Program Implementation Document

INTERNAL

Project Number: 58017-001
Loan and Grant Numbers: LXXXX
August 2025

Democratic Socialist Republic of Sri Lanka: Strengthening Integrated Health Care and Governance for Universal Health Coverage Program

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PURPOSE OF THE PROGRAM IMPLEMENTATION DOCUMENT

The developing member country is wholly responsible for implementing the program supported by results-based lending. Asian Development Bank Staff support the results-based lending program design and implementation.

The program implementation document consolidates the essential program implementation information. It is a management tool that supports effective program implementation, monitoring, and reporting. It is developed throughout program processing and should be discussed with the developing member country at loan negotiations. It is a living document that should be refined and kept up-to-date during program implementation.

ABBREVIATIONS

ADB	=	Asian Development Bank
COVID-19	=	corona virus disease
CPD	=	continuous professional development
DLI	=	disbursement-linked indicator
DMC	=	developing member country
DPMM	=	Department of Project Management and Monitoring
E&S	=	environmental and social
EPL	=	environment protection license
FHB	=	Family Health Bureau
IEC	=	International Electrotechnical Commission
ISO	=	International Organization for Standardization (ISO)
IVA	=	independent verification agency
M&E	=	monitoring and evaluation
MOHMM	=	Ministry of Health and Mass Media
MOU	=	memorandum of understanding
MRI	=	Medical Research Institute
MSD	=	Medical Supply Division
NCD	=	noncommunicable diseases
NMRA	=	National Medicines Regulatory Authority
NSFDHS	=	National Strategic Framework for the Development of Health Services
PID	=	program implementation document
PAP	=	program action plan
PCO	=	Program Coordination Office
PDHS	=	Provincial Director of Health Services
RBL	=	results-based lending
RDHS	=	Regional Director of Health Services
RFQ	=	request for quotations
RRP	=	Report and Recommendation of the President
SBD	=	standard bidding documents
SDG	=	Sustainable Development Goals
UHC	=	universal health coverage

I. PROGRAM DESCRIPTION

1. With the adoption of Sustainable Development Goals (SDGs) and universal health coverage (UHC) in 2015, the Government of Sri Lanka realigned the Sri Lanka National Health Policy (SLNHP)[1] in 2016 and developed the National Strategic Framework for the Development of Health Services 2016 to 2025 (extended to 2030) (NSFDHS).[2] The proposed results-based loan (RBL) aims to support NSFDHS by strengthening the country-wide network of first referral hospitals that provide secondary health care services to the population and initiatives to strengthen good governance in the central and provincial health ministries of Sri Lanka.[3]

2. The RBL program will finance components of NSFDHS on (i) supporting the provision of integrated secondary curative health care services, (ii) enhancing the control and prevention of communicable diseases and future pandemics, and (iii) improving health sector governance for better health administration. The RBL program is aligned with the geographic scope and implementation arrangements of NSFDHS as both cover secondary hospitals nationwide. With respect to implementation arrangements, as the secondary hospitals are managed and delivered within the nine provincial councils, the RBL program will support results achieved at both the central and provincial levels. It will also strengthen the government program to improve coordination and integration at the local primary and tertiary healthcare levels and with non-healthcare stakeholders for providing elderly care including palliative and rehabilitation services, disease surveillance and prevention of diseases. It will also support governance improvement measures on pharmaceutical, finance, and procurement to achieve better governance results, which will be jointly delivered by provinces and Ministry of Health and Mass Media (MOHMM).

3. Table 1 summarizes the overall scope of the government program and the scope of the RBL program.

Table 1: Program Scope
(as of 21 July 2025)

Item	Broader Government Program	Results-Based Lending Program
Outcome	Efficiency, quality, and accessibility of preventive, primary, secondary, and tertiary health care services improved for UHC.	Efficiency and quality of secondary health services improved as first referral care.
Key outputs	Strengthening and reforming (i) curative services, (ii) preventive and communicable disease control services, (iii) rehabilitation services, (iv) health administration and human resource for health, and (v) health financing for UHC with cross-cutting digitization and improvement of pharmaceutical supply chain	• First referral care services enhanced. • Pandemic prevention, preparedness, and response enhanced. • Health sector technical capacity and pharmaceutical supply chain management improved.
Activities	Activities related to strengthening: • Quality, safety, efficiency, and integration of curative care at	• Enhancing planning, budgeting, monitoring, capacity of MOHMM and 9 provincial level councils

