INTEGRATED, INNOVATIVE & QUALITY PRIMARY HEALTHCARE REFORMS IN SRI LANKA 2024

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PRIMARY HEALTHCARE SYSTEM ENHANCING PROJECT 2024-2028

DIRECTORATE OF PLANNING – MANAGEMENT, DEVELOPMENT, AND PLANNING UNIT

MINISTRY OF HEALTH - 2024

Integrated, Innovative & Quality Primary Healthcare Reforms 2024

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Primary Healthcare System Enhancing Project 2024-2028

Directorate of Planning

Management, Development & Planning Unit

2024

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Integrated, Innovative & Quality Primary Healthcare Reforms 2024

BACKGROUND

Under the healthcare reforms in Sri Lanka, the Primary Healthcare Reforms 2024 constitute one of the essential components of the nation's healthcare system. These reforms aim to provide people-centered, innovative, and high-quality integrated primary healthcare services to achieve Universal Health Coverage (UHC). Primary care includes Primary Medical Care Units (PMCU) and Divisional Hospitals categorized as types A, B, and C. Collectively, these institutions are known as Primary Medical Care Institutions (PMCI). Sri Lanka currently has a total of 1,061 PMCIs.

As part of the Primary Healthcare Reforms 2024, one or two type A or B Divisional Hospitals in each district will be upgraded to Base Hospital C. Base Hospital C will include all facilities available in Divisional Hospital A, with a special focus on geriatrics, palliative care, and internal medicine services. This includes separate bed facilities for geriatric and palliative patients.

The World Health Organization defines primary healthcare as a whole-of-society approach to health that focuses on people's needs at the earliest possible stage—covering health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care—delivered as close as possible to individuals' daily environments. This strategy ensures that healthcare is delivered in a way that centers on people’s needs and respects their preferences. It should provide high-quality, person- and family-centered primary healthcare built on safety, accessibility, and continuous relationships.

Universal Health Coverage (UHC) ensures that all individuals have access to and receive the quality healthcare services they need without incurring financial hardship due to healthcare costs. UHC includes a full range of essential health services, spanning health promotion, prevention, treatment, rehabilitation, and palliative care. Primary healthcare is central to achieving high-quality universal health coverage.

Integrated care is defined as care that is coordinated across all professionals, facilities, and support systems. Innovation addresses the need for solutions to healthcare challenges, bringing significant benefits to one or more groups and introducing new approaches within the framework of reforms. Integrated primary care combines medical and behavioral sciences to

comprehensively address the spectrum of problems patients present at primary medical care facilities.

The integration of public health into primary care encompasses a wide range of activities, including health promotion, health education, prevention, chronic disease management, screening, immunization, communicable disease control, information systems development, implementation of best practice guidelines and care packages, need assessments, quality assurance, monitoring and evaluation, professional development, and community engagement. Such integration ensures individualized care and system efficiency.

Primary healthcare systems should be interconnected with secondary and tertiary hospitals through referral services to enhance system efficiency. Population empanelment has been carried out by assigning each person to a PMCU based on travel time and distance, as outlined in General Circular No: 01-01/2022 dated 03-02-2022 on Population Empanelment for Delivery of Primary Healthcare to Achieve Universal Health Coverage.

The implementation of shared care clusters at the district level, as described in Circular No: 01-06/2019, and the reorganization and strengthening of the primary care service delivery system (Circular No: 01-18/2019) further bolster the primary healthcare system. Circular No: 01-18/2019 emphasizes assigning the empaneled population in each Grama Niladhari division to the nearest PMCI and identifying referral institutions for every PMCI country. Currently, each primary healthcare unit typically serves an empaneled population of 10,000–15,000 individuals and it can be reduced the empaneled population in the future.

Additionally, a letter issued by the Director General of Health Services (DGHS) on the supervision and coordination of clusters established under HSEP (Letter No: HP/HPC/01/2019, dated 21st March 2019) complements this process. This initiative has been further supported by the development of guidelines for the utilization of primary healthcare services.

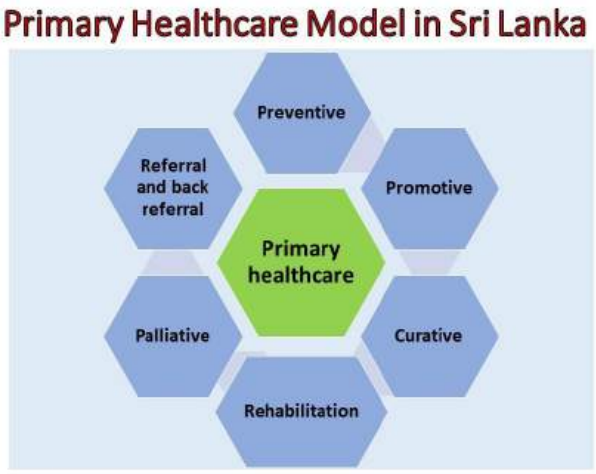

Figure 1: Main Components at Primary Healthcare

Sri Lanka has streamlined the UHC process by developing the Policy on Healthcare Delivery for UHC in 2018. It focuses on many strategies to achieve UHC. The following picture shows the strategies described under the UHC policy.

