Food Program: Sri Lanka joint Rapid Food Assessment, 2022.

²⁸ https://climateknowledgeportal.worldbank.org/sites/default/files/2021-05/15507-WB_Sri%20Lanka%20Country%20Profile-WEB.pdf

²⁹ ND-GAIN, Global Climate Change Readiness Index, 2021: <https://gain.nd.edu/our-work/country-index/rankings/>

³⁰ https://climateknowledgeportal.worldbank.org/sites/default/files/2021-05/15507-WB_Sri%20Lanka%20Country%20Profile-WEB.pdf

³¹ https://www.climatelinks.org/sites/default/files/asset/document/Sri%20Lanka%20Climate%20Info%20Fact%20Sheet_FINAL.pdf

³² <https://thinkhazard.org/en/report/231-sri-lanka>

³³ IFRC. (2024). LKA: Flood – 2023-09 – Monsoon Floods and Dengue outbreak. <https://go.ifrc.org/emergencies/6679/details>

³⁴ Ministry of Health, Nutrition, and Indigenous Medicine of Sri Lanka. (2018, October 22) Hospitals in Floods and Landslides: Responders and Survivors. https://saarc-sdmc.org/sites/default/files/programmes_doc_upload/Sri-Lanka-Country-Presentation-Floods-and-landslides-22-10-2018.pdf



(b) a shift of local health seeking behavior toward using PMCIs as the first point of care; and (c) an improvement in service utilization outcome. For instance, screening for NCDs for less than five percent of the age 35 years and older empaneled population of the 550 Project facilities rose from five percent to 60 percent³⁵ and more than 75 percent of females between 35–45 age cohort have been screened for cervical cancer at PMCIs. PSSP also fosters active community engagement through Friends of Facility Committees (FFCs) at PMCIs (>75 percent of PMCIs have FFCs in place).³⁶ PSSP also promoted more focus on quality of care.

18. **To weatherproof Sri Lanka’s health system amidst demographic and epidemiological shifts and an evolving macroeconomic context, it is imperative to build on the successes of PSSP and ensure the future adaptability of the PHC system.** This should be done thorough (a) strengthening and extending the efforts implemented in half the country through PSSP, (b) reinforcing the quality improvement initiatives at PMCIs to augment the availability and utilization of high-quality service, (c) addressing the bottlenecks in health labor markets, driven by shifting demands on the workforce due to epidemiological and demographic transitions, fiscal changes, and migration trends, and (d) supporting rationalized investments to strengthen both the health workforce and broader health systems in addressing emerging disease burden and preparedness and response for health emergencies.

C. Relevance to Higher Level Objectives

19. **The Project is consistent with the World Bank’s Country Partnership Framework (CPF) for the period FY2024–2027³⁷ discussed by the World Bank Board of Executive Directors on June 28, 2023 (Report No. 182326-LK).** The Project will contribute to achieve the second higher level objective of the CPF, “Protected and Enhanced Human and Natural Capital.” The Project is aligned with Objective 4 of the CPF is to “Sustain and Strengthen Health, Education and Social Protection Systems” by continuing the focus to strengthen access, quality, and efficiency of the primary healthcare system. The CPF also recognizes the need to tackle the growing burden of NCDs and promote healthy aging for healthy and productive human capital. The Project will scale up with adaptation and expansion PSSP interventions to tackle other important challenges such as NCD management, aging, and mental health. Additionally, the Project will complement the IDA financed Social Safety Nets project to build capacity for the GoSL to review and refine programs to better address emerging fiscal challenges, such as the burden of an aging population.
20. **The Project will contribute to the achievement of SDG 3—ensure healthy lives and promote well-being for all at all ages.** One of the targets for 2030 under SDG 3 is to ‘reduce by one-third premature mortality from NCDs through prevention and treatment’. Investment in early detection and management of NCDs, a primary focus of this Project is crucial to the achievement of this SDG target. The Project also contributes to the SDG 3 target for universal health coverage—ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services—by increasing the utilization and quality of necessary PHC services as well as ensuring the availability of essential medication.
21. **The Project is fully aligned with Sri Lanka’s Nationally Determined Contribution (NDC, updated 2021) and national climate policies.** The NDC³⁸ sets out a target of a 15.4 percent reduction in greenhouse gas (GHG) emissions by 2030 compared to a business-as-usual scenario. The Project is anticipated to make a considerable contribution to improving climate adaptation and resilience and is not expected to substantially contribute to GHG emissions which is aligned with Sri Lanka’s commitment to reduce GHG emissions. The country’s NDC, National Adaptation Plan (2016)³⁹,

³⁵ MoF. 2023. Independent Verification Report on Disbursement Linked Results of the Primary Health Care System Strengthening Project of Sri Lanka Nov 2023.

³⁶ World Bank. 2023. Implementation Status & Results Report Dec 2023. Sri Lanka: Primary Health Care System Strengthening Project.

³⁷ World Bank, 2023. <https://documents1.worldbank.org/curated/en/099060523101512718/pdf/BOSIB0abb778e20650b1540d16634cb4fb1.pdf>

³⁸ Ministry of Environment. (2021, September). Sri Lanka Updated Nationally Contributions. https://climate-laws.org/document/sri-lanka-first-ndc-updated-submission_3a50

³⁹ Ministry of Mahaweli Development and Environment. (2016). National Adaptation Plan for Climate Change Impacts in Sri Lanka – 2016 – 2025. <https://www4.unfccc.int/sites/NAPC/Documents%20NAP/National%20Reports/National%20Adaptation%20Plan%20of%20Sri%20Lanka.pdf>



National Policy on Climate Change (2023)⁴⁰, and the Sri Lanka Climate Prosperity Plan (2022)⁴¹ outline the health impacts of climate change and adaptation measures to build resilience to climate risks and climate sensitive diseases.

22. **The Project is also aligned with the GoSL's health sector priorities.** The Project will support the priorities, strategies and action areas mentioned in the National Strategic Framework for Development of Health Services (2016 – 2025), Report of the Public Expenditure Review Committee on Rationalization of Government Expenditure Relating to the Ministry of Health (2023) and with the Ministry of Health Reorganizing Primary Health Care in Sri Lanka (2017). It will also support activities for effective quality health coverage universally by strengthening the country's PHC system and community-based prevention and health promotion.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

To improve access and quality of primary health care services across all districts of Sri Lanka.

PDO Level Indicators

- Women aged 35 to 45 years who tested positive for cervical cancer followed up (Percentage)
- People aged 35 years and above (men and women) who are screened and diagnosed with hypertension, effectively managed, and followed up (Percentage)
- PMCI meeting four out of five minimum capabilities (Number)^{PBC}
- Availability of palliative and geriatric services at selected PMCIs in each Regional Director of Health Services (RDHS) division (Number)

B. Project Components

23. **Component 1: Increase availability of comprehensive PHC services at PMCIs and Medical Officer of Health offices (US\$90 million).** Component 1 aims to strengthen (a) the minimum capabilities⁴² of 1,031 PMCIs and 354 MOH offices across Sri Lanka's nine provinces, enhancing their ability to provide comprehensive PHC services, aligning with Sri Lanka's national PHC reorganization strategy. Additionally, it will strengthen the array of services offered, ensuring an integrated approach to PHC with a focus on NCD prevention and management programs, geriatric and palliative care as well as readiness for climate-related emergencies and other emerging challenges such as emerging and reemerging communicable diseases.
24. **Subcomponent 1.1: Ensuring availability of essential inputs at PMCIs and MOH offices (US\$50 million).** The subcomponent aims to augment the capacity and operational efficiency of PMCIs, with special focus on availability of essential equipment, supplies, medicines, laboratory testing, and transport capacity. Project financing will support: (a) updating the national essential medicine list for PMCIs and other levels of care; (b) purchasing quality essential medicines, medical supplies, equipment, and laboratory reagents for PMCIs and MOH offices; (c) undertaking minor civil works to refurbish PMCI infrastructure to make them climate resilient and energy efficient; (d) procuring information technology (IT) networking equipment for improved laboratory networking facilities; (e) installing internet

⁴⁰ Ministry of Environment. (2023, November). National Policy on Climate Change. <https://www.climatechange.lk/CCS2023/NPCCEnglish.pdf>

⁴¹ Government of Sri Lanka. (2022). Sri Lanka Climate Prosperity Plan. Preliminary Report. <https://www.v-20.org/resources/publications/sri-lanka-climate-prosperity-plan>

⁴² The minimum capabilities of PMCIs encompass: (a) minimum presence of trained personnel (two medical officers and one nursing officer per PMCI); (b) a basic set of diagnostic instruments and equipment; (c) a minimum stock of essential medicines that meet national quality standards; (d) basic laboratory investigation capabilities, either with an on-site laboratory or through a network with a designated apex laboratory; and (e) capacity for emergency care provision.



connection at PMCI; (f) procuring IT equipment to improve the inter-operability and inter-connectivity of health IT systems; (g) purchasing motorcycles to allow dispatching of medical samples (of which at least 50 percent will be e-bikes); (h) procuring vehicles to strengthen transport of waste to the nearest hospital with incinerator facilities; (i) refurbishing existing wastewater treatment facilities to better treat liquid waste generated from laboratory facilities; (j) procuring double cabs to strengthen PHC supervision activities at grass root level; and (k) employing innovative climate-resilient design of infrastructure (e.g., solar panels and cool roofs) at PMCI. Activities (c), (g), (h), (i), (j), and (k) will be carried out in line with the country's climate vulnerabilities and emission reduction commitments. Those will also be part of country's investment in climate mitigation and adaptation solutions. In addition, the above proposed procurement of equipment and electronic devices for PMCI will follow set energy-efficiency and water-efficiency standards.

25. **Subcomponent 1.2: Sustaining and strengthening primary health workforce at PMCI (US\$30 million).** To overcome human resources for health (HRH) challenges, this subcomponent will support medium-term HRH planning, particularly the development of an HRH optimization strategy to strengthen recruitment, retention, distribution, and task-shifting protocols of health workers in PMCI. The subcomponent will also finance minor refurbishment of PMCI staff quarters.
26. **Subcomponent 1.3: Expanding the PMCI service package to include additional services (US\$10 million).** This subcomponent will support the provision of an expanded package of PHC services to address (a) the growing NCD burden (including mental health), (b) increasing care needs of the rapidly aging population, GBV survivors, children with special needs, school children, and oral health, and (c) the urgent needs for the PHC system to be more prepared to respond to future pandemic and climate-related disaster risks. Under GoSL's new shared cluster model for PHC, expanded PHC services will be provided in a continuum of different types of health facilities—apex hospitals, PMCI, as well as MOH offices. To meet these new demands, the subcomponent will finance: (a) undertaking minor civil work and refurbishments for PMCI to provide the expanded service packages, including emergency treatment units (ETUs) to function as heat clinics during extreme heat conditions); (b) purchasing vital sign monitoring equipment; (c) purchasing motorbikes and bicycles (including e-bikes) to facilitate provider visits to patient homes and communicable disease surveillance activities; (d) purchasing equipment for remote diagnostics and consultations to expand telemedicine capacity in PMCI and support home-based care and continued service provision during natural disasters; (e) renovating and refurbishing daycare facilities for elderly as well as procurement of elderly friendly equipment and furniture; (f) purchasing high dependency beds for secondary care apex hospitals which are linked to PMCI in the shared cluster model to strengthen their capability of handling related referrals for obstetric care and neonatal care; (g) upgrading Divisional Hospitals through renovation, refurbishment and procurement of necessary equipment to provide basic specialist care facilities; and (h) providing TA to strengthen community support services at MOH offices to facilitate provision of mental health care services and services for GBV survivors.
27. **Component 2: Strengthen the quality of clinical and person-centered care at PMCI (US\$50 million).** While component 1 focuses on the availability of services, particularly related to structural elements, component 2 focuses on quality and person-centeredness of care. Activities under this component will include: (a) enhancing capacity of HRH; (b) strengthening pharmacovigilance systems for safer use of medicines; (c) scaling up a multisectoral coordination mechanism to facilitate coordinated and integrated care across facility types and geographies; and (d) strengthening governance systems for quality assurance at the facility level.
28. **Subcomponent 2.1: Building capacity for human resources for health (US\$15 million).** This subcomponent aims to ensure that health care providers across all PMCI are adequately capacitated to provide clinical care that is responsive to citizen needs and expectations as well as natural disasters and pandemics. It will therefore support operating costs, consulting, training and workshops related to: (a) the implementation of the Continuous Professional Development (CPD) strategy; (b) the development of updated guidelines and trainings for integrated NCD care provision (including mental health care), risk factor management, geriatric and palliative care, care for GBV survivors, climate resilient and



mitigation practices, emergency care, pandemic shocks, and disaster preparedness; (c) refresher in-service trainings to enhance interpersonal experiences of care and improve return for follow-up care; (d) the development of support tools to promote responsiveness and patient-centered care concepts; (e) capacity building on important topics including quality improvement processes and metrics, clinical audits, healthcare quality and safety implementation and monitoring practices, leadership and management, use of electronic medical records, referral mechanisms (including for survivors of GBV), management of climate-sensitive illnesses, as well as environment-friendly and sustainable healthcare practices; and (f) the strengthening of provincial and district level training centers by undertaking minor refurbishments to enable use of modern technology such as distance learning platforms.