[1] Government of Sri Lanka. 2017. *Sri Lanka National Health Policy 2016–2025*.
[2] Government of Sri Lanka, Ministry of Health. 2017. *National Strategic Framework for Development of Health Services, 2016–2025.*
[3] Secondary care hospitals in Sri Lanka provide four basic specialties (medicine, surgery, pediatric, obstetrics and gynecology) and other defined specialties psychiatry, orthopedic, ear, nose, throat (ENT) and eye care to manage patients needing specialist care that are not available in primary care hospitals, while tertiary hospitals provide added specialties. Based on the treatment capacity, the secondary care hospitals are further classified by Type A and Type B base hospitals.

Item	Broader Government Program	Results-Based Lending Program
	primary, secondary, and tertiary hospitals • Preventive care, including communicable disease control • Rehabilitation services, including elderly and disability care services • Health sector planning, management, and monitoring capacity and measures related to efficiency, accountability, and transparency, including digitization • Pharmaceutical procurement and supply chain management • Health care workforce management • Health financing protection and accessibility of free health care services	• Improving accessibility of secondary care services via care pathways linking to primary and tertiary hospitals, preventive services, and non-health services, especially for elders, women, young people, key populations and disabled persons • Enhancing quality assurance, procurement efficiency, and supply chain management of pharmaceuticals • Standardizing service provision packages at secondary care levels • Improving the quality and safety of secondary care services, including the introduction of national anti-biotic stewardship program • Improving the infrastructure capacity and process efficiency of secondary hospital • Introducing climate resilience and mitigation measures to secondary hospitals and pharmaceutical supply chain • Strengthening hospital waste disposal and environment cleanliness • Enhancing disease control, surveillance, and laboratory testing capacity through One Health approach • Replacing existing manual systems for patient management, procurement, and healthcare workforce management by digital platforms for efficiency and transparency improvement
Expenditure size	$12,051.9 million	$660 million
Main financiers and their respective total amounts	Government: $11,725 million[4] ADB: $106.9 million World Bank: $150 million JICA: $70 million	Government: $553.1 million ADB: $100 million loan and $6.9 million ADB-administered grant cofinancing from PPPR Fund.
Geographic coverage	Nationwide	Nationwide
Implementation period	2025 to 2030	2025 to 2030

ADB = Asian Development Bank, JICA = Japan International Cooperation Agency, MOHMM = Ministry of Health and Mass Media, UHC = universal health coverage.

[a] Whole sector budget of 2025–2030. Annual expenditure is estimated based on consultations with the Ministry of Health and Mass Media and provincial councils.

Sources: ADB and Ministry of Health and Mass Media estimates.

II. RESULTS AND DISBURSEMENT

A. The Results-Based Lending Program's Overall Results

1. Program Results Framework

4. The RBL program's impact will be to attain a healthier population with UHC that contributes to the economic and social development of Sri Lanka, which aligns with the impact of the SLNHP. The outcome will be efficiency and quality of secondary health services improved as first referral care.[5] The outcome progress will be measured by two indicators: (i) tracking the efficiency

[4] Whole sector budget of 2025–2030. Annual expenditure is estimated based on consultations with Ministry of Health and Provincial Councils.

[5] The design and monitoring framework for the proposed RBL program is in Appendix 3.

improvement through the percentage reduction in the waiting time of patients requiring selected elective surgical procedures (cataract surgeries, hernia repairs, and hysterectomies) (DLI 1); and (ii) tracking the quality of care improvement through the percentage reduction of hospital-acquired infections (surgical site infections and cannula infections) reported at secondary hospitals (DLI 2).[6] Three outputs will support the stakeholders to achieve the outcome.