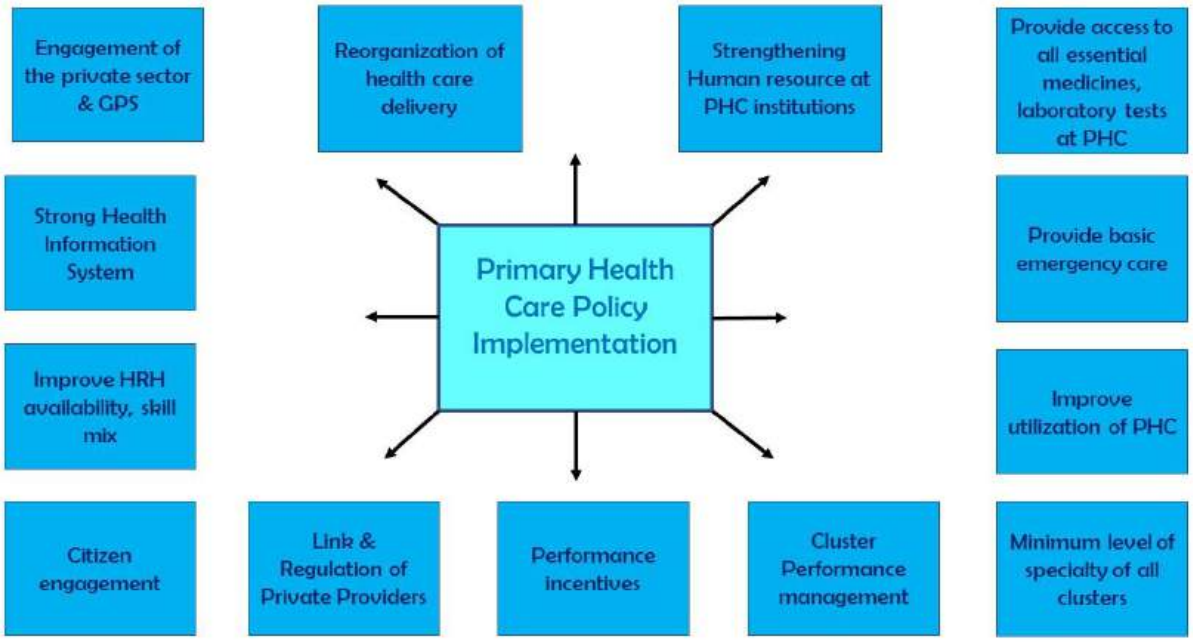

Figure 2: Strategies of the Universal Healthcare Policy

The action framework for the implementation of the UHC policy was developed as a policy implementation tool for a five-year period (2018–2024). The Ministry of Health (MoH) is responsible for closely monitoring the implementation status of the policy's action framework, with responsibilities assigned to different sections. In 2019, the Sri Lanka Essential Health Services

Package (SLESP) was published, outlining the comprehensive range of services to be provided at each level.

For specific details regarding the services offered by PMCUs, please refer to:

http://www.previousmoh.health.gov.lk/moh_final/english/public/elfinder/files/publications/2020/SLESP2019.pdf

The required infrastructure is essential for primary healthcare service delivery, as it determines how inputs are combined to facilitate the delivery of a series of interventions or health actions. Please refer to the Physical Space Norms for Primary Healthcare Facilities established under the HSEP (**Circular Number 01-29/2018**).

ROLES OF PRIMARY HEALTHCARE INSTITUTIONS:

1. **First Contact Care:**
    - Acts as the initial access point for individuals seeking healthcare services.
    - Facilitates prevention, early diagnosis, treatment, and management of health conditions, reducing the need for specialized and emergency services.
    - Provides continuity of care, building long-term patient-provider relationships that are central to effective health management.
2. **Comprehensive and Integrated Care:**
    - Offers a broad range of services, including preventive, curative, rehabilitative, and palliative care.
    - Addresses both physical and mental health needs.
    - Integrates care across various levels of the healthcare system (e.g., coordination with secondary and tertiary care, social services, and public health).

3. **Health Promotion and Disease Prevention:**
    - Focuses on promoting healthy lifestyles through education, promoting mental wellbeing, and counseling.