29. **Subcomponent 2.2: Scaling up integrated care platforms (US\$30 million).** Bypassing of PMCI in favor of receiving care at higher-level facilities leads to system inefficiencies related to overcrowding of secondary and tertiary facilities and higher spending. Moreover, fragmented information systems negatively affect care continuation and coordination. To address those challenges, this subcomponent will finance operating, consulting and non-consulting services for the design and implementation of a referral and back-referral system. This will involve strengthening integrated platforms and networks of health facilities, and utilization of personal health records (PHR) to coordinate patient care and ensure patient information transfer between facilities. The PHRs will also help identify the vulnerable population for treatment in case of any climate shock or emergency. This subcomponent will also finance procurement of equipment required for the optimization of palliative, rehabilitative, and geriatric care, and communicable disease control activities, including equipment required for stepdown approach in palliative, geriatric, and domiciliary care.
30. **Subcomponent 2.3: Strengthening governance systems for quality assurance (US\$5 million).** Ensuring high-quality clinical and person-centered care provision requires robust quality assurance architecture and practices. Therefore, this subcomponent supports local technical assistance (TA) and operational, consulting and non-consulting costs related to: (a) updating and developing tools and guidelines for PMCI quality management, including introduction of systems to institutionalize clinical audits, incident reviews, and near-misses; (b) revising, standardizing and digitizing the Quality Supervision Tools; (c) supporting the enhancement of medicine packaging to be consumer-friendly and ensure quality and safe use of medicines; (d) supporting the strengthening of the pharmacovigilance system to ensure the safe and effective supply of medications and medical equipment; (e) supporting standardized reporting tools and improved labeling practices in dispensing areas; (f) supporting standardized routine patient experience surveys; (g) supporting the update of supervision protocols and accountability measures; (h) supporting trainings on quality management and clinical audits; (i) strengthening the Directorate of Healthcare Quality and Safety and the Quality Management Units in the Regional Director of Health Services (RDHS) division; and (j) strengthening the promotion of patient safety culture in PMCI.
31. **Component 3: Strengthen health promotion, community empowerment and citizen engagement (US\$4 million).** While improved capacity and quality of care at PMCI will enhance the availability of curative care service, it does not guarantee utilization of services and improvements in health outcomes. Further, the scope of PHC goes beyond what is provided by PMCI, including prevention, promotion, risk factor management and behavior change particularly during climate-related disasters. Component 3 will therefore focus on addressing demand-side constraints through health promotion, community empowerment, citizen engagement, and a strengthened interface between communities and PMCI.
32. **Subcomponent 3.1: Managing health promotion and NCD risk factors (US\$3 million).** Given low awareness among the public, particularly regarding the services available at PMCI, this subcomponent will support the development and implementation of a comprehensive social and behavior change communication (SBCC) strategy to raise public awareness of available preventive and curative healthcare services that the public can utilize, including care options at PHC during pandemic and climate-related emergencies. The SBCC strategy will also encourage women to use the available health services at PMCI. Moreover, the SBCC strategy will address NCD risk factors to raise awareness and change lifestyle behaviors, especially among women as they have higher prevalence of risk factors such as insufficient



physical activity, overweight and high cholesterol compared to men. Strengthening of adoption of healthy food culture by acts and regulations and strengthening water quality surveillance at provincial and national level will also be supported. Further, there are no solid mechanisms at the district level for NCD coordination. Therefore, this subcomponent will support a strategy to strengthen the multisectoral coordination mechanism at the district level to coordinate NCD risk factor management and other critical illnesses. Opportunities will be explored to build capacity of multi-sectoral committees to conduct targeted community awareness programs, including on GBV prevention and NCD risk factors for women.

33. **Subcomponent 3.2: Strengthening citizen engagement for preventive and curative care (US\$1 million).** The FFCs⁴³ and the Grievance Redress Mechanism (GRM) established at each PMCI serve as the cornerstones of citizen engagement at PMCIs. This subcomponent aims to (a) strengthen and expand FFCs and GRM at all PMCIs, (b) revise community engagement guidelines to include community empowerment and inclusion of people with disabilities and older adults' strategies, and (c) develop and implement strategies/guidelines to strengthen linkages between FFCs and mother support groups (especially to mobilize women for behavior change as well as service utilization) or any other village level platform through the provision of TA.
34. **Component 4: Project management and monitoring and evaluation (US\$6 million).** This component will finance activities related to Project implementation management, capacity building, monitoring and evaluation (M&E), operations research, and ministry-level supervision.
35. **Subcomponent 4.1: Project Management, Monitoring and Evaluation (US\$5 million).** Key activities to be conducted by the Project Coordination and Management Unit (PCMU) will include: (a) project management, reporting, and supervision; (b) technical support for procurement activities, financial management (FM), and environmental and social safeguards activities; (c) learning and knowledge exchange; (d) M&E and impact evaluations; (e) capacity building related to NCD management; (f) surveys and operations research (including monitoring the progress on climate-related activities); and (g) institutionalization of a national excellence award in PHC. To support knowledge generation and operations research, two large-scale surveys are proposed: a nationally representative survey to assess the quality of PHC services from the supply-side and a population-based demand-side survey to assess prevalence, risk factors, diagnosis, treatment, and effective management of NCDs. TA will prioritize supporting analytical activities to inform the HR optimization strategy. Other surveys will be conducted to track changes in key Project-relevant indicators as well as impact evaluation studies to ascertain the Project's impact on knowledge, attitudes, perception, and behavior.
36. **Subcomponent 4.2: Strengthening Project Monitoring and Management capacity at Ministry Level (US\$1 million).** This subcomponent will support: (a) strengthening project monitoring capacity of the Management Development and Planning Unit of the MoH by procuring vans for the supervision of field level activities, and computers and related IT equipment to strengthen the digitization of information and real time data collection for central monitoring of Project activities at the MoH; and (b) facilitating the development of the M&E system by financing TA activities and by procuring necessary IT equipment to facilitate national level monitoring of Project progress at the Department of Project Management and Monitoring (DPMM) of the Ministry of Finance (MoF).
37. **Component 5. Contingent emergency response component (CERC) (US\$0 million).** A CERC is included in the Project in accordance with IPF Policy, paragraphs 12 and 13, for Situations of Urgent Need of Assistance and Capacity Constraints. This will allow for rapid reallocation of the IDA loan and IDA credit uncommitted funds in the event of an eligible emergency as defined in OP 8.00.⁴⁴ An Annex to the Project Operations Manual ('CERC Annex') to guide the

⁴³ FFCs include members from the facility and community (including women members) and involve regular meetings, with the aim of soliciting feedback from the community and ensuring service responsiveness especially for women, children, and disadvantaged populations.

⁴⁴ An eligible emergency is defined as an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact associated with natural or man-made crises or disasters. Such events include a disease outbreak.



activation and implementation of the CERC, and a CERC Environmental and Social Management Framework (ESMF) will be prepared within three months of the loan and credit effectiveness. The Project's ESMF includes the CERC environmental and social assessment and initial requirements. For the CERC to be activated, and financing to be provided, the GoSL will need to (a) submit a request letter for CERC activation and the evidence required to determine eligibility of the emergency as defined in the CERC Annex, (b) submit an Emergency Action Plan, including the emergency expenditures to be financed, and (c) meet the environmental and social requirements as agreed in the Emergency Action Plan and Environmental and Social Commitment Plan (ESCP).

38. Performance-Based Conditions (PBCs). A portion of disbursements for financing of expenditures for PHC service delivery will be linked to PBCs (Table 1). The PBCs are designed to provide additional incentives for the development and adoption of critical operation processes and staffing necessary to provide minimum packages of care at Sri Lanka's PMCs. PBC1 and PBC2 support achievements in Component 1; PBC3 and PBC 4 support Component 2. PBCs will incentivize the completion of critical actions in the results framework. Three of the PBCs address pharmaceutical challenges: availability of essential drugs (PBC 1), revised list of what qualifies as essential drugs (PBC 2), and safer drug dispensing (PBC 4). In addition, improved governance of drug procurement using e-procurement is supported by an intermediate results indicator (IRI). Project eligible expenditures linked to PBCs in Components 1 and 2 include good, works, non-consulting services, consulting services, training and workshops, and operating expenses (US\$30 million). Project eligible expenditures not conditional on PBCs under Components 1, 2, 3 and 4 include: goods, works, training and workshops, operating expenses, and incremental operations costs (US\$120 million).

Table 1. PBCs by Project Components

#	Comp onent	PBC Focus Area	Problem Statement	PBC	Amount (US\$ million)
PBC 1	1	Increased availability of minimum capabilities at PMCs	To have the ability to provide minimum packages of care, it is critical that over time all PMCs can ensure the availability of essential drugs along with other minimum capabilities at PMCs level	PMCs meeting the mandatory requirement of ensuring availability of essential drugs and three out of four remaining minimum capabilities	15
PBC 2	1	Increased availability of essential drugs	The list of essential drugs has not been updated since prior to the COVID-19 pandemic. An updated list for each level of care is essential to streamline drug procurement and standardize prescription protocols	Revision and adoption by MoH of list of essential medicines at different levels of care	5
PBC 3	2	Improved quality of care	The absence of clear protocols for managing NCDs and directing patient care to the appropriate level of medical care leads to over-crowding at the secondary level and under-utilization at the primary level	Manual / Guideline and Standard Operating Procedures (SOPs) for NCD screening, diagnosis, treatment, and management, including referral and counter-referral pathways developed and endorsed by MoH	5
PBC 4	2	Improved quality of care	Weakness in drug safety and pharmacovigilance at PMCs	Number of PMCs implementing all three safe drug dispensing practices	5
				Total	30



C. Project Beneficiaries

39. **The direct beneficiaries of the Project are the citizens of Sri Lanka and the health care providers working in the public health sector.** The largest impact is expected among people accessing PHC services, and especially men and women who are screened for, diagnosed with, and treated for NCDs. The Project will support the GoSL to ensure that all PMCs have the services, capacitated HR, medicines and supplies required to provide care to the population, including those living in areas that are most prone to climate induced events. The Project will also target the geriatric population (>60 years of age) who have a greater chance of having a severe or catastrophic health incident due to NCDs or any other shocks. The Project will also include measures to increase population awareness of and demand for care at PMCs, including care for GBV survivors and mental health. While most of the Project's systems and institutional strengthening activities will take place at the national and provincial levels, supporting community-level activities will be prioritized.