5. **Output 1: First referral care services enhanced.** This output will address the gaps in services at secondary hospitals that provide first referral services across the country. Secondary hospitals cater to the elderly patients, noncommunicable disease (NCD) patients, patients requiring surgeries, laboratories, and imaging services, and vulnerable population services like gender-based violence and related support, adolescent and youth services, elders and disabled persons support services. This output will support secondary care hospitals to provide a comprehensive package of services. To deliver comprehensive service packages, they require adequate staff, facilities, and patient information services to support referrals from primary care. The facilities should be upgraded and designed for staff and patient convenience and climate- and disaster- resilient. This output will introduce measures to reduce the bypassing of primary health care facilities to secondary health care and beyond by formalizing the referral pathways. These initiatives will improve the service availability aspects of UHC in Sri Lanka. There are three DLIs under this output: (i) DLI 3 to strengthen multiyear and annual planning and budgeting for decentralized health services, technical capacity for new equipment and pharmaceutical products, introduction of national guidelines for secondary health services, and human resource management capacity; (ii) DLI 4 to enhance patient-centered secondary care services, including rehabilitation and NCD diagnostic services, especially for women and vulnerable groups, and introduce improved biomedical waste management and climate resilience measures in secondary hospitals;[7] and (iii) DLI 5 to strengthen continuum of care by implementing the shared care cluster service delivery approach between secondary and primary health care facilities, institutionalizing the patient referral and back-referral care pathways, supported by the digital patient information system. The list of type A and B base hospitals that are within the scope of the RBL program is provided in Appendix 1.[8]

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[6] Waiting times of patients for procedures is known to be a very sensitive indicator of a hospital 's performance as it indicates efficiency, quality, and patient satisfaction. But definitions used can vary and therefore in the Sri Lankan context waiting time is defined as the time (in days) the patient has to wait from the day the decision was made by the patient and the surgeon until the day when the surgery is carried out. Similarly, hospital-acquired infections (HAI) are infections that patients acquire while receiving treatment at the hospital for another illness. HAI is an outcome measure of health service quality and patient safety with implications on patient's illness, risk of complications, cost to patient and facility and longer length of stay. High HAIs also indicate high anti-microbial resistance (AMR) levels in a hospital. Majority of secondary care hospitals in Sri Lanka, monitor this indicator routinely, but as it requires follow up of patients following discharge from hospital under reporting is not unlikely.

[7] The RBL program will support measures such as (i) reducing greenhouse gas emissions; (ii) improving water management; (iii) sourcing food locally and reducing food waste; (iv) improving water, sanitation, and hygiene; (v) improving energy efficiency by purchasing energy-efficient appliances and lighting systems, using renewable energy sources, conducting energy audits to identify inefficiencies, and investing in building renovations to enhance insulation, ventilation, and thermal comfort; (vi) building stronger infrastructure to withstand extreme weather or heatwaves; (vii) relocating infrastructure from vulnerable areas; (viii) making a disaster response plan available for activation during climate-related disasters affecting the hospital; and (ix) promoting behavioral changes among staff.

[8] Secondary care hospitals, known as first referral hospitals, refer to health care facilities that provide four basic specialties (medicine, surgery, pediatric, obstetrics and gynecology) and other defined specialties such as psychiatry, orthopedic, ear, nose, throat (ENT) and eye care to manage patients needing specialist care that are not available in primary medical care institutions (PMCIs), while tertiary hospitals provide added specialties. Based on the treatment capacity, the secondary care hospitals are further classified by Based Hospital Type A and Type B. The RRP uses the terminology of first referral hospitals when emphasizing the role of secondary care hospitals in the integration of curative care services with PMCIs and tertiary hospitals through patient referral care pathways.

6. **Output 2: Pandemic prevention, preparedness, and response enhanced.** This output will address identified gaps in pandemic prevention, preparedness, and response related activities. Sri Lanka is lagging in adopting technology like geographic information systems (GIS) and comprehensive electronic systems, for public health surveillance and diagnostic laboratory capacity and disease surveillance capacity. This output includes interventions to develop a state-of-the-art centre for disease control with GIS or e-system based disease surveillance system linking hospitals to communities for early detection of notifiable diseases and for advancing the quality assurance of laboratory services. DLI 6: notifiable disease surveillance and quality assurance of public health laboratories improved will address the gaps by establishing Sri Lanka Centre for Disease Control, enabling early warning of notifiable diseases, and improving quality assurance of pathology, biochemistry, haematology and microbiology laboratories.