- Implements screening and early detection programs for chronic diseases (e.g., diabetes, hypertension, cancer).
- Facilitates community-based health initiatives such as vaccination and nutritional programs.
- Primordial prevention and Screening for nationally identified diseases according to the target groups

4. **Patient-Centered Care:**
    - Respect the preferences, needs, and values of individuals and families.
    - Encourages shared decision-making, promoting patient autonomy and engagement in their health.
    - Supports self-management of chronic conditions, enhancing patients' ability to maintain their well-being.
5. **Community Health and Social Determinants of Health:**
    - Recognizes and addresses social, economic, and environmental factors that affect health, such as housing, education, employment, and nutrition.
    - Engages with communities to identify local health issues and collaborate on solutions.
    - Promotes equity by tailoring interventions to meet the needs of vulnerable or marginalized groups.
    - Encourage community participation through hospital development committees.
6. **Accessibility and Affordability:**
    - Ensures that healthcare services are accessible, affordable, and available to all, regardless of socioeconomic status.
    - Reduces barriers to healthcare (e.g., financial, geographical, cultural) to achieve universal health coverage.
    - Provides services in a culturally competent manner that respects the community's diversity.
7. **Continuity and Coordination of Care:**

- Coordinates with specialists, hospitals, and other healthcare providers to ensure seamless transitions in patient care.
- Monitors and follows up on patients, ensuring that treatments are effective and health outcomes are optimized.
- Manages referrals and communication across the healthcare system to prevent fragmentation of care.

8. **Response to Public Health Challenges:**
    - Plays a critical role in managing public health emergencies, such as outbreaks, epidemics, and pandemics.
    - Acts as a platform for disseminating public health information and mobilizing community resources.
    - Supports resilience by adapting to changing health needs, such as aging populations or new health threats.

The Sri Lankan healthcare sector is facing several major challenges due to demographic changes, increase Non-Communicable Diseases, some stagnant Sustainable Development Goal indicators, insufficient achievement of the Universal Healthcare Index (UHI- 67 in the year 2023), increased out-of-pocket health expenditures as well as higher demands and expectations from well-informed citizens. The primary healthcare sector in Sri Lanka also faces the same challenges that impact its effectiveness.

These challenges are multifaceted, encompassing human resources, infrastructure, policy, and social determinants of health. Further to that human resource constraints, geographical and regional disparities, infrastructure and resource limitations, the lack of integration between different levels of care (primary, secondary, and tertiary) and between public and private healthcare providers result in inefficiencies and delays in treatment. The lack of Robust Health Information systems to track patient records, disease surveillance, and service utilization, and insufficient linking of PMCIs with cluster hospitals hampers planning and decision-making in PMCI level.

These challenges were further exacerbated by the COVID pandemic and economic crisis

which disrupted supply chain management and laboratory networking. Consequently, there has been underutilization of inpatient facilities in Primary Healthcare Institutions, overburdening of secondary and tertiary hospitals with non-specialized care, insufficient follow-up of referral cases, loss of follow-up in referral cases, and inadequate control of hypertension and diabetes in the community. Additionally, the healthcare system faces issues such as poor quality in supply chain management, a lack of geriatric, palliative, and rehabilitation services at the primary healthcare level, and an overall insufficient delivery of quality healthcare services.

The assessment of Sri Lanka's progress toward the Sustainable Development Goals shows limited improvement, further affected by ongoing economic challenges in the country.

In response, the Ministry of Health aims to develop a well-functioning and fully utilized primary healthcare system supported by trained and motivated health workers, well-maintained infrastructure, and a reliable supply of medicines and technologies. This effort is backed by adequate funding, strong health plans, evidence-based policies and care packages, and continuous monitoring and evaluation under the Primary Healthcare Reforms initiative. The goal is to maintain the quality of healthcare services and improve the Universal Health Coverage Index in Sri Lanka.

The reorganization effort includes upgrading PMCUs to model PMCUs that meet minimum standards for delivering the Sri Lanka Essential Health Services Package (SLESP). This involves fulfilling human resource requirements, developing policies and protocols for PMCUs, establishing personal health records and information management systems, creating a laboratory network, ensuring the availability of essential drugs, and improving citizen engagement.

KEY COMPONENTS OF HEALTH PROMOTION IN PRIMARY HEALTHCARE INSTITUTIONS:

Preventive Services:

- Conduct routine screenings for conditions such as hypertension, diabetes, cancer, and mental health disorders.
- Implement immunization programs for children and adults to prevent infectious diseases.

- Provide health education on topics such as nutrition, exercise, smoking cessation, and the harmful use of alcohol.
- Promote health at the primary healthcare level by preventing diseases, enhancing healthy behaviors, and creating supportive environments for good health practices. This includes addressing the underlying social, environmental, and behavioral determinants of health.
- Focus on screening and early identification of other diseases.

2. Patient and Community Education:

- Offer information and resources to help individuals maintain healthy lifestyles.
- Promote understanding of chronic disease management and the importance of adhering to treatment plans.
- Conduct community workshops on topics such as maternal health, breastfeeding, sexual health, and safe water practices.