D. Results Chain

Figure 1: Results Chain



E. Rationale for Bank Involvement and Role of Partners

40. **The Project leverages the Bank's existing portfolio in the health sector in Sri Lanka.** As detailed previously, it specifically builds on the PSSP. Sri Lanka's recent Bank engagements, including the Second Health Sector Development Project (P118806) and the COVID-19 Emergency Response and Health Systems Preparedness Project (ERHSP; P173867) were executed through IPF instruments. The PSSP has been executed through IPF with Disbursement Linked Indicators instrument. Thus, the GoSL and MoH have significant experience and a good track record of results-based fund flow mechanism with Bank operations. Further, the Bank brings global knowledge and experience of (a)



expanding service coverage in countries undergoing an epidemiological transition and increasing burden of non-communicable disease, (b) improving the quality of health service delivery, and (c) improving health information systems and PFM for better health systems governance and management. The Project will also support essential operating expenditures to provide essential medicines and support for institutional strengthening. Therefore, in the context of increased stresses on the health system, the Project will provide assurance that essential quality health care services are provided to citizens.

41. **There is strong commitment from DPs to support the PHC program in Sri Lanka.** In this context, the MoH, under the leadership of Director General of Health Services, has established a committee to ensure coordination, harmonization and alignment of financing and TA provided by DPS to support the PHC system strengthening support and overall sector performance. The main DPs involved in health other than the World Bank are Asian Development Bank, the European Union, the German Agency for International Cooperation, the Global Fund, Japan International Cooperation Agency, International Labor Organization, United States Agency for International Development, United Nations Children's Fund, United Nations Population Fund, WHO and the World Food Program. The Health Sector Development Partner Forum meets periodically to facilitate joint planning and conduct joint reviews of the sector performance. The Project will closely coordinate with the Asian Development Bank (ADB) which supports secondary and tertiary healthcare. In addition, the Project will coordinate with other DPs (e.g., ADB, UNOPS) to provide TA to improve governance of pharmaceuticals.

F. Lessons Learned and Reflected in the Project Design

42. **The Project design considers key lessons learned from global experience with addressing NCDs through primary care and from Sri Lanka's own experience with PHC reorganization implemented through the PSSP.** The PHSEP will replicate the core elements of the PSSP while introducing adaptation and expansion as needed. Specifically, informed by global evidence on the importance of comprehensive PHC (including integration of mental health care) and PMCI health care provider feedback, the PHSEP will introduce an expanded essential service package (building on the Essential Service Package for NCDs introduced during PSSP) that will include services for mental health, geriatric care, pre-hospital ambulatory care, rehabilitation, stepdown care, and services for survivors of GBV (including counseling services for survivors of sexual exploitation and abuse). The PSSP implementation experience, which involved unexpected adaptation of PHC facilities to respond to the COVID-19 pandemic, demonstrated the importance of incorporating basic emergency response and preparedness measures, including for infectious disease management. The PHSEP design therefore includes scale-up of these services and capacities. The PHSEP design therefore includes development and implementation of strategies to raise awareness about preventive and curative services available at PMCIs, and expansion of FFCs to strengthen community engagement and facilitate responsive care.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

43. **The MoH will be the primary implementing agency (IA) from the GoSL responsible for implementing the Project.** The MoH will oversee day-to-day operations and be responsible for setting policy and standards and updating protocols for strengthening the PHC system. It will also be responsible for M&E of the performance of the sector, including the PHC system, using administrative data and periodic surveys.
44. **A National Steering Committee (NSC) will be established through issuance of a government circular. The NSC will meet quarterly to provide oversight, monitor implementation progress, and provide overall guidance to the Project.** The NSC will be chaired by the Secretary of the MoH with the participation of the Provincial Health Secretaries and Provincial Directors of Health. The additional members consist of the Secretary finance commission, nine provincial



Chief Secretaries, representatives from the central MoH and provincial MoH, External Resources Department, National Planning Department, the National Budget Department and Treasury Operations Department, Management Services Department and DPMM of the MoF and any others as necessary. The NSC will be established within 30 days of effectiveness.

45. **The Provincial Councils will provide oversight and coordination through the provincial health authorities that will implement the provincial-level Project activities.** Sri Lanka has nine provinces, each with its own provincial council and administrative structure. Each Provincial Council will establish a Project Provincial Working Committee (PPWC) within 30 days of effectiveness. Each PPWC will meet quarterly to provide oversight, monitor implementation progress, and provide overall guidance on the provincial level Project activities. The Provincial Departments of Health Services (PDHS) are responsible for adopting protocols and planning and implementing the PHC reorganization and strengthening activities per the set standards. Therefore, the MoH will be working closely with the provincial health authorities through the Chief Secretary of each province in coordinating, monitoring, and reporting on the Project implementation.
46. **A PCMU anchored at the MoH will be established.** The PCMU will be responsible for carrying out the day-to-day overall Project coordination and management. A Project Operational Manual (POM) will guide implementation of Project activities and include details on implementation arrangements, including fiduciary management, safeguards management, PCMU staffing and Terms of Reference (TORs), and PBC verification protocols. The staffing structure will be based on effort required to manage the technical, fiduciary and safeguards risks and will be reviewed regularly. The PCMU will be established and fully staffed within two months of Project effectiveness.

B. Results Monitoring and Evaluation Arrangements

47. **Progress in achieving the PDO will be assessed by routine measurement and monitoring of the PDO indicators, intermediate results indicators, and PBCs.** The routine Project M&E will be integrated into the MoH and provincial-level monitoring and reporting systems, supplemented by the PCMU which will have a full-time M&E specialist who will facilitate the regular collection and reporting of the Project results. The indicators will be reviewed during quarterly meetings held by the central and provincial MoH, and information will be shared with the DPMM for monitoring purposes. At least annual reviews of performance will be conducted by the NSC, and the NSC will review reports on the progress of the PHC reorganization. A midterm review and independent evaluation of the Project will be conducted in 2026.
48. **PBCs verification will be conducted in accordance with the PBC verification protocol by an agency with the necessary level of independence from the Project implementers, credibility, and authority to lead the verification process.** The detailed PBC verification plan is included in the POM. For independent verification of PBCs, it has been agreed that the DPMM will be the verification agency. The DPMM and PCMU will jointly select an organization (firm, research center, or other type of institution) to provide necessary technical support for the verification process, based on TORs agreed by the Bank. The DPMM will verify achievement of PBCs based on the results reported by the MoH. Details in the POM.
49. **The routine monitoring of result framework and PBCs will rely on different types of data.** The process-related results will be verified following the review of the official document (policy, circular, or other instrument), ensuring that the content of the document is consistent with the required definition for that PBC, the document has necessary approval authority and was issued as required by the standard Government procedure. PBCs and intermediate results indicators related to service delivery capacity, supply, and adherence to new guidelines and procedures requiring data to be reported at the facility level through the relevant sources. Verification of intermediate result and outcome-related PBCs at the facility level will involve the application of standard MoH data quality audit methods. Thus, verification will involve (a) reviewing evidence at the GoSL, MoH or provincial levels that the actions and processes have taken



place with the necessary authority and with the agreed content, and (b) applying the standard data quality audit methodology at the facility level for PBCs dependent on reporting through Health Management Information System (HMIS).

50. **Surveys, impact evaluation studies and independent midterm evaluation.** Studies to understand provider- and population-level change will be conducted through national surveys and other studies as deemed appropriate. This research will be used to understand whether the expected changes are occurring and to introduce strategic course corrections, when appropriate. The studies will be done in collaboration with external technical experts, key Project implementers, local research organizations and DPs.

C. Sustainability

51. **The Project is expected to be sustainable beyond the Project duration.** The sustainability is bolstered by clear political leadership and government ownership evidenced by the position paper 'Reorganizing Primary Health Care in Sri Lanka: Preserving Our Progress, Preparing Our Future', alongside the GoSL's commitment outlined in the National Health Policy 2016–2025, its five-year national health master plan, and Sri Lanka's Vision 2025, emphasizing the importance of reorganizing primary-level curative institutions, including PMCIs. These commitments are crucial for long-term investment in PHC. Additionally, the MoH is in the process of updating the national health policy for the next five years, further improving the PHC reorganization process. The Project design aligns with key government policies and initiatives such as updating essential medicine lists, fulfilling minimum human resource requirements, adopting e-procurement systems, utilizing health information management systems, and expanding PHC packages with clinical guidelines and protocols, all of which are expected to significantly enhance the quality and efficiency of Sri Lanka's healthcare system. Moreover, the Project's sustainability is reinforced by a thorough consultative process, with the MoH conducting stakeholder consultations with various experts and stakeholders, contributing to building a coalition of support for PHC reorganization. The MoH has also established a strong coordination mechanism to harmonize planned technical and investment support for PHC system strengthening.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

52. **The Project design of adaptive scale-up of ongoing Bank-supported PSSP is technically sound and aligned with best global practices.** The Project is informed by global evidence, notably the Lancet Global Health Commission, advocating for investing in foundational aspects and care processes to enhance health outcomes and system confidence. It adopts a holistic approach to improve PHC through discrete investments targeting both foundational and process-related improvements, aiming to alleviate overcrowding in higher-level facilities and promote patient-centered integrated care at the primary level. Lessons from the PSSP have been thoroughly investigated and documented^{45,46} providing valuable insights for scaling up across all PMCIs. The service package at PMCIs is set to expand to address crisis-related needs, such as mental health and geriatric care, with a timely inclusion of step-down and home-based care, identified as priorities for efficiency gains during economic crises. Quality issues in NCD management, like poor linkages in the care cascade, highlight the importance of improving care quality, supported by clinical audits and patient experience surveys. Citizen engagement is crucial to bridge the gap in demand for PHC services and community-based health promotion activities. With a comprehensive set of supply and demand side interventions, the Project is primed to effectively pave the way for improved PHC access and quality, leading to better health outcomes.

⁴⁵ Nair *et al.* 2023.

⁴⁶ Thekkur *et al.* 2023. [Empanelment of the Population to the Primary Medical Care Institution of Sri Lanka: A Mixed-Methods Study on Outcomes and Challenges](#). *Healthcare*, 11(4):575.