7. **Output 3: Health sector technical capacity and pharmaceutical supply chain management improved.** This output will address measures related to improving transparency and governance in the sector through introduction and/or improving inter-operability of digital systems for managing and monitoring human resources for health, procurement, and finance services at both the MOHMM and nine provincial councils. It also includes interventions to further strengthen the pharmaceutical staff capacity, storage, and quality assurance facilities in the pharmaceutical supply chain system in the country. There are two DLIs under this output: (i) DLI 7: logistics capacity and quality assurance of the pharmaceuticals enhanced through improving the storage condition of pharmaceuticals with climate proofing measures and expanding capacity of quality assurance laboratories of National Medicines Regulatory Authority and its network; and (ii) DLI 8: procurement management capacity enhanced by expediting the digitization of government procurement and introducing good procurement practices in the health sector.

8. **Program results framework:** The RBL program is defined as the secondary health care program with governance strengthening measures of the country. This includes first referral services for patients who can come as a referral or if the patient comes directly to a base hospital type A and B.

Table 2: Results-Based Lending Program Results Framework

(as of 4 April 2025)

Disbursement-Linked Indicators	DLI/ Non DLI	Baseline Value	Baseline Year	Target Values				
				Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
Outcome: Efficiency and quality of secondary health services improved as first referral care								
DLI 1: Average waiting time of patients for 3 elective surgeries (cataract, hernia repair and hysterectomy) (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 30%[i]	**DLI**	M:103 days F: 88 days	2024					30% from baseline
DLI 2: Surgical site hospital-acquired infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 40% [ii]	**DLI**	M:816 per 10,000 admissions F:628 per 10,000 admissions	2024					40% from baseline
Output 1: First referral care services enhanced								
DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened								
3a. Concurrence by the Finance Commission and the DGHS of the costed 5-year action plan by each province and from MOHMM for BHs under MOHMM respectively for first referral hospitals development (BHs A&B) for 2025–2029.	**DLI**	NA	2024	Yes				
3b. Concurrence by the Finance Commission and DGHS of the 10 costed detailed annual plans for next year's investments in first referral hospitals (BHs A&B) under 9 provinces and MOHMM respectively.[iii]	**DLI**	NA	2024	Yes	Yes	Yes	Yes	Yes
3c. Health technology assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives.[iv]	**DLI**	NA	2024		At least 2		At least 4	At least 7
3d. Approved 8 national guidelines for the provision of services at BHs A&B.[v]	**DLI**	No	2024		Yes			

Disbursement-Linked Indicators	DLI/ Non DLI	Baseline Value	Baseline Year	Target Values				
				Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
3e. Health human resource (i) databases adopting the national ID number (with sex disaggregated data) operational at MOHMM and provinces, and (ii) HRH unit functional at MOHMM	**DLI**	NA	2024			Yes		
DLI 4: Patient-centred secondary care services with quality, safety, and climate resilience measures enhanced.								
4a. % of BHs A&B implementing quality and safety measures.[vi]	**DLI**	38% with 3 initiatives	2024		50% with 3 initiatives		50% with 5 initiatives	
4b. % BHs A&B providing identified services related to women, children, youth, elderly, and persons with disabilities.[vii]	**DLI**	0%	2024			25%		50%
4c. % BHs A&B with facilities available for lipid profile, HBA1c and troponin I tests.	**DLI**	28%	2024			At least 50%		
4d. % of BHs A&B with functional physiotherapy and/or rehabilitation unit.[viii]	**DLI**	18%	2024				At least 40%	
4e. % of BHs A&B that have obtained environment protection license and scheduled waste management license from the Central Environmental Authority.	**DLI**	12%	2024				At least 50%	
4f. % of identified BHs A&B that have renovated/ expanded/repaired staff quarters.[ix]	**DLI**	0	2024				At least 20%	At least 40%
4g. % of secondary hospitals (BHs A&B) that provide day surgical services.[x]	**DLI**	0	2024				At least 20%	At least 40%
4h. Number of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province)[xi]	**DLI**	0	2024				At least 5 labs	At least 9 labs
4i. % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures.[xii]	**DLI**	6%	2024				20%	30%
DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized.								
5a. % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular.[xiii]	**DLI**	0	2024		At least 75%			
5b. % of clusters (with BHs A&B as Apex) with a functioning digital information system.[xiv]	**DLI**	0	2024		10%	At least 20%		