1. **Behavioral Interventions:**

- Provide counseling services to encourage healthy behaviors.
- Address risk factors like sedentary lifestyles, poor diet, and substance abuse.
- Facilitate support groups for mental health and chronic disease management.

2. **Environmental Health Initiatives:**

- Collaborating with local authorities to ensure safe living conditions.
- Promote clean water, sanitation, and waste management in communities.
- Create supportive environments like smoke-free zones and safe recreational spaces.
- Ensure proper waste disposal facilities

3. **Community Engagement and Empowerment:**

- Involve community members in identifying health priorities.
- Build capacity through training local health workers.
- Encourage participation in health planning and decision-making processes.

4. **Integrated Care Approach:**
    - Coordinate care across different health services (e.g., linking primary care with specialized services).
    - Implement stranded laboratory testing packages for screening and treatable conditions at the level of primary healthcare and links to higher levels of hospitals for specialized care.
    - Empaneling the population and clustering the hospitals
5. **Monitoring and evaluation of institutional data**
    - Generate evidence through institutional data analysis and use it to design effective local interventions.

In summary, PMCI services should adopt a patient-centered, comprehensive approach, serving as the foundation of a robust health system that contributes to overall health improvement, sustainability, and the achievement of universal health coverage.

ADVANTAGES OF PRIMARY HEALTHCARE INSTITUTIONS AFTER REORGANIZATION:

1. **Improved Health Outcomes:**
    - Early diagnosis, treatment, and management of diseases help reduce morbidity and mortality.
    - Preventive care, including vaccinations and screenings, lowers the risk of severe health conditions.
    - Comprehensive management of chronic diseases reduces complications and improves quality of life.
2. **Cost-Effectiveness:**
    - PMCI focuses on prevention and early intervention, reducing the need for expensive hospitalizations and specialized treatments.
    - Decreases the overall healthcare expenditure for individuals and health systems.
    - Promotes rational use of resources, optimizing healthcare spending.

3. **Enhanced Accessibility:**

    - Primary healthcare services are often closer to where people live and work, making them more accessible.
    - Reduces geographical, financial, and cultural barriers to healthcare.
    - Ensures that underserved and rural communities have access to essential health services.

4. **Continuity of Care:**

    - Establishes long-term relationships between patients and healthcare providers.
    - Facilitates comprehensive care throughout different life stages, from childhood to old age.
    - Provides consistent monitoring and follow-up, ensuring ongoing health management.

5. **Holistic and Person-Centered Approach:**

    - Addresses the whole person rather than just individual health issues.
    - Integrates physical, mental, and social health care, considering the broader determinants of health.
    - Encourages shared decision-making, aligning care with patient values and preferences.

6. **Better Coordination of Care:**

    - Acts as the central hub for coordinating care across various levels of the healthcare system.
    - Facilitates smooth referrals to specialized care when necessary.
    - Reduces fragmentation and duplication of services, improving efficiency and outcomes.

7. **Promotes Health Equity:**

- Focuses on delivering care that is fair, inclusive, and tailored to the needs of diverse populations.
- Addresses social determinants of health, such as housing, education, and nutrition.
- Reduces health disparities by providing equitable access to health services.

8. **Community Engagement and Empowerment:**

- Involves communities in health planning and decision-making.
- Promotes health literacy and self-care, empowering individuals to take charge of their health.
- Strengthens community resilience by building local capacity and addressing local health priorities.

9. **Enhanced Resilience to Health Crises:**

- Primary healthcare plays a critical role in managing public health emergencies, such as epidemics and pandemics.
- Serves as a platform for community education and mobilization during health crises.
- Adapts to changing health needs, providing a buffer during periods of increased health demand.

10. **Focus on Preventive and Health Promotion Services:**

- Prioritizes health education, lifestyle modification, and behavioral interventions.
- Implements community-wide health promotion campaigns, targeting smoking cessation, healthy eating, and physical activity.
- Reduces the incidence and prevalence of both communicable and non-communicable diseases.

OVERALL IMPACT EXPECT FROM THE PRIMARY HEALTHCARE REORGANIZATION:

Primary healthcare provides a strong foundation for an effective and sustainable healthcare system, leading to healthier populations, reduced healthcare costs, and improved health equity. By emphasizing preventive care, continuity, and accessibility, and ensuring that health systems are patient-centered, proactive, and resilient, primary healthcare can deliver people-centered, innovative, and quality integrated services to achieve Universal Health Coverage.