53. **The economic justification for investing in PHC is evident.** There is strong global evidence that a well-functioning PHC system with robust continuum of care reduces total hospitalization, use of emergency department, and avoidable admissions of ambulatory care sensitive conditions.⁴⁷ In Sri Lanka, over 90 percent of hospital budget is spent at the secondary and tertiary care levels while leaving less than 10 percent of resources to the primary level. Improving the capability and quality of care at PHC level and shifting bulk of the patients to the more cost-effective primary care level is expected to improve the health system efficiency. Many activities in the Project (such as hypertension control and cervical cancer screening) are shown to be cost-effective as per global evidence from Disease Control Priority 3.⁴⁸ An economic analysis undertaken as part of the Implementation Completion and Results Report of the Sri Lanka Second Health Sector Development Project (P118806) suggested scaling up of hypertension screening and management alone yielded an economic return higher than the IDA credit of US\$200 million. The Transforming Egypt's Healthcare System project (P167000) estimated the return-to-investment to be US\$2.33. Further, the Project will have a positive implication from an equity perspective. In Sri Lanka, the poor rely more on public PHC services and therefore will benefit from the improved access and quality of PHC services.
54. **An economic analysis identified that the benefit of the Project will likely far outweigh its investment.** As the comprehensive health benefit by the Project are too complex to quantify, we conducted a threshold analysis to simulate the minimum level of health benefit needed for the Project to break-even in benefit-cost ratio (BCR) (i.e., BCR=1.0). Disability-adjusted life years (DALYs) was used to quantify the health benefit that were converted to monetary values assuming a GDP per capita gain for each DALY averted. Under the baseline scenario, at least 0.88 percent reduction of DALYs amenable to PMCI care is needed for the Project to be cost-beneficial (i.e., BCR >1.0). On the effect of health promotion and preventive activities for NCD risk factors, NCD DALYs need to be reduced by at least 0.97 percent for baseline scenario. If both effects meet the minimum requirements, the BCR will be 2.0 or higher, and the Project will avert 110 thousand DALYs or more over 5 years. In a previous analysis of the Second Health Sector Development project (P118806), scaling up hypertension screening alone was estimated to have averted 59 thousand DALYs in year 2017. Given that the Project will scale up prevention, screening, and management of many NCD and risk factors, it is very likely that the health benefit will significantly exceed the minimum DALYs required to be averted in the base scenario, and actual BCR of this Project be way higher than 2.0.
55. **Paris Alignment Assessment:** The operation is aligned with the goals of the Paris Alignment for mitigation, adaptation, and resilience.
56. **Mitigation goal and risk reduction measures:** Most Project activities are universally aligned with the Paris Agreement on climate change. However, under subcomponent 1.1. the Project will finance the upgrading and refurbishment of PMCI facilities. To reduce the possibility of GHG emissions, energy efficiency measures will be adopted to meet EDGE level 1 certification. In addition, a consultant will be hired to conduct energy efficiency assessment to meet at least 20 percent energy efficiency compared to standard practice, according to the EDGE level 1 criteria.
57. **Adaptation goal and risk reduction measures:** Sri Lanka is highly vulnerable to flooding, storm surges, cyclones, and drought. Under subcomponent 1.1, the Project will finance: (a) climate-shock-resilient building design for the upgrading and refurbishment of PMCI facilities to ensure continuity of health service delivery and minimize the risk of climate shocks to health facilities, which will also reduce risks to health workers supported under subcomponent 1.2; (b) the installation of solar energy systems at PMCIs. To reduce damage to solar panels by strong winds, hurricane clips will be used to fasten the panels; and (c) the refurbishment of wastewater treatment facilities. To reduce heavy rainfall and floods and flood risk to wastewater treatment facilities, climate projections will be incorporated into the refurbishment plans/designs to enhance the capacity of wastewater treatment facilities. For subcomponent 1.3, to reduce flood, landslide and strong wind damage to the procured ambulances, motorbikes and bicycles, procedures on

⁴⁷ WHO. 2018. Building the economic case of primary health care: a scoping review.

⁴⁸ Prabhakaran Det al. 2017. Cardiovascular, Respiratory, and Related Disorders. DCP3, Vol. 5. Washington DC: World Bank.



operation during climate shocks will be incorporated in the operation guidelines and drivers will be trained on these procedures. In addition, dispatchers will be provided with real-time weather data and forecasts, especially those operating in climate vulnerable areas to avoid days of extreme events when planning home visits. Under subcomponent 2.2, scale up of integrated care platforms will include protocols for care during climate shocks and district and local plans for climate and health emergency preparedness and response, including at health facilities, to minimize the risk to health facilities and activities financed by the Project.

B. Fiduciary

(i) Financial Management

58. **The World Bank fiduciary requirements and guidelines that apply to IPF as per Bank Policy also apply to IPF PBC.** The PCMU that will be established at MoH will be the IA that will handle Project finances and be responsible for overall Financial Management. A FM assessment was carried out by the Bank. Proposed FM arrangements are found to be satisfactory provided that the proposed risk mitigatory measures, as agreed by MoH, are implemented in due course. At this stage, FM residual risk is assessed as Substantial due to the new instrument, a new PCMU to be established and the magnitude of the tasks to be handled. Residual risk will continue to remain at Substantial until such time the newly set up PCMU demonstrates its capability of maintaining acceptable FM arrangements for the Project for a reasonable period of implementation. The FM risk will be reassessed and adjusted as appropriate.
59. **Components 1 and 2 will operate on an IPF PBC approach for a part of expenditures.** The disbursements will be based on the achievement of PBCs and on reporting of underlying expenditures attributable to the PBC part. The disbursement amount will be based on the lower of (a) incurred expenditures, and (b) pricing of PBC. In any period, the unutilized amounts from the two aspects can be rolled over for disbursement in subsequent periods. All other non PBC parts of components 1-4 will follow a traditional IPF approach.
60. **The overall disbursement methods available to be used under the Project will be advance, reimbursement, direct payments, and special commitments.**
61. **Two Designated Accounts (DAs) will be opened for the Project.** The financial reporting for the Project funds will be carried out through the submission of Interim Unaudited Financial Reports (IUFRs). The Project will be subject to a regular internal audit. Financial statements of the Project, prepared by the PCMU, will be audited annually by the National Audit Office of Sri Lanka (NAOSL). Currently there are no ineligible expenditures or overdue audit reports under projects implemented by MoH.

(ii) Procurement

62. **In accordance with the World Bank's "Procurement Regulations" for IPF Borrowers (Procurement in Investment Project Financing Goods, Works, Non-Consulting and Consulting Services, Fifth Edition September 2023), all procurement activities for this project shall be carried out.** The "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," as amended on July 1, 2016, will govern this project. Additionally, all procurement shall adhere to the terms of the Financing Agreement and the Project Procurement Strategy for Development (PPSD) and Procurement Plan (PP), as agreed with the World Bank. The IA, bidders, and service providers shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraph 3.33 of the Section III, Governance, Fraud and Corruption and Annex IV on Fraud and Corruption of the Procurement Regulations.
63. **The MoH shall be primarily responsible for the procurement planning, administration, contract management, and decision-making pertaining to the PHSEP.** A formal PCMU will be set up with a procurement specialist and two procurement support staff as stated in the Financing Agreement. Given the specialized character of the financing instrument, capacity development will be required for smooth implementation.



64. **All provincial procurements will be centralized and managed by the IA in consultation and collaboration with the respective provincial authorities.** Provincial representatives shall also serve on the technical evaluation and procurement committees, in addition to being consulted concerning the compilation of the TOR, specifications, bidding documents, Bill of Quantities and evaluations and contract award. The respective Province will supervise and administer the contracts for the province. The mechanisms for record maintenance and reporting will be determined jointly by the IA and the province.
65. **The PPSD devised by the IA defines the planned procurement activities for the Project and identify procurement-related impediments at the national and institutional levels along with a strategy to surmount them.** The IA has formulated the PP encompassing the activities required for the initial eighteen months of project implementation. The procurement monitoring instrument, Systematic Tracking of Exchanges in Procurement (STEP), will be used to record and process the procurement related transactions.
66. **Prior engagements with the sector through Bank-funded operations unveiled specific obstacles to implementation in the fiduciary domain, primarily concerning governance.** The residual procurement risk is classified as "Substantial" according to the assessments performed and subject to the application of agreed-upon risk mitigation measures. During implementation, risks will be reviewed and adjusted as required. Risks and corresponding mitigation measures are summarized in the Annex 1.

C. Legal Operational Policies

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

D. Environmental and Social

67. **The overall environmental risk of the Project is assessed to be “moderate” given the Health and Safety risks associated with minor civil works of existing PMCIIs including refurbishments works and generation of additional health care waste (HCW) due to improving quality and increase services across all districts of Sri Lanka.** Key environment risks associated with minor civil works includes sourcing, transport and storage of construction materials, generation of dust, noise, disposal of construction debris and excavated materials, pollution from fuel and lubricants, soil erosion and pollution of surface and ground water resources, generation of solid and liquid wastes, and health and safety issues for construction workers and public. However, since the scale of construction is minor, the Project will pose limited risks during the construction stage. The potential negative impacts envisaged during the operations stage are related to the generation, handling, and disposal of HCW. Improper management of HCW could cause various health and safety concerns for the health care facility staff, waste collectors, patients, and nearby communities as well as risks to the environment through several routes of contamination including open dumping, burning, and mixing with storm water runoff causing widespread pollution and spread of diseases. Therefore, an Environment and Social Code of Practice (ESCP) will be developed to manage environment and social impacts during minor civil works while a Health Care Waste Management Plan will be developed taking into consideration the collection, handling, storage, disposal of HCW. The Project will also invest in implementing solar energy systems at PMCIIs to improve energy efficiency and energy security. These would generate electronic and hazardous waste at their end-of use stage which could potentially contaminate the soil, surface, and groundwater. In addition, refurbishment of existing wastewater treatment facilities will be carried out to manage liquid waste generated from improved laboratories.



68. **The social risk of the Project is assessed to be “Low”.** The sexual exploitation and abuse/sexual harassment (SEA/SH) risk of the Project was also rated ‘low’ determined through the application of the World Bank’s SEA/SH Risk Rating tool for health sector projects. There will be no involuntary land acquisition or resettlement related impacts as the Project will only support minor civil works such as renovations and refurbishments of existing PCMIs. Therefore, key social risks include: (a) community and occupational health and safety related risks and impacts from minor civil works including disturbances to ongoing clinics; (b) potential SEA/SH risks due to construction workers entering hospital premises, though labor influx is minimum as the civil works are minor in nature; (c) exclusion related risks especially to elderly, people with disabilities and bedridden patients living in remote locations due to lack of equitable and universal access to information on health services for these groups; (d) risks associated with assuring data protection and privacy of patient records during storing and processing by the HMIS; and (e) potential forced labor risks with the supply of solar panels. Associated risks and impacts related to civil works, including health, safety and SEA/SH risks can easily be managed following a proper ESCOP and adopting a SEA/SH prevention Code of Conduct by contractors and their workers. In addition, the Project will strengthen the existing SEA/SH service provision at PMCI level and ensure adequate referral pathways. Exclusion related risks will be mitigated through the delivery of targeted essential services including home-based care services and by (a) ensuring universal access for vulnerable groups who experience mobility challenges, and (b) engaging the FFCs to support and reach out to these groups. Data protection and privacy risks will be mitigated by complying with key national legislation related personal data protection and computer crimes during the implementation of the e-HIMS. Forced labor risks with solar panel suppliers will be addressed by enhanced procurement mitigation measures. The ESCP⁴⁹ and Stakeholder Engagement Plan⁵⁰ have been disclosed on May 24, 2024 and May 19, 2024 respectively.

V. GRIEVANCE REDRESS SERVICES

69. **Grievance Redress.** Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the Bank’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the Bank’s independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank’s Grievance Redress Service (GRS), visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the Bank’s Accountability Mechanism, visit <https://accountability.worldbank.org>.

70. **Paris Alignment.** Sri Lanka is highly prone to natural disasters and climate change, bringing a direct impact on the poor and vulnerable. The 2019 Global Climate Risk Index ranks Sri Lanka as the second-most climate change affected country in the world. The main disasters affecting the country include (a) flooding, which is the most frequent and costly natural hazard, (b) droughts which negatively affect food production and electricity power generation, and (c) coastal erosion, storm surges, and cyclones, with damage to coastal natural capital such as coral reefs and mangroves. The exponential rise in temperatures is expected to affect human health and put downward pressure on agricultural yields, including key staples. Without adaptative action, the projected increase in the frequency and

⁴⁹ https://pssp.health.gov.lk/images/pdf/Environmental_and_Social_Commitment_Plan_Negotiated_-_24-May-2024_clean.pdf

⁵⁰ https://www.pssp.health.gov.lk/images/pdf/PHSEP_Stakeholder_Engagement_Plan_SEP-19May2024.pdf



intensity of extreme precipitation events may put lives, livelihoods, and infrastructure in jeopardy. Predicted climate change trends will have disproportionate impact across Sri Lanka's poorest and most marginalized communities.