Disbursement-Linked Indicators	DLI/ Non DLI	Baseline Value	Baseline Year	Target Values				
				Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
5c. % of BHs A&B that have a functional Patient Information Centre.[xv]	**DLI**	0	2024			At least 50%, 3 criteria		
5d. % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas.[xvi]	**DLI**	0	2024				At least 60%	
5e. The number of care pathways that have at least 1 circular and/or guideline defining the standard package of care that includes gender-sensitive care provision, [xvii] 1 referral and back referral guideline and 1 training programme developed and uploaded to the continuous professional development (CPD) system.	**DLI**	0	2024					10
Output Pandemic prevention, preparedness, and response enhanced 2:								
DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved.								
6a. Sri Lanka Centre for Disease Control functional.	**DLI**	NA	2024	Detailed design	10% constructed	Function-al		
6b. Medical Research Institute (MRI) building renovations completed.	**DLI**	NA	2024		Detailed cost estimates	100%		
6c. % of BHs A&B hospitals updating / reporting notifiable diseases via the GIS based early warning system.[xviii]	**DLI**	0	2024		At least 30%	At least 60%		
6d. % of BHs A&B that use the external quality assurance system of the MRI at all 4 labs of the pathology, biochemistry, hematology and microbiology.	**DLI**	0	2024		At least 50%	At least 75%		
6e. National Investment Plan for Strengthening Health Emergency Prevention, Preparedness, and Resilience developed with gender sensitive measures included.[xix]	**Non DLI**	NA	2024					Plan developed
Output 3: Health sector technical capacity and pharmaceutical supply chain management improved								
DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced.								
7a. % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities.	**DLI**	0	2024		Cost estimates available			At least 50%

Disbursement-Linked Indicators	DLI/ Non DLI	Baseline Value	Baseline Year	Target Values				
				Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
7b. The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.	**DLI**	No	2024		Cost estimates available			Yes
7c. The % change of number of tests that can be performed by the NMRA (NMQAL) directly or via laboratories under MOUs and/or agreements in line with the established risk-based sampling and testing approach.	**DLI**	57 tests	2024				90% increase from baseline	
DLI 8: Procurement management capacity enhanced.								
8a. % of procurement entities of the MOHMM and 9 PDHS offices that complete all 3 of these steps: (i) has the master procurement plan updated in the e-GP system PROMISe.lk, (ii) has the annual procurement plan in the e-GP system PROMISe.lk, and (iii) utilizes PROMISe.lk for all RFQ contracts identified in the annual procurement plan.	**DLI**	0	2024		At least 50% MOHMM PEs	At least 50% Provinces PEs		
8b. No. of framework agreements signed for pharmaceuticals and medical supplies (excluding buy back).	**DLI**	0	2024			At least 10		
8c. Standard bidding documents (SBDs) for pharmaceuticals and medical equipment (i) developed; (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back).	**DLI**	0	2024		Developed	50%		
8d. % change in the average time taken from request to initiation of repairs/service, etc. of a building or a medical equipment at centrally managed hospitals.	**DLI**	90 days	2024			20% reduction from baseline		