The services available at PMCUs :

PMCUs are expected to provide the following PHC services on an outpatient basis.

a) Outpatient care

b) Emergency care

c) Continuum of care (pre-organized referral system in place)

d) Rehabilitative care

e) Palliative care

f) Diagnostic services

g) Medical supplies

h) Prevention and management of communicable diseases

i) Prevention and management of Non-Communicable Diseases (NCDs)

j) Health promotion and community empowerment

k) Supportive care for maternal and child health

l) Conducting mobile care services

m) Disaster preparedness and response

n) Basic elderly healthcare services including palliative care

THE SERVICES AVAILABLE AT DIVISIONAL HOSPITALS:

Divisional Hospitals are expected to provide the following PHC services on an outpatient basis and in-ward basis:

a) Outpatient care

b) Emergency care

c) Continuum of care (pre-organized referral system in place)

d) Rehabilitative care

e) Palliative care

f) Diagnostic services

g) Medical supplies

h) Prevention and management of communicable diseases

i) Prevention and management of Non-Communicable Diseases (NCDs)

j) Health promotion and community empowerment

k) Supportive care for maternal and child health

l) Conducting mobile care services

m) Disaster preparedness and response

n) Basic elderly healthcare services including palliative care

o) In-ward patient care

All primary Healthcare Institutes should be a people-friendly community center and it should be accredited in the future. Further to that, Continuous education for the staff on standard care packages will improve the quality delivery of services through their greater investment with better achievement and reduce out-of-pocket expenditure.

Linking with the community by establishing “Suwa Mithro” or Hospital Development Committees is essential. The objective is to actively involve the community in delivering quality, culturally appropriate

healthcare services, in line with local needs and priorities, while balancing service delivery based on the people's needs.

All services should be included: effective, efficient, equitable care and integrated care with people-centered services. It should be linked to the cluster for necessary laboratory testing and further referrals when required.

ADMINISTRATION AND PLANNING FOR PMCI:

- All PMCIs are under the administration of the PDHS/RDHS and technical inputs are given by the line Ministry. National technical guidelines and care packages relevant to primary healthcare settings should be implemented under the administration of PDHS/RDHS. The planning unit and the quality unit attached to each RDHS unit should monitor and ensure the quality of each PMCI under the guidance of the PDHS/RDHS.

- The empaneled population should be identified and updated on a yearly basis, disaggregated by gender and age categories (below 5 years, adolescent and youth, adult, and elderly). Disease demographic data should be identified for the empaneled area, according to advice from the relevant technical Directorate of the MoH. All these data should be available at the RDHS level.

- All PMCUs should be operated according to the PHC manual issued by the MoH. All PMCUs Should provide OPD services during weekdays from 8 am to 4 pm, on Saturday from 8 am to 12 noon. PMCU are kept closed on Sundays unless directed by the relevant Regional Director of Health Services. OPD of Divisional hospitals should be open weeks days from 8 am to 12 noon & from 2 pm to 4.00 pm, on Saturdays from 8 am to -2 noon & on Sundays, and public holidays from 8. 00 am to 10 am. Divisional hospitals are open for admissions 24 hours.
- All services included in the Manual on Management of PMCUs and the Management of Divisional Hospitals, issued by the Ministry of Health should be provided in an integrated manner, and locally suitable innovative methods can be identified (E.g.: Healthy food choices demonstrations, Exercise sessions for the community, Open Gym Instructions for the community, Counselling sessions for adolescents and youth, alcohol and smoking session programmes, etc..)

- PMCIs should collaborate closely with the apex hospital and have a quarterly meeting chaired by Medical Superintendents of the apex hospital to improve the quality of referral and back referrals to overcome challenges and barriers for the referral system, data sharing, and laboratory services. Further to that, need to collaborate with Base Hospital C for Geriatric and palliative care.
- Accreditation of PMCI should be done in a phased-out manner after the establishment of the Patient Safety and Accreditation Bureau for the Ministry of Health
- PMCI Annual action plan should be developed and approval should be obtained by the RDHS /PDHS. Implementation should be done according to the approved plan. Monitoring of the Annual action plan should be done by the CCP/MO/Planning with the guidance of the RDHS.
- Clinical audits for commonly identified diseases and expanding of services should be done by the quality unit of the RDHS level with the supervision of the RDHS.
- Proper sewerage facilities and wastewater management systems should be available in each PMCI and free from environmental risk. Each PMCI should adopt Green building concepts that focus on energy efficiency, sustainability, and environmentally friendly concepts.
- Plan for obtaining a Schedule Waste Management License and Environmental Protection License for PMCI in a phased-out manner in each district.
- Utilize available guidelines and circulars issued by the relevant technical directorates (eg: Maternal and child health, Non-communicable diseases, communicable diseases, Gaeriatrics, rehabilitation, and palliative services, Good pharmacological practices, mental health, health promotional activities, Eye care, Mental Health, etc..)
- PDHS/RDHS can arrange some model centers for Telemedicine to improve treatment services in consultations with the Directorate of Health Information.
- Open Gym should be started in the PMCI where there is enough space. Utilization of the Open Gym should be encouraged through the hospital development committees.
- Link with the closest Medical officer of Health for health promotional activities and addressing vulnerable and risk populations.
- A Capacity building plan for different staff categories should be developed and all staff categories should undergo at least one training per year. All primary healthcare medical

officers and nurses should undergo common NCD and Communicable disease and accident and Emergency management training. (Some training can be included as a pre-appointment training). All RDHS &PDHS should be responsible for providing Professional capacity development training for staff of the PMCIs in different areas with the collaboration of technical directorates of the MoH.