71. **Furthermore, approximately half of Sri Lanka's population (48.8 percent) lacks adequate disaster preparedness, a critical vulnerability exacerbated by the escalating risks associated with climate change.** Additionally, 35.6 percent face vulnerabilities and deprivation concerning access to water sources, amplifying the challenges posed by the multi-faceted crisis. This situation raises considerable concerns, particularly given the potential impact of El Niño coupled with large scale internal displacement and continuing effects of climate change. Observations from the Food and Agriculture Organization and the World Food Program suggest that food insecurity may escalate further. Owing to its susceptibility to climate change, coupled with two consecutive seasons of subpar harvests and diminished imports of food grains due to foreign exchange constraints, approximately 6.3 million individuals in Sri Lanka are currently grappling with moderate to severe acute food insecurity.
72. **Gender. In response to gaps identified, the Project will address care needs of GBV survivors, and support health services to improve cervical cancer screening and diagnostic.** To enhance access to GBV services, 'Mithuru Piyasa' crisis centers at additional PMCI locations will be expanded, coupled with training of healthcare providers. Activities include financing operational costs, providing TA, developing updated care guidelines, and training on integrated NCD and mental health care for GBV survivors. Training curriculums for healthcare providers to improve screening, treatment, and referrals, including for people with disabilities, Lesbian, Gay, Bisexual, Transgender, Intersex, and elderly women, will also be updated. The Results Framework tracks the Number of 'Mithuru Piyasa' (GBV support centers) established at PMCIs; and Number of people (male/female) who obtained services from 'Mithuru Piyasa' centers at the national level. To address low screening rates for cancer, the Project will support an integrated approach to PHC with a focus on NCD prevention and management programs. The Project will track the percentage of cervical cancer positive cases (identified by pap smear) who receive timely screening result feedback, referral for treatment, and followed up according to guidelines as a proportion of all women between the age 35 to 45 who tested positive from the PMCI's cervical cancer screenings.
73. **Citizen engagement. The Project's Citizen's Engagement approach using the FFCs introduced by the PSSP will be further strengthened and utilized as the main mechanism for community outreach.** FFCs will serve as a bridge between the PMCIs and local communities and fulfill variety of functions, by assisting the PMCIs to: (a) tailor their services to the needs and priorities of the local community based on feedback obtained from the community; (b) raise awareness of local communities regarding available medical services and the importance of various medical treatments and procedures; (c) support to handle grievances or complaints raised by community members; and (d) help PMCIs to mobilize resources, monitor the performance of various PMCI services, and generally contribute to the optimal functioning of PMCIs and community health overall. Under the PHSEP, FFCs will be further capacitated through trainings to provide tangible skills and tools to enhance FFC impact and introduce systems to monitor FFC activities to capture the key outcomes and learnings to enhance PMCIs approaches to community outreach. The Project will build in mechanisms to obtain feedback from patients to assess the quality and satisfaction of the PMCI services offered. Accordingly, the Project includes two indicators in its results framework: Percentage of PMCIs conducting annual patient experience surveys using standardized tools, and percentage of PMCIs with active FFCs.

VI. KEY RISKS

74. **Based on the Systematic Risk Rating Tool, the overall risk of the Project is considered Substantial.** Macroeconomic risk is assessed as "high". Political and governance, fiduciary, and sector strategies and policy risks are assessed to be "substantial". All other risks are assessed as "moderate". A short description of each of the key risks and their respective mitigation measures are provided below.



- Macroeconomic: Sri Lanka has a narrow path to recovery with high downside risks that cannot be ignored. The high risk is primarily due to a highly uncertain economic environment in the country. Furthermore, there are challenges in smooth flow of funds from central to the local level due to ongoing fiscal constraints. In addition, foreign exchange shortages persist and could disrupt Project implementation. However, the primary health system predominantly procures locally manufactured supplies and is therefore largely insulated from foreign exchange rate shocks, and the Project is supporting salary-related expenditures and other inputs to mitigate risks.
- Political and governance: The upcoming elections can possibly result in political volatility that may impact the health sector engagement. To mitigate this risk, a multi-sectoral steering committee will be appointed to provide Project oversight and monitor implementation progress, and a series of stakeholder consultations will be organized, including the private sector and civil society, to proactively mitigate these risks.
- Fiduciary: While the MoH has developed significant fiduciary capacity under the Bank-financed health projects, capacity gaps remain. A strong team will be established within MoH, and the agreed fiduciary risk mitigation measures will be monitored. Fiduciary capacity building will also be provided throughout the Project.
- Sector Strategies and Policies: Given the social and economic context, there is a substantial outflow of health workers which might impact smooth implementation of the Project. As a mitigation strategy, the Project will have a PBC that includes availability of health staff at the facility level.



VII. RESULTS FRAMEWORK AND MONITORING

PDO Indicators by PDO Outcomes

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
To improve access and quality of primary healthcare services across all districts of Sri Lanka					
Women aged 35 to 45 years who tested positive for cervical cancer followed up (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
10	10	25	35	45	55
People aged 35 years and above (men and women) who are screened and diagnosed with hypertension, effectively managed, and followed up (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
30	30	35	40	45	50
PMCs meeting four out of five minimum capabilities (Number) ^{PBC}					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
550	550	598	670	773	825
Availability of palliative and geriatric services at selected PMCs in each Regional Director of Health Services (RDHS) division (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	0	7	12	17	26

Intermediate Indicators by Components

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
Increase availability of comprehensive PHC services at PMCs and Medical Officer of Health offices					
PMCs which adopt the expanded package of services (including mental health, palliative, geriatric, and rehabilitative care) (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	0	25	45	55	65
Primary care institutions (PMCs and MOH) with transport facilities for dispatching samples for investigations to designated apex laboratories (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
50	50	55	65	75	85
Revision and adoption by MoH of the list of essential medicines for different levels of care (Text) ^{PBC}					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028



None	-	-	Revised and endorsed by MoH	Continued	Continued
PMCs with capacity to respond to pandemics and infectious disease outbreaks (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
30	30	35	45	55	65
People receiving quality health, nutrition and population services (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
-	-	-	-	-	-
Strengthen the quality of clinical and person-centered care at PMCs					
Conduct annual clinical audits according to revised guidelines for improvement of quality and safety of healthcare institutions (Text)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
No	-	-	-	Conducted	Conducted
PMCs conducting annual patient experience surveys using standardized tools. (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	-	-	10	30	40
Primary healthcare staff trained on integrated essential packages (NCDs, geriatric care, family medical care, mental health care, palliative care, and A&E services) (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	-	-	20	40	60
Annual National Continuous Professional Development programs implemented (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	-	-	10	10	10
PMCs using personal health records and implement referrals (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
50	50	55	65	75	85
PMCs equipped with solar power (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	0	0	100	200	250
PMCs implementing all three safe drug dispensing practices (Number) ^{PBC}					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	0	0	258	515	825
Manual/ guidelines and SOPs for NCD screening, diagnosis, treatment and management, including referral and counter-referral pathways developed and endorsed by MoH (Text) ^{PBC}					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
None	-	-	-	Adopted and endorsed	Continued



Strengthen health promotion, community empowerment and citizen engagement					
PMCs with active Friends of Facilities committees (Percentage)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
50	50	55	65	75	85
People (disaggregated by male/female) who obtained services from Mithuru Piyasa centers at the national level (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
15,510 (women) 841 (men and children)	15,510 (women) 841 (men and children)	16,000 (women) 900 (men and children)	17,000 (women) 950 (men and children)	18,000 (women) 1000 (men and children)	19,000 (women) 1,250 (men and children)
Develop district-level guidelines for multi-sectoral NCD action plan (Text)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
None	-	-	Developed	Implemented	Implemented
Comprehensive social and behavioral change communications strategy updated and implemented (Text)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
Yes	-	-	Updated	Implemented	Implemented
Project management and monitoring and evaluation					
Revise guidelines/ strategies for citizen engagement/GRM (Text)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
Guidelines exist	-	-	-	Revised	Implemented
Conduct population based demand-side survey to assess prevalence, risk factors, diagnosis, treatment, and effective management of NCDs (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
-	-	-	-	-	Survey conducted
Implementation of the e-procurement system for national level procurement activities (Text)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
None	None	The MoH has issued an internal circular mandating the use of e-procurement for procurement under its purview	The project's procurement activities are managed through an e-procurement system (accounting for 50% of contracts managed by the Project)	The project's procurement activities are managed through an e-procurement system (accounting for 60% of contracts managed by the Project)	The project's procurement activities are managed through an e-procurement system (accounting for 70% of contracts managed by the Project)
Contingent emergency response component (CERC)					

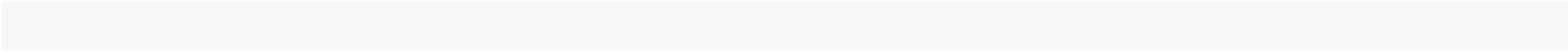
Performance-based Conditions (PBC)

Period	Period Definition
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Period 1			01 July 2024 to 31 December 2024		
Period 2			01 January 2025 to 31 December 2025		
Period 3			01 January 2026 to 31 December 2026		
Period 4			01 January 2027 to 31 December 2027		
Period 5			01 January 2028 to 31 December 2028		

Baseline	Period 1	Period 2	Period 3	Period 4	Period 5
1:PMCs meeting four out of five minimum capabilities (Number)					
550	550	598	670	773	825
0.00	0.00	2,618,182.00	3,927,272.00	5,618,182.00	2,836,364.00
PBC allocation		15,000,000.00	As a % of Total PBC Allocation		50%
2:Revision and adoption by MoH of the list of essential medicines for different levels of care (Text)					
None	-	-	New list of essential medicines for different levels of care adopted by MoH	Revised and endorsed by MoH	Revised and endorsed by MoH
0.00	0.00	0.00	5,000,000.00	0.00	0.00
PBC allocation		5,000,000.00	As a % of Total PBC Allocation		16.67%
3:Manual/ guidelines and SOPs for NCD screening, diagnosis, treatment and management, including referral and counter-referral pathways developed and endorsed by MoH (Text)					
None	None	-	Manual for NCD screening, diagnosis, treatment and management, including referral and counter-referral pathway developed and endorsed by MoH, and has been published	-	Adopted and endorsed
0.00	0.00	0.00	5,000,000.00	0.00	0.00
PBC allocation		5,000,000.00	As a % of Total PBC Allocation		16.67%
4:PMCs implementing all three safe drug dispensing practices (Number)					
0	0	200	400	600	825
0.00	0.00	1,212,121.00	1,212,121.00	1,212,121.00	1,363,637.00
PBC allocation		5,000,000.00	As a % of Total PBC Allocation		16.67%





Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

To improve access and quality of primary health care services across all districts of Sri Lanka	
Women aged 35 to 45 years who tested positive for cervical cancer followed up (Percentage)	
Description	This indicator measures the percentage of cervical cancer positive cases (identified by pap smear) who receive timely screening result feedback, referral for treatment, and followed up accordingly to guidelines as a proportion of all women between the age 35 to 45 who tested positive from the PMCI's cervical cancer screenings.
Frequency	Annual
Data source	PMCI routine health records and Family Health Bureau routine data
Methodology for Data Collection	Data Quality Assessment Methodology used to assess service delivery reports from service providers through to the MoH
Responsibility for Data Collection	MoH (DDG, Public Health Services)
People aged 35 years and above (men and women) who are screened and diagnosed with hypertension, effectively managed, and followed up (Percentage)	
Description	This indicator measures the percentage of diagnosed hypertension patients who have been effectively treated and meet blood pressure control targets. The treatment and blood pressure control targets are per MoH guideline and SOPs. This indicator will be reported as gender disaggregated.
Frequency	Annual
Data source	PMCI routine health records and Directorate of NCD routine data
Methodology for Data Collection	Reported by PMCIs through the provinces to the Directorate of NCD at the MoH
Responsibility for Data Collection	MoH (DDG, NCD)
PMCIs meeting four out of five minimum capabilities (Number) ^{PBC}	
Description	<p>This indicator measures the number of PMCIs that meet the mandatory requirement of the minimum availability of essential drugs along with three out of the four remaining capabilities. These capabilities are expected to enhance the PMCI's capacity to provide comprehensive and quality primary healthcare services to the population they serve. The 5 minimum requirements are as follows:</p> <ul style="list-style-type: none"> o Mandatory requirement – The PMCI has minimum availability of essential drugs o The PMCI has minimum number of health staff (at least two medical officers and one nursing officer) at any given time o The PMCI has minimum operational equipment according to defined requirements. o The PMCI has laboratory testing capacity (on-site or through a networked laboratory) o The PMCI has the capacity to provide acute emergency care (ETU facility) <p>The denominator will be the total number of PMCIs in the country.</p>
Frequency	Annual
Data source	PMCI/ MOH office routine data
Methodology for Data Collection	Reported by PMCIs and MOH offices through the provinces to MoH
Responsibility for Data Collection	MoH (DDG, Medical Services)
Availability of palliative and geriatric services at selected PMCIs in each Regional Director of Health Services division (Number)	
Description	This indicator measures the number of RDHS divisions which have at least one PMCI within the division that can provide geriatric care and palliative care services. By project closing, all RDHS divisions in Sri Lanka are targeted to have geriatric and palliative care services available, in at least one PMCIs per division.
Frequency	Annual
Data source	PMCI/ MOH office routine data
Methodology for Data Collection	Reported by PMCIs through the provinces to MoH



Responsibility for Data Collection	MoH (DDG, Medical Services)
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Monitoring & Evaluation Plan: Intermediate Results Indicators by Components

Increase availability of comprehensive PHC services at PMCI and Medical Officer of Health offices	
PMCI which adopt the expanded package of services (including mental health, palliative, geriatric, and rehabilitative care) (Percentage)	
Description	This PBC reflects the intention of the MoH to revise the essential drug lists for different levels of care. The available essential drug list will be reviewed and thoroughly scrutinized by a panel of technical experts to identify the essential drugs commonly used at the PHC level. This process will include the deletion/omission of drugs as needed and the also the inclusion of necessary drugs in line with the expanded service package, with special provision to accommodate the back referral process. The PBC will consider the revision and endorsement of the drug lists following standard government processes.
Frequency	One time
Data source	MoH publications, currnet and revised drug lists
Methodology for Data Collection	Review of documentation to ensure conformity with definition/description and ensure that it was endorsed following appropriate government procedure.
Responsibility for Data Collection	MoH (DDG, Medical Supplies Division [MSD])
Primary care institutions (PMCI and MOH) with transport facilities for dispatching samples for investigations to designated apex laboratories (Percentage)	
Description	The indicator refers to the number of primary care institutions that have transport facilities for dispatching samples to apex laboratories, adhering to the MoH sample transportation guidelines/SOPs.
Frequency	Annual
Data source	PMCI/MOH office routine data/project monitoring system
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCI through the provincial authorities to t Planning Unit, MoH/PCMU.
Responsibility for Data Collection	MoH (DDG, Laboratory Services)/PCMU
PMCI with capacity to respond to pandemics and infectious disease outbreaks (Percentage)	
Description	The indicator refers to the percentage of PMCI that provide the expanded package of services: mental health, palliative, geriatric, and rehabilitative care . The denominator will be the total number of Divisional Hospitals A&B in the country and the baseline is 214.
Frequency	Annual
Data source	PMCI/MOH routine data
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCI through the provincial authorities to t Planning Unit, MoH/PMU.
Responsibility for Data Collection	MoH (DDG, Medical Services)
Revision and adoption by MoH of the list of essential medicines for different levels of care (Text) ^{PBC}	
Description	This PBC reflects the intention of the MoH to revise the essential drug lists for different levels of care. The available essential drug list will be reviewed and thoroughly scrutinized by a panel of technical experts to identify the essential drugs commonly used at the PHC level. This process will include the deletion/omission of drugs as needed and the inclusion of necessary drugs in line with the expanded service package, with special provision to accommodate the back referral process. The PBC will consider the revision and endorsement of the drug lists following standard government processes.
Frequency	One time
Data source	MoH publications, currnet and revised drug lists
Methodology for	Review of documentation to ensure conformity with definition/description and ensure that it was endorsed



Data Collection	following appropriate government procedure.
Responsibility for Data Collection	MoH (DDG, Medical Supplies Division [MSD])
People receiving quality health, nutrition and population services (Number)	
Description	The description, methodology of measurement, baseline and end target will be filled at first ISR.
Frequency	
Data source	
Methodology for Data Collection	
Responsibility for Data Collection	
Strengthen the quality of clinical and person-centered care at PMCI	
Conduct annual clinical audits according to revised guidelines for improvement of quality and safety of healthcare institutions (Text)	
Description	This indicator will assess that clinical audits are conducted in accordance with the standards and guidelines provided in the revised National Guidelines for the Improvement of Quality and Safety of Healthcare Institutions.
Frequency	Annual
Data source	Routine PMCI/Quality Secretariat data
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCIs through the provincial authorities to the Quality Secretariat/MoH/PCMU
Responsibility for Data Collection	MoH (DDG Planning-Quality Secretariat)
PMCI conducting annual patient experience surveys using standardized tools. (Percentage)	
Description	The training modules will include Essential Service Package on NCDs, modules on geriatric care, mental health, palliative care, rehabilitative care, emergency preparedness at the primary care level, quality improvement, clinical audit, healthcare quality and safety, leadership and management, and basic principles family medicine). The training content may be revised as needed.
Frequency	Annual
Data source	MoH publications/project monitoring system
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCIs through the provincial authorities
Responsibility for Data Collection	MoH (DDG-Planning (Director ETR) /PCMU
Primary healthcare staff trained on integrated essential packages (NCDs, geriatric care, family medical care, mental health care, palliative care, and A&E services) (Percentage)	
Description	The training modules will include Essential Service Package on NCDs, modules on geriatric care, mental health, palliative care, rehabilitative care, emergency preparedness at the primary care level, quality improvement, clinical audit, healthcare quality and safety, leadership and management, and basic principles family medicine). The training content may be revised as needed.
Frequency	Annual
Data source	MoH publications/project monitoring system
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCIs through the provincial authorities
Responsibility for Data Collection	MoH (DDG-Planning (Director ETR) /PCMU
Annual National Continuous Professional Development programs implemented (Number)	
Description	The program should entail training and methodologies for improving knowledge and skills of primary health care staff, to support their continuous professional development. A minimum of 10 training programs should be held per year.



Frequency	Annual
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review of the content, coverage and frequency of training programs.
Responsibility for Data Collection	MoH, (Director, ETR) /PCMU
PMCI's using personal health records and implement referrals (Percentage)	
Description	This indicator refers to the unique identification of each patient and could be paper based or electronic. The denominator will be the total number of PMCI's in the country and the baseline is 50.
Frequency	Annually
Data source	MoH as reported by the provincial authorities
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCI's through the provincial authorities
Responsibility for Data Collection	MoH, DDG-Planning, DDG-NCD/PCMU
PMCI's equipped with solar power (Number)	
Description	The denominator will be the total number of Divisional Hospitals A&B in the country and the baseline is 214.
Frequency	Annually
Data source	MoH as reported by the provincial authorities
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCI's through the provincial authorities
Responsibility for Data Collection	MoH, DDG-MS/PCMU
Manual/ guidelines and SOPs for NCD screening, diagnosis, treatment and management, including referral and counter-referral pathways developed and endorsed by MoH (Text) ^{PBC}	
Description	The guidelines and SOPs should describe the related protocols in screening, diagnosis, and management in line with the available services and resources at PHC level.
Frequency	One time
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review of guidelines/SOPS to ensure conformity with the definition/description and ensure that it was endorsed following appropriate government procedure.
Responsibility for Data Collection	MoH – DDG, NCD/PMU
PMCI's implementing all three safe drug dispensing practices (Number) ^{PBC}	
Description	The indicator will assess the number of PMCI's adhering to all three drug safety practices: 1) labelling key information in all 3 languages, 2) segregation of looks-alike, sounds-alike medication at all levels of dispensing - drugstores, wards, pharmacies, and 3) separation and labelling of high alert medicines. The baseline is 0, and the end target is 825 PMCI's.
Frequency	Annual
Data source	MoH routine data, IVA (DPMM)
Methodology for Data Collection	The method will involve evaluate routine PMCI data and conduct field verifications to sampled PMCI's and do observations on the actual drug safety practices to check adherence with labeling and segregation of medication.
Responsibility for Data Collection	MoH (DDG medical services) and IVA (DPMM)
Strengthen health promotion, community empowerment and citizen engagement	
PMCI's with active Friends of Facilities committees (Percentage)	
Description	Active community engagement committees refer to "Friends of the Facility" committees with minutes of having met at least 3 times in the previous year. The denominator will be the total number of PMCI's in the country and the baseline is 50.
Frequency	Annual
Data source	MoH as reported by PMCI's/provincial authorities



Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCs through the provincial authorities
Responsibility for Data Collection	MoH, DDG-PHS (Director, Health Promotion Bureau) /PCMU
People (disaggregated by male/female) who obtained services from Mithuru Piyasa centers at the national level (Number)	
Description	This will include all people (disaggregated by male and female) who have obtained services from all Mithuru Piyasa centers in the country, including Divisional A&B Hospitals (encouraged to disaggregate by level of service provision).
Frequency	Annual
Data source	MoH through Director, Family Health Bureau and provincial authorities
Methodology for Data Collection	A checklist will be prepared, and routine reporting will be done by the PMCs through the provincial authorities
Responsibility for Data Collection	MoH, DDG-PHS (Director, Family Health Bureau) /PCMU
Comprehensive social and behavioral change communications strategy updated and implemented (Text)	
Description	The strategy should entail the key areas and methodologies in line with the extended primary care service package and should focus on key principles of people centered, integrated primary care.
Frequency	One time
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review of strategy availability and application
Responsibility for Data Collection	MoH (Director Health Promotion Bureau)/PCMU
Develop district-level guidelines for multi-sectoral NCD action plan (Text)	
Description	This indicator intends to facilitate better integration and improved coordination between the multiple stakeholders involved in NCD control and management at the district level.
Frequency	One time
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review action plan availability and application
Responsibility for Data Collection	MoH, DDG-Planning, DDG-NCD/PCMU
Project management and monitoring and evaluation	
Revise guidelines/ strategies for citizen engagement/GRM (Text)	
Description	The updated strategy/guidelines should be in line with the extended primary care service package.
Frequency	Annual
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review of revised strategy availability and application
Responsibility for Data Collection	MoH, Additional Secretary Medical Services/PCMU
Conduct population based demand-side survey to assess prevalence, risk factors, diagnosis, treatment, and effective management of NCDs (Number)	
Description	This survey should capture the prevalence of NCD risk factors and the level of diagnosis, treatment and management of health conditions.
Frequency	One time
Data source	MoH publications/project monitoring system
Methodology for Data Collection	Review of survey process and results
Responsibility for Data Collection	MoH, DDG-Planning, DDG-NCD/PCMU