A&B = type A and type B, BH = base hospital, CPD = continuous professional development, DGHS = district general hospitals, e-GP = electronic government procurement, FHB = Family Health Bureau, HAI = Hospital Acquired Infection, HBA1c = hemoglobin A1c test, HRH = human resource for health, ISO/IEC = International Organization for Standardization/International Electrotechnical Commission, MOHMM = Ministry of Health and Mass Media, MOU = memorandum of understanding, MRI = Medical Research Institute, MSD = medical supply division, NA = not applicable, NMRA = National Medicines Regulatory Authority, NMQAL = National Medicines Quality Assurance Laboratory, SBD = standard bidding documents

i Secondary care hospitals, known as first referral hospitals, refer to health care facilities that provide four basic specialties (medicine, surgery, pediatric, obstetrics and gynecology) and other defined specialties such as psychiatry, orthopedic, ear, nose, throat (ENT) and eye care to manage patients needing specialist care that are not

available in primary medical care institutions (PMCIs), while tertiary hospitals provide added specialties. Based on the treatment capacity, the secondary care hospitals are further classified by Based Hospital Type A and Type B. There are 82 Base Hospitals to be supported by the RBL program

[ii] The baseline calculation for surgical site infections (defined as infections that develops at the site of a surgical site, within 30 days of the procedure, or within one year if an implant or foreign body is involved) reported from Base Hospitals were calculated using a few methods as there is large scale underreporting of this indicator due to both lack of resources and poor follow up of all cases of surgeries following discharge from hospitals up to 30 days following the surgery. The number reported from the hospitals was adjusted 20-fold to reflect the numbers from surveys carried out at tertiary and secondary care hospitals in Sri Lanka and in India and from the number of reported caesarian section related surgical site infections reported to the Quality unit of the MOHMM.

[iii] The progress report should indicate expenditure statement showing more than 80% allocation utilization and reporting of the relevant results achievement of the previous year and the completed safeguard checklist for proposed activities in the implementing year should be included.

[iv] Implementation achievement will be measured for at least 7 of the 8 areas: (i) approved organization structure,(ii) Technical expert panel appointed, (iii) a dedicated budget line in the MOHMM, (iv) Essential medicines List (EML) revised and updated, (v) Technical specifications of medical equipment uploaded in MOHMM website, (vi) use of the web-based Need Assessment and Prioritization Model (NAPM) for new medical equipment, (vii) mechanism identified to request new pharmaceuticals, and (viii) Cost accounting system in place.

[v] The guidelines include: (i) Elderly and women friendly services, (ii) Hospital laboratory quality enhancement, (iii) Provision of day surgical services, (iv) Mithuru Piyasa and Yowun Piyasa, (v) Guidelines on establishing Green, Healthy and Safe Hospitals, (vi) services as a cluster of hospitals linking with preventive services and population, (vii) Guidelines on establishing norms for standardizing facilities at Base Hospitals, and (viii) Patient Information Centre.

[vi] Relates to five areas: (i) pharmaceutical labelling, (ii) good pharmaceutical storage practices, (iii) early warning score (Patient Observation Chart), (iv) adverse events submission box, and (v) antibiotic prescription chart.

[vii] Includes the provision of 7 areas guided by the relevant circulars issued by the MOHMM: (i) availability of male, female, disability access toilets in OPD, clinic waiting areas; (ii) holding bars in walking areas in OPD area, clinic area and corridors leading to wards and labs; (iii) access to drinking water in OPD and clinic waiting areas; (iv) adequate seating available at clinics and OPD; (v) special easy access options for people with special needs at registration, pharmacy, laboratory; (vi) provision of gender-based violence care services (Mithuru Piyasa) that includes, but not limited to, initial assessment of survivor's physical and mental condition, addressing her immediate medical needs, processing her intake, including referral services provided, especially to social workers, shelters, and police or local enforcement agencies tasked with supporting GBV survivors, all the while ensuring her privacy and safety from retaliation by her perpetrator; and (vii) Provision of adolescent health care services (Yowun Piyasa) with adequate privacy.

[viii] Functional physiotherapy or rehabilitation unit will have defined equipment for physiotherapy and for speech therapy and occupational therapy (as appropriate), physical space, patient friendly convenient access with mechanisms for integration with primary medical care institutions, and link to social service officers and assistive device providers.