- Provide for family healthcare approach for the empanel population and innovative methods can be adopted for improvement of the well-being of the people with community engagement
- Established Elderly-friendly, adolescent-friendly, people-friendly healthcare services in every PMCI.
- Arrange Staff well-being programmes with private-public partnerships
- Make sure availability of checklist for procedures (instrument, essential drugs, service components)
- Arrange annual validations of diagnostic instruments with the support of the RDHS and the help of the quality unit of the RDHS level.

DATA SHARING

- All PMCIS should submit required data to RDHS level. RDHS will share the data with the D/PHC and D/PHC will provide national, provincial, and district data to end user level (PMCIs) on a quarterly/ biannual basis. These data summaries should be presented to the provincial-level committees. All strengths, challenges, and barriers should be discussed, and make recommendations for improvement by the PDHS/RDHS.
- Monitoring checklists relevant to the PMCIs should be assessed by institutional level and it should be evaluated by each RDHS level
- Digital health Information systems should be developed in a phased-out manner, in consultation with the Director of health information.

Primary Healthcare Reorganization -2024 is supported by the World Bank's Primary Healthcare System Strengthening Project (2024 to 2028) in Sri Lanka.

PRIMARY HEALTHCARE SYSTEM ENHANCING PROJECT (2024 TO 2028) IN SRI LANKA, SUPPORTED BY THE WORLD BANK

PRIMARY HEALTHCARE SYSTEM ENHANCING PROJECT (2024- 2028)

Primary Healthcare reorganization will be supported by the Primary Healthcare System Enhancing Project (2014-n 2028) in Sri Lanka, funded by the World Bank. This aims to improve access and quality of primary health care services across all districts of Sri Lanka. The project, often funded by the World Bank, focuses on building a more equitable and efficient healthcare system that meets the needs of the population, especially vulnerable communities. Here are some key components and objectives of the project:

OBJECTIVES:

1. **Strengthen Primary Healthcare Services**: Improve the quality and accessibility of services at primary care institutions, ensuring people receive timely and effective care.
2. **Enhance Service Delivery**: Upgrade infrastructure, provide essential medical equipment, and ensure the availability of medicines at primary healthcare centers.
3. **Capacity Building**: Train healthcare staff, including doctors, nurses, and support staff, to enhance skills and provide better patient care.
4. **Health Information Systems**: Implement digital health records and systems for better tracking of patient data, resource management, and decision-making.
5. **Community Engagement and Health Promotion**: Promote community involvement in health planning and increase awareness about the benefits of primary healthcare

STRATEGIES:

1. **Empowering Primary Medical Care Institutions (PMCIs)**: Transforming PMCIs into well-resourced and functional centers that provide a comprehensive range of primary care services in an environment-resilient manner.
2. **Focus on Non-Communicable Diseases (NCDs)**: Addressing the growing burden of NCDs by improving screening, early diagnosis, and management through primary healthcare.
3. **Decentralized Service Provision**: Enabling better service delivery by delegating more responsibility to local health units and reducing reliance on secondary and tertiary care.
4. **Accident and emergency care: Providing** immediate and urgent medical attention to individuals suffering from acute illnesses, injuries, or life-threatening conditions by

stabilizing, life-saving interventions, triage and prioritization, pain management and symptom relief, diagnosis and treatment, referral when necessary

5. **Adress Communicable Diseases:** The aim of preventing and managing communicable diseases is to reduce the transmission, morbidity, and mortality associated with infectious diseases. This is achieved through a combination of public health strategies, medical interventions, and community engagement
6. **Public-Private Partnerships**: Encouraging collaborations with the private sector to expand healthcare access and resources.

EXPECTED OUTCOMES:

1. Improved health outcomes and reduced burden on tertiary healthcare institutions.
2. Higher patient satisfaction and trust in primary healthcare services.
3. Greater equity in health service delivery across different regions and demographics.
4. Strengthened capacity to manage and respond to public health challenges.

This project is part of a broader effort to build a resilient health system that can respond effectively to both routine health needs and public health emergencies in Sri Lanka to achieve Universal Health Coverage.

The total cost of PHSEP is US$ 170 million including the contribution of US$ 20 million (6,000 million LKR) by the Government of Sri Lanka for taxes and duties.