Implementation of the e-procurement system for national level procurement activities (Text)	
Description	<p>This indicator has three sub-indicators:</p> <p>Sub-indicator 1: The MoH has issued an internal circular mandating the use of e-procurement for procurement under its purview. (Year 1)</p> <p>Sub-indicator 2: The project's procurement activities are managed through an e-procurement system (accounting for 50% of contracts executed through the Project by year 2 and 70% by year 4).</p> <p>Sub-indicator 3: Time saved in the procurement process for the project's activities by using the e-procurement</p> <p>Overall, this indicator aims to improve the supply chain management system and ensure a steady supply of medical supplies at PMCIs by reducing the duration of the procurement process. The e-GP system improves transparency by disseminating information about procurement opportunities and contract awards, accounting for at least 50% of procurement opportunities and 50% of contract awards in the Project.</p>
Frequency	Annual
Data source	<p>Data published by the MSD on the e-GP platform.</p> <p>Baseline will be defined from PSSP (P163721) data.</p>
Methodology for Data Collection	PSSP data before e-procurement implementation will set the efficiency baseline. Comparisons will be made using electronic procurement system data.
Responsibility for Data Collection	MoH (MSD) with the assistance from e-GP Secretariat

Verification Protocol: Performance Based Conditions

1: PMCIs meeting four out of five minimum capabilities (Number)	
Formula	<p>This scalable PBC would be costed at US\$54545.45 per increase in the cumulative number of PMCIs meeting the mandatory requirement of the minimum essential drug availability along with three out of the four remaining capabilities, beyond the baseline of 550 up to a total amount of US\$15 million for an end project target of 825 (80% of all 1031 PMCIs).</p> <p>Following the adoption of the revised list of essential medicines (see PBC 2), for PMCIs to have meet the minimum requirement for the availability of essential medicines, the revised and endorsed list of drugs is used to satisfy this condition by the end of year 5 of the project.</p>
Description	<p>This IR reflects the intention of each PMCI to meet the mandatory requirement of the minimum availability of essential drugs along with three out of the four remaining capabilities. These capabilities are expected to enhance PMCI capacity to provide comprehensive and quality primary healthcare services to the population they serve. These 5 minimum requirements are the following:</p> <ul style="list-style-type: none"> ○ Mandatory requirement – The PMCI has minimum availability of essential drugs ○ The PMCI has minimum number of health staff (at least two medical officers and one nursing officer) at any given time ○ The PMCI has minimum operational equipment according to defined requirements. ○ The PMCI has laboratory testing capacity (on-site or through a networked laboratory) ○ The PMCI has the capacity to provide acute emergency care (ETU facility)
Data source/ Agency	Reported by PMCIs (through provincial authorities) to MoH
Verification Entity	IVA (DPMM)
Procedure	The Data Quality Assessment Methodology will be used to assess reports from PMCIs (through provincial authorities) to the MoH. The sample taken would include both new/additional PMCIs as well as previously reported PMCIs, to indicate that facilities previously reported have been maintained. The sample frame would be designed to sample a sufficient number of PMCIs who have previously met the condition, and separately a



	sufficient number of PMCI that are assessed to have achieve the condition based on the above indicated methodology used by MoH.
2: Revision and adoption by MoH of the list of essential medicines for different levels of care (Text)	
Formula	This PBC is time-bound. US\$5 million can be disbursed if the revision and endorsement was completed no later than the end of year 3 of project implementation
Description	This time-bound PBC reflects the intention of the MoH to revise and endorse the essential drug lists for different levels of care. The revision will be done by a panel of technical experts who will review the current drug lists by adding/omitting drugs as needed and as appropriate for different levels of care. The PBC will consider the revision and endorsement of the drug lists following standard government processes.
Data source/ Agency	MoH publications
Verification Entity	IVA (DPMM)
3: Manual/ guidelines and SOPs for NCD screening, diagnosis, treatment and management, including referral and counter-referral pathways developed and endorsed by MoH (Text)	
Formula	This PBC is time-bound. Endorsement of the guidelines by MoH is to be accomplished by the end of the third year of project implementation. 100 percent of the PBC is unlocked upon timely endorsement. US\$5 million can be disbursed upon endorsement of guideline.
Description	<p>This PBC reflects the intention of the MoH to develop/revise guidelines and SOPs appropriate for use by PHC providers. The guidelines/SOPs should be evidence-based and follow good institutional practice, based on international practice but adapted for Sri Lankan conditions.</p> <p>The activity reflects that these protocols would be developed/revise and endorsed following standard government procedures that will be further described in the Project Operational Manual.</p> <p>Guidelines and SOPs would include:</p> <ul style="list-style-type: none"> ○ Risk stratification based on population risk factors, ○ Screening and diagnosis protocols, ○ Management protocols, ○ Referral protocols, and ○ Essential drug and diagnostic (equipment and lab test) requirements.
Data source/ Agency	MoH publications
Verification Entity	IVA (DPMM)
4. PMCI implementing all three safe drug dispensing practices (Number)	
Formula	US\$6,060.6 per additional PMCI implementing drug safety practices. Total PBC value is US\$5 million
Description	The indicator will assess the number of PMCI adhering to all three drug safety practices: 1) labelling key information in all 3 languages, 2) segregation of looks-alike, sounds-alike medication at all levels of dispensing - drugstores, wards, pharmacies, and 3) separation and labelling of high alert medicines. The baseline is 0, and the end target is 825 PMCI.
Data source/ Agency	MoH routine data
Verification Entity	IVA (DPMM)
Procedure	The IVA will evaluate routine PMCI data and conduct field verifications to sampled PMCI and do observations on the actual drug safety practices to check adherence with labeling and segregation of medication.

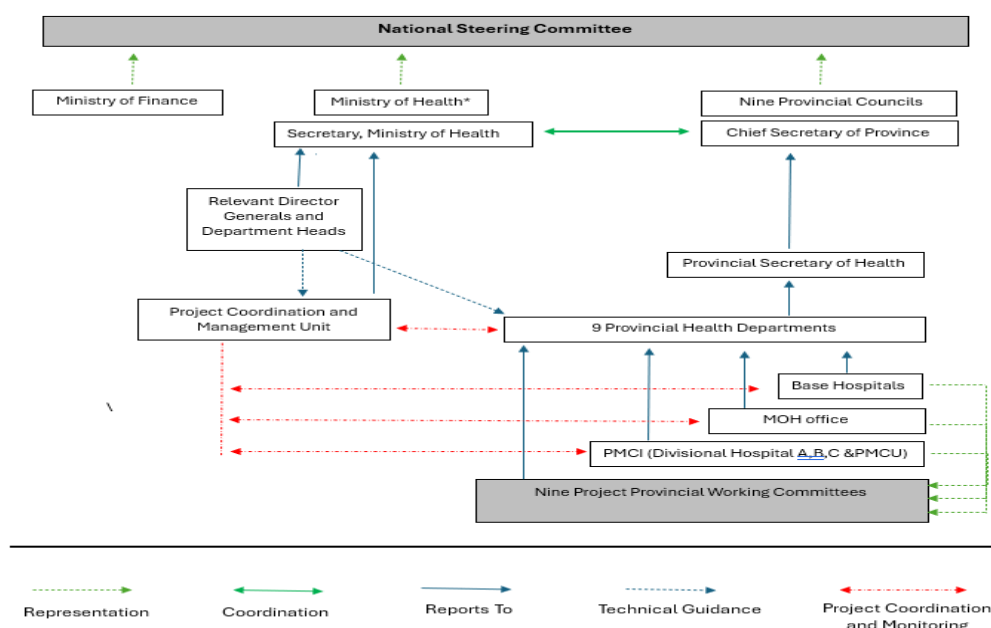


ANNEX 1: Implementation Arrangements and Support Plan

A. INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

1. **The PCMU anchored at the MoH will implement the Project under the oversight of the MoH and the NSC.** PCMU will consist of the following key positions: Project Director (who reports to the Secretary, Ministry of Health, and Director General for Health Services), Deputy Project Director, Project Officers, Procurement Specialists, FM Specialists, Accountants, MoH Internal Auditor, M&E Officers, Communications and Information and Communication Technology Officers, Environment and Social officer, with other relevant administrative and technical support staff. The Project management structure may be enhanced by incorporating specific provincial and regional personnel due to the significant transformation within the health sector facilitated by the Project. This expansion accounts for the increased duties in coordination and reporting on the Project's performance. Specific job descriptions and responsibilities for each position will be established. The staffing structure will be based on effort required to manage the substantial stakeholder and technical risk and will be reviewed from time to time to ensure that it is consistent with the workload and requirements. The Project implementation arrangements are presented in Figure A.
2. **Implementation Support Plan:** Implementation support will include (a) biannual implementation support missions (ISMs), (b) technical meetings and field visits between the formal ISMs, (c) on-demand external technical expertise, (d) virtual communications platform, and (e) audit and FM reporting. The World Bank will make available health specialists and operational staff, including fiduciary, environmental and social specialist staff/consultants for ISMs, as well as on-demand technical/operational requests to provide implementation support to the PCMU. In addition, the World Bank will organize regular video conferences to discuss issues in real time and provide technical advice to address implementation issues. Finally, the World Bank will provide technical support for training and continuous stakeholder consultations and will monitor compliance with the ESMF and POM during ISMs.

Figure A. Project Implementation Arrangements



*The Ministry of Health is the focal agency for health reforms and the development of health policy and strategies, and is responsible for the national monitoring systems for health services.



B. DETAILED FINANCIAL MANAGEMENT ARRANGEMENTS

3. Expenditures under all components will be centralized and responsibility will rest with the FM staff of the proposed PCMU under MoH. No fund transfers would happen through the Project to the provinces.

Table A1: Financial Management Risks and Mitigation Measures

Risk	Mitigation Measure
Bank funded operation covering first time an intervention such as IPF PBC in health sector and a new PCMU proposed to be established under MoH	<ul style="list-style-type: none"> - FM arrangements have been designed taking into consideration the MoH's history of engagement in Bank operations and also building through their experience of implementing results-based operations and IPFs. - MoH has agreed that qualified, experienced staff, knowledgeable in financial management and preferably having prior experience handling World Bank or donor funded operations, will be deployed. Capacity building interventions and continuous handholding support for FM staff will be provided by the Bank. - The finance manager is expected to work on a full-time basis and provide guidance and direction to ensure that the FM arrangements are implemented to the satisfaction of the MoH and the World Bank. A dated covenant is included for the establishment of PCMU with suitable staff including the Finance Specialist. - A dated covenant is included to POM by PCMU including a chapter on FM arrangements
Funds provided to health sector being used for other purposes	<ul style="list-style-type: none"> - A ring-fenced arrangement both at MoF level and PCMU level is adopted by using dedicated DAs and LKR accounts. Continuous monitoring on the use of funds through IUFs submitted, internal audit reports, external audit reports and transactions reviews jointly carried out with procurement is embedded into project design. No funds transfer to other entities is contemplated.
Weak and less frequent coverage of internal audit	<ul style="list-style-type: none"> - An internal audit mechanism will be adopted by MoH soon after effectiveness. The internal audits will be conducted on a regular basis based on an internal audit plan. A dated covenant has been included for finalizing the mechanism and commencement of internal audit.