[ix] The staff quarters renovated/expanded/repaired needs to be guided by the currently available staff facilities by staff category and should ensure that staff accommodation is available for minimum of 4 specialist consultants, for Intern medical officers (in relevant BHAs), for House officers, nurses, supplementary staff and support staff as guided by MOHMM and/or province circulars. New constructions for staff quarters will not be approved and only existing staff quarters can be renovated/expanded/repaired. Staff quarters will be designed with women's safety in mind.

[x] Definition of "Day surgical services" will be based on the new guidelines and will include: availability of staffing arrangements, reporting arrangements with a new register in place, and facilities for day surgeries with patient admissions, pre-op, post-op and discharge occurring within the day for a surgical procedure (e.g. eye surgery/lump removal/wound toilet, etc.) and facilities for day surgical service theatre accessible for day procedures under Eye, ENT, General Surgery, Gyne and Obstetrics, and dental, with waiting area, recovery area, with access to the Central Sterile Supplies Department (CSSD), pre-op room, and changing rooms or staff resting rooms by gender.

[xi] Will be guided by the new Circular which will be based on the ISO 15189 standard managed via the Sri Lanka Accreditation Board, and the WHO Laboratory Quality Standard of 2011.

[xii] Climate resilience is defined as the process of integrating climate change adaptation and mitigation strategies into development plans to have hospitals defined as a green, healthy and safe by the MOHMM new guideline that will be issued. Initiatives are related to (i) reducing greenhouse gas emissions; (ii) improving water management; (iii) sourcing food locally and reducing food waste; (iv) improving water, sanitation and hygiene (WASH) measures; (v) improving energy efficiency by purchasing energy efficient appliances and lighting systems, utilizing renewable energy sources like solar power, conducting energy audits to identify inefficiencies, and investing in building renovations to enhance insulation, ventilation and thermal comfort; (vi) building stronger infrastructure to withstand extreme weather;(vii) relocating

infrastructure from vulnerable areas are considered; (viii) availability of a Disaster Response Plan for activating during a climate related disaster situation affecting the hospital; and (ix) promoting behavioral changes among staff.

[xiii] The guideline to be issued by the MOHMM will give further guidance on defining clusters with empaneled populations linking BHs as the apex with lower referral facilities, MOHMM services for basic primary care and preventive services and inter sectoral services. This will include a laboratory cluster.

[xiv] The ongoing ADB financed HSEP is supporting the development of a software (OpenMRS based) and a pilot of it in 2 clusters Thambuthegama and Dambulla clusters in Anuradhapura and Matale districts. The same software or another software should be adopted to interconnect the cluster hospitals to provide better continuity of care. A functioning system will be defined as a system that (i) links all feeder hospitals with the Apex hospital, (ii) is able to give a Patient health number to all registered patients, (iii) and allows a patient can go to any hospital in the cluster where all previous tests and records can be extracted via the digital system. This will be measured using the following five criteria. All hospitals in the cluster should adopt this system (i) for patient registration, (ii) to report notifiable disease to relevant medical officer of health area, (iii) for authorized health professionals to retrieve patient information, laboratory testing information and radiology related information (iv) use the outpatient department module and (v) use the Clinic modules.

[xv] A functional Patient Information Centre will be managed by a dedicated Development Officer/s and/or Nursing Officer/s and will have a hotline phone number. It will (i) provide appointment services to patients referred from PMCIs, other hospitals, Well Women Clinics, Healthy Life Style Centers (HLCs), family planning services, school medical inspections, dental inspections, sexually transmitted disease clinics, antenatal clinics, and medico legal units, (ii) link to other sectors for social services, legal services for women's medico legal issues, non-governmental organizations for key population services; (iii) provide disability support for special needs patients includes and (v) complaints and/or suggestions box or another mechanism to receive, review and act on complaints and suggestions.

[xiv] Care Pathways: (i) Accident and emergency care service package; (ii) Comprehensive emergency obstetric care facilities EMOC, Special Baby Care units, adolescent reproductive services; (iii) Medical care package for managing heart diseases and CVAs; (iv) Medical care package for managing lung diseases; (v) Medical, rehabilitative and palliative care package; (vi) Medical care package for managing diabetes mellitus; (vii) Medical care package for managing selected cancers; (viii) Comprehensive package of surgical services; (ix) Comprehensive package for Nephrology services; (x) Care Package for dental services; (xi) Care package for Eye and ENT services; (xii) Care package for Mental Health and Supporting services (xiii) Comprehensive package for laboratory and imaging services; (xiv) Antibiotic Stewardship Programme; and (xv) Comprehensive Medico legal services.