PROJECT COMPONENTS

(i) Increase availability of Primary Healthcare services at Primary Healthcare Institutions and Medical Officers of Health areas across all nine provinces of Sri Lanka

(ii) Strengthen the quality of clinical and person-centered care at PMCIs

(iii) Strengthen health promotion, community empowerment and citizen engagement and

(iv) Project Management and Monitoring and Evaluation

PERFORMANCE BASED CONDITIONS

This project is linked to the performance. The amount of US$ 30 million is linked to essential "performance-based conditions" which should fulfill separate quality improvement activities. Those are PMCIs meeting four out of five minimum capabilities, Revision and adoption by MoH of the list of essential medicines for different levels of care, Manuals/guidelines, and SOPs for NCD screening, diagnosis, treatment, and management, including referral and counter-referral pathways developed and endorsed by MoH and PMCIs implementing all three safe drug dispensing practices.

Finally, this will be a primary healthcare reform in Sri Lanka to improve utilization of primary healthcare services which provide comprehensive primary healthcare services to citizens of Sri Lanka and reduce out-of-pocket expenditure. This will expedite the achievement of universal healthcare coverage and achieving Sustainable Development Goals.

PERFORMANCE-BASED CONDITIONS (PBC) BY PROJECT COMPONENTS (THESE ARE LINKED TO 30 USD)

#	Component	PBC Focus Area	Problem Statement	PBC
PBC 1	1	Increased availability of minimum capabilities at PMCIs	To have the ability to provide minimum packages of care, it is critical that over time all PMCIs can ensure the availability of essential drugs along with other minimum capabilities at PMCIs level	PMCIs meet the mandatory requirement of ensuring the availability of essential drugs and three out of four remaining minimum capabilities
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 the list of essential medicines at different levels of care
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

PBC 4	2	Improved quality of care	Weakness in drug safety and pharmacovigilance at PMCIs	Number of PMCIs implementing all three safe drug dispensing practices

PRIMARY HEALTHCARE SYSTEM ENHANCING PROJECT (PHSEP)

(P181564) – YEAR 2024-2028

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
PMCIs 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 PMCIs 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 PMCIs and Medical Officer of Health offices					
PMCIs 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 (PMCIs 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
PMCIs 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
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
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 PMCIs					
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
PMCIs 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
PMCIs 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
PMCIs equipped with solar power (Number)					
Mar/2024	Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	0	0	100	200	250
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
PMCIs 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
Strengthen health promotion, community empowerment and citizen engagement					
PMCIs 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)
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
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
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)

PTO..

MONITORING & EVALUATION PLAN: PDO INDICATORS BY PHSEP DEVELOPMENT

Objective 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 Assessmnet 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	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: 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) The denominator will be the total number of PMCIs in the country.
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)

MONITORING & EVALUATION PLAN: INTERMEDIATE RESULTS INDICATORS BY COMPONENTS

Increase availability of comprehensive PHC services at PMCIs and Medical Officer of Health offices	
PMCIs 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 also the inclusion of necessary drugs in line with the expanded service package, with special provisions 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, current 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 (PMCIs 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 PMCIs through the provincial authorities to the Planning Unit, MoH/PCMU.
Responsibility for Data Collection	MoH (DDG, Laboratory Services)/PCMU
PMCIs with capacity to respond to pandemics and infectious disease outbreaks (Percentage)	
Description	The indicator refers to the percentage of PMCIs 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 PMCIs through the provincial authorities to the 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 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])
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 PMCIs	
Conduct annual clinical audits according to revised guidelines for the improvement of the quality and safety of healthcare institutions (Text)	
Description	This indicator will asses 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 Secratariat 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)
PMCIs conducting annual patient experience surveys using standardized tools. (Percentage)	
Description	The training modules will include the 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, converage and frequency of training programs.
Responsibility for Data Collection	MoH, (Director, ETR) /PCMU
PMCIs 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 PMCIs 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 PMCIs through the provincial authorities
Responsibility for Data Collection	MoH, DDG-Planning, DDG-NCD/PCMU
PMCIs 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 PMCIs 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
PMCIs implementing all three safe drug dispensing practices (Number) [PBC]	
Description	The indicator will assess the number of PMCIs 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 PMCIs.
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 PMCIs 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	
PMCIs 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 PMCIs in the country and the baseline is 50.
Frequency	Annual
Data source	MoH as reported by PMCIs/provincial authorities
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-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 PMCIs 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 prevelance 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	This indicator has three sub-indicators: Sub-indicator 1: The MoH has issued an internal circular mandating the use of e-procurement for procurement under its purview. (Year 1) 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). Sub-indicator 3: Time saved in the procurement process for the project's activities by using the e-procurement 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.
Frequency	Annual
Data source	Data published by the MSD on the e-GP platform. Baseline will be defined from PSSP (P163721) data.
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	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). Following the adoption of the revised list of essential medicines (see PBC 2), for PMCIs to 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.
Description	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's capacity to provide comprehensive and quality primary healthcare services to the population they serve. These 5 minimum requirements are the following: • Mandatory requirement – The PMCI has minimum availability of essential drugs • The PMCI has the 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 PMCIs that are assessed to have achieved 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 were 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 guidelines.
Description	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. The activity reflects that these protocols would be developed/revised and endorsed following standard government procedures that will be further described in the Project Operational Manual. Guidelines and SOPs would include: • 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. PMCIs 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 PMCIs 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 PMCIs.
Data source/ Agency	MoH routine data
Verification Entity	IVA (DPMM)
Procedure	The IVA will evaluate routine PMCI data and conduct field verifications to sampled PMCIs and do observations on the actual drug safety practices to check adherence with labeling and segregation of medication.