4. **Budgeting.** The PCMU will forecast the required resources to be budgeted for the Project and these forecasts will need to be incorporated in the overall MoH budget estimates. Separate budget codes (line items) as required and relevant, for components will be set up for the Project under the MoH. The PCMU can implement the activities under the Project by using the budgetary provision provided under foreign funds (finance code 12) as relevant. GoSL own funds that will fill in for counterpart funds (finance code 17) may also be provided based on request and requirements if any, to finance salary/salary top ups/allowance of regular government staff who may get assigned to PCMU to work for the Project.
5. **Fund flow and disbursement arrangements.** It is anticipated that two dedicated DAs will be opened for the project, which will be operated and managed by the PCMU. The DAs would be US\$ denominated, opened at Central Bank of Sri Lanka in the name of the Deputy Secretary to Treasury, with a unique sub ledger number. One DA (DA1) would be for parts operating on IPF PBC under components 1-2 and the other DA (DA2) would be for all other parts of components 1-2 and components 3-4. In case of expenditures under components 1 and 2, disbursement would be first made under withdrawal category 1 and then under withdrawal category 2 under Credit A. Withdrawal category 2 under Credit A would be disbursed first before commencement of disbursement under withdrawal category 2 of IDA



Credit B-SML. The World Bank will remit advances into the DAs equivalent to projected expenditures for a six-month period. Two separate LKR accounts linked to DAs, may also be opened for the respective parts of components to cover local currency expenditures. Disbursement of funds from Bank will be report based using IUFRs. The PCMU will submit quarterly IUFRs to the World Bank within 45 days of the end of each period. There will be two IUFRs required to be prepared and submitted to the World Bank by the PCMU, one each for expenditures incurred on account of IPF PBC parts of component 1-2 and for rest of expenditures incurred on account of parts of components 1-4. Both IUFRs will track actual expenditures incurred in the form of goods, works, consultancies, non-consultancies, training, operating costs, and incremental operating costs. The format of IUFRs has been agreed and is attached to the Disbursement and Financial Information Letter. Withdrawal applications will be prepared by the PCMU and replenishments to the DA will be based on the IUFRs approved by the World Bank.

6. **The overall eligible expenditures** that the Bank will finance has been determined for the parts of components operating under IPF PBC as follows: (a) goods; (b) consultancies and non-consulting services (c) civil works; (d) training; and (e) operating costs. The rest of the parts under components 1 and 2 as well as components 3 and 4 that are operating under a traditional IPF approach will finance expenditures such as goods, consultancy services, non-consultancy services, training and incremental operating costs that will be including for Project management and institutional strengthening.
7. **Accounting policies and procedures.** Accounting practices of the project will be governed by the Government Financial Regulations, applicable circulars, and manuals. The approval and authorization controls are in place and properly documented. The FM staff in the PCMU will coordinate closely with technical staff at MoH, provincial councils and PDHS, to ensure that a systematic verification of invoices is carried out before payment. PCMU will maintain separate sets of accounts for the project and records, registers as applicable. Expenditures will be separately tracked under components and subcomponents, and GoSL accounting and reporting systems are considered acceptable and reliable.
8. **Internal audit.** Currently the internal audit units of GoSL, including MoH, are operating with significant staffing constraints that limits their coverage of projects and other special requirements. Accordingly, it is agreed that for Project, the internal audit will be carried out by either MoH internal audit unit or an internal auditor hired specifically for the Project as per Management Audit circular 02/2016. This will be finalized during early implementation, and commencement of internal audit is expected within one year of effectiveness.
9. **External audit.** The annual external audit of the project financial statements will be carried out by the NAOSL and the audit reports along with the Management Letter (ML) will be submitted by the PCMU to the World Bank within six months after the end of the financial year.

Table A2. Audit Reports

Implementing Agency	Audit Report	Auditor	Date
PCMU at MoH - component 1-2 for IPF PBC part	Annual project financial statements and ML	NAOSL	June 30 each year
PCMU at MoH – other parts of component 1-4	Annual project financial statements and ML	NAOSL	June 30 each year

C. DETAILED PROCUREMENT ARRANGEMENTS

10. **Risk Assessment:** The more recent involvements within the sector, including both the ERHSP and PSSP facilitated by the World Bank, encountered challenges in sourcing supplies, notably within the pharmaceutical sector, attributed to its specialized nature and the operational constraints experienced during the pandemic and concurrent financial crisis. Procurements within the health sector have revealed specific obstacles in fulfilling fiduciary responsibilities, primarily



centered around governance. The mitigation measures recommended for the Project are formulated by considering insights gained from previous operations, and these have been incorporated into the Project's procurement strategy. A summary of the risks and their corresponding mitigation measures is provided below.

Risks	Proposed Mitigation Measures
Staff turnover and heavy caseload limit central procurement oversight and capacity, exacerbated by a lengthy internal procurement review and approval process.	The portfolio's issues can be resolved by implementing project protocols, enhancing HR through procurement staff, and ensuring consistent oversight and compliance with procurement procedures with the Bank procurement team.
Provincial levels struggle with procurement procedures due to limited capacity, resources, and oversight, leading to difficulties in IA and provincial coordination regarding the completion of procurements.	All procurement processes will be centralized and processed by the IA. Contract management will be exclusively the responsibility of the provincial level; Ensure that all procurement processes for the provinces include provincial representation.
A politically contentious environment specifically at the Ministry due to the recent developments that will almost certainly hinder the project procurement procedure and decision-making will be decelerated.	Full fledge project team to be established by Effectiveness to ensure that key procurement staffing positions are in place with authority levels clearly documented and staff informed of Bank's procurement procedures.
Inadequate forecasting, prolonged procurement lead times, lack of strategic planning, limited market influence, and minimal use of framework agreements and economies of scale lead to inefficiencies in procurement, frequent emergencies, supply shortages, and higher prices.	Enhance procurement lead times by implementing process automation where possible, enhancing coordination and streamlining workflows. Actively interact with suppliers to gain insights into the market and guarantee a consistent supply chain. Implement the e-procurement system once it becomes operational to ensure a more centralized and transparent processes and real-time data sharing.
Procedural setbacks resulting from the slow delivery of technical inputs required to commence the procurement process.	Technical decisions must be scheduled so as not to compromise the procurement process's efficiency and quality.
Due to insufficient application of STEP, activities were marked as delayed or pending implementation in the previous operations. Contract delays and/or non-completion due to insufficient capacity for contract management.	IA will designate staff for STEP, arrange training, process activities, upload documentation, and use Contract Management Module in the STEP for effective monitoring and timely completion of milestones.
Delayed contract awarding, finalization of PPs and evaluations due to inefficient planning and a lack of technological support in monitoring and contract administration.	Implement STEP procurement planning, adopt e-procurement system, streamline contract evaluation and awarding, and establish physical monitoring for contract efficacy.
Governance-related risks. Managing noncompliance, corruption, and fraud.	IA will conduct ex-ante due diligence on shortlisted firms before awards against the internal databases and World Bank's recommended sanctions lists through STEP. World Bank will conduct post-review of contracts at regular intervals and joint fiduciary audits to prevent recurrence of errors during implementation.

11. Procurement context by country: The Procurement Guidelines and Manuals that regulate public procurement in Sri Lanka are published by the Department of Public Finance in addition to the Financial Regulations. This encompasses the procurement of goods, work, and services in its entirety. The Guidelines exhibit a positive comparison to both the



Model Procurement Law of the United Nations Commission on International Trade Law and international best practices. The Twenty-First Amendment reinstated the National Procurement Commission, which the Twentieth Amendment had abolished to promote excellence in public sector procurements and good governance. Bids are solicited using Standard Bidding Documents issued by the previous National Procurement Agency for Goods, Non-consulting Services, and Works based on CIDA documents. Regarding public procurement, the essential contract law contains no explicit provisions. Public procurement in the country is governed exclusively by the Financial Regulations and the Guidelines; no other legislation falls under this purview.

12. **National procurement conditions:** In accordance with paragraph 5.3 of the Procurement Regulations, when approaching the national market (as specified in the PP tables in STEP), the country's own procurement procedures may be used. All Consultancy Services shall be procured following Procurement Regulations and World Bank's Standard Procurement Documents (SPDs). When the Borrower uses its own national open competitive procurement arrangements as set forth in the GoSL Procurement Guidelines, such arrangements shall be subject to paragraph 5.4 of the Procurement Regulations and the following conditions: "In accordance with paragraph 5.3 of the Procurement Regulations, the request for bids/request for proposals document shall require that Bidders/Proposers submitting Bids/Proposals present a signed acceptance at the time of bidding, to be incorporated in any resulting contracts, confirming application of, and compliance with, the World Bank's Anti-Corruption Guidelines, including without limitation the World Bank's right to sanction and the World Bank's inspection and audit rights." Further shall be subject to following conditions when applying national procurement procedures: (a) only bidding documents acceptable to the Bank shall be used for all national open competitive procurement; (b) the request for bids/request for proposals document shall require that bidders/proposers submitting bids/proposals present a signed acceptance at the time of bidding, to be incorporated in any resulting contracts, confirming application of, and compliance with, the Bank's Anti-Corruption Guidelines, including without limitation the Bank's right to sanction and the Bank's inspection and audit rights; and (c) the eligibility of bidders shall be as defined under Section III of the World Bank Procurement Regulations for IPF Borrowers (Procurement Regulations). In case of any inconsistency between the procurement arrangements based on GoSL Procurement Guidelines and the World Bank's Procurement Regulations, the latter shall prevail.
13. **Procurement thresholds:** The PP shall set forth those contracts which shall be subject to the Bank's prior review. All other contracts shall be subject to post review by the Bank. The procurement method and prior review thresholds that are associated with the "Substantial" risk are outlined in the Procurement chapter of the Project Operations Manual.
14. **Selection methods for procurement of goods, works, non-consulting services and consulting services:** Unless otherwise specified in the PP, the Request for Bids (Open-International) method may be utilized to acquire all procurements. The PP may, under the Bank's Procurement Regulations, specify alternative methods of selection, market approaches, and arrangements. In a similar fashion, the agreed PP will specify the contract type and selection methods, the market approach (international/national, open/limited/direct), for each consultant selection following the Bank's Procurement Regulations.
15. **Standard Procurement Documents (SPDs):** World Bank's SPDs shall be used for all contracts subject to international competitive procurement and those contracts specified in the STEP.
16. **Summary of the PPSD:** The PPSD comprises high number of relatively moderate-value, straightforward goods procurements, along with a few minor works procurements involving small-scale renovations and enhancements at Provincial institutes, a limited number of non-consulting services as well as less complex consulting services, including those associated with the PBCs. Component 1 primarily entails the procurement of locally sourceable items such as medical supplies, essential medical equipment for primary and geriatric care, small-scale infrastructure, solar energy systems with battery backups, waste disposal systems at PMCIs, bolstering of ETUs at PMCIs, telemedicine-related procurements, mobility enhancements, and improvements to youth centers. The initial 18-month PP allocates



approximately US\$39 million for these activities. Components 2, 3, and 4, with a combined allocation of approximately US\$4.5 million, anticipate a blend of goods, works, non-consulting, and consulting services, primarily comprising low-risk, small-scale items. The consulting services encompass individual consultancies, primarily geared towards furnishing TA and capacity building to achieve PBCs under Components 2 and 4. Given the presence of local firms capable of delivering services relevant to these consultancies, a national approach is warranted for procuring these packages. A comprehensive summary of the activities outlined in the PPSD is provided in the Procurement chapter of the Project Operations Manual.

17. **Solar procurement:** The Project aims to develop solar energy systems with battery backups for PMCIIs. To reduce forced labor risks, the Bank requires bidders to provide two declarations: a Forced Labor Performance Declaration and a Forced Labor Declaration. The IA will also include enhanced language on forced labor in procurement contracts. Primary suppliers must identify and remedy any forced labor risks under Environmental and Social Standard 2 (ESS2), and if necessary, shift to suppliers meeting ESS2 requirements. A specimen bidding document and contract agreement will be agreed with the World Bank.