ANNEX -1 MAIN PROJECT ACTIVITIES

Department of National Planning has approved project funding for the undermentioned activities

1.1.1	Renovations of PMCI and provision of Daycare facilities for Elderly	2.1.9	Renovation of training centres including NIHS-equipment
1.1.2	Facilitation of Laboratory Networking and provision of IT Equipment	2.2.1	Procurement of US Scanners for early cancer detection centres
1.1.3	TA for Software Platform & Maintenance	2.1.8	Procurement of equipment required for training centers including NIHS-Equipments
1.1.4	Provision of Solar Panels	2.1.9	Renovations for training centers including NIHS-Civil work

1.1.5	Procurement of Bikes, Including e-bikes for sample transportation	2.2.1	Procurement of US Scanners for early cancer detection centres (Located in BHCs) (2 per district @3 Mn)
1.1.6	Procurement of Lorries (small) for transportation of clinical waste	2.2.2	Upgrading DHs as BHCs- Civil work
1.1.7	Refurbishment of existing wastewater treatment plants (Construction of Sewerage Seepage Beds and soakage pits)	2.2.3	Upgrading DHs as BHCs-Equipment
1.1.8	Strengthening field activities in Provinces	2.2.4	Structural Alterations for Palliative, Rehabilitative and Geriatric care
1.1.9	Ambulance Boat for Jaffna	2.2.5	Equipment for Palliative, Rehabilitative, and Geriatric care
1.1.10	Crew cab for reach to the difficult area for Puttalam	2.2.6	Equipment required for domiciliary care
1.1.11	Procurement of Dental Equipment	2.2.7	Equipment required for Communicable disease Management (Infusion pumps, Syringe pumps, Sucker machines, etc)
1.1.12	Renovations of Dental Clinics	2.3.1	Renovation of Regional and Provincial Drug stores
1.1.13	Renovation of Primary care unit in Ratnapura	2.3.2	Strengthening quality assurance system in Central/Provincial Units
1.2	Renovation of Staff Quarters	2.3.3	Strengthening Central/ Provincial Planning Units
1.3.1	Building jogging paths and exercise areas in 300 PMCI	2.3.4	Provision of water quality equipment for labs
1.3.2	Renovation of MOH offices	2.3.5	Procurement of pill dispensers for DH A/B/C/300 Nos)
1.3.3	Community Health centers at MOH offices (Mental Health and GBV)	2.3.6	Quality aspects are covered by Directorate of Quality and Safety
1.3.4	Community Health centers at MOH offices (Mental Health and GBV)-Equipment	2.3.7	Patient Culture Surveys
1.3.5	Provision of Motor Bikes for PHMM	2.3.8	Procurement of Lorries for transportation of medicine/drugs / pharmaceuticals (20nos x Rs 15Mn
1.3.6	Procurement of motor Bikes for PHNO	2.3.9	Provision of Forklifts for Drug stores (Eight
1.3.7	Procurement of motorbikes for PHI	2.3.10	Racks for drugs in PMCI
1.3.8	Procurement of Vital Sign Monitoring equipment	3.1.1	Social Behavioral Change Communication campaign for NCD risk factor reduction and promotion of services in PMCI
1.3.9	Procurement of Digital BP meters	3.2.1	FFC & Grievance redressal System
2.1.1	Training of NCD guidelines for MOs and Nos including Printing	4.1	PMU
2.1.2	Training on Palliative and rehabilitative care	4.2.1	Strengthening project monitoring capacity at the Central level and strengthening field activities (3 Double Cabs and three ten seater vehicles)
2.1.3	Training on Phrmaco vigilance for Dispensers and Pharmacist including Printing	4.2.2	Project monitoring activities by Central Monitoring Team, including field visits
2.1.4	Training on Quality Management for regional Quality Units	4.2.3	National-level monitoring of Project progress at the Department of Project Management and Monitoring (DPMM) of the Ministry of Finance (MoF)-covered under 1.1.2 and 1.1.3
2.1.5	CPD points		

2.1.7	2 Buses for training centers		
2.1.8	Renovation of training centres including NIHS Civil work		