[xvii] Gender-sensitive care is an integral part of patient-centered care, where the biological and cultural context of a patient's needs are considered, to understand the medical interventions required for a patient, e.g., stigma/discrimination faced by women/adolescent girls in seeking reproductive health-related services, or blame experienced by married women for uncontrolled pregnancies, or social limitations of women in seeking health care, or refusal of some women to be seen by male doctors, among others

[xviii] The epidemiology unit of Sri Lanka monitors 28 notifiable diseases. Currently notification from hospital to the respective medical officer of health area is via the postal system for Group B diseases. A GIS based system that can manage disease surveillance is currently developed under TA funds and the disease surveillance module under OPEN MRs is available.

[xix] The gender sensitive measures are defined to include 3 aspects in the plan: (i) population aspect: The plan will identify interventions / role of the female led community groups (eg. mothers' clubs and village societies). (ii) health worker aspect: measures need to be addressed related to female health worker safety when working within emergency health situations and (iii) health sector aspect where notification of the 28 notifiable diseases of Sri Lanka will be reviewed from a sex differentiated manner to early identify sex-related differences in notifiable diseases in Sri Lanka.

Source: Annual Health Bulletin 2023, Completed Data collection tool for the baseline calculations developed by ADB staff and personal communications with relevant units, Directorate of the Provinces.

2. Implementation Status

9. Table 3 below will be completed for the previous 6 months of results and achievements by the Government and submitted to ADB and Department of Project Management and Monitoring biannually by (i) January 2026, (ii) July 2026, (iii) January 2027, (iv) July 2027, (v) January 2028, (vi) July 2028, (vii) January 2029, (viii) July 2029, (ix) January 2030, (x) July 2030. All 9 PDHSs and the MOHMM will submit their respective results prior to the deadlines and the summary report will be developed by the PCO. The status of **all indicators** in Table 2 above will be reported in the Table 3, Status of the Results Framework. The target value for reporting period will be the program target value identified in Table 2 above. Actual achievement should be given both as during the past 6 months achievement and the cumulative value.

Table 3: Status of the Results Framework
(as of {date})

Results Indicators[a]	Baseline Value	Baseline Year	Target Value {Year}	Actual Achievement {Year}
To be submitted Biannually from January 2026 for previous 6 months				
Outcome				
1.				
2.				
Outputs				
3.				
4.				
Other Results				
5.				
6.				

Source(s): List table source(s).

B. Disbursement-Linked Indicators

1. Description of Disbursement-Linked Indicators

10. The RBL program will have eight DLIs. Subset of indicators of each of the eight DLIs as well as their yearly targets are summarized in the table below.

Table 4: Disbursement-Linked Indicators
(as of 4 April 2025)

Disbursement-Linked Indicators	Baseline Value	Baseline Year	Target Values				
			Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
Outcome: Efficiency and quality of secondary health services improved as first referral care							
DLI 1: Average waiting time of patients for 3 elective surgeries (cataract, hernia repair and hysterectomy) (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 30%[i]	Male:103 days Female: 88 days	2024					30% from baseline
DLI 2: Surgical site hospital-acquired infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 40%[ii]	Male: 816 per 10,000 admissions Female: 628 per 10,000 admissions	2024					40% from baseline
Output 1: First referral care services enhanced							
DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened							
3a. Concurrence by the Finance Commission and the DGHS of the costed 5-year action plan by each province and from MOHMM for BHs under MOHMM respectively for first referral hospitals development (BHs A&B) for 2025–2029.	NA	2024	Yes				
3b. Concurrence by the Finance Commission and DGHS of the 10 costed detailed annual plans for next year's investments in first referral hospitals (BHs A&B) under 9 provinces and MOHMM respectively.[iii]	NA	2024	Yes	Yes	Yes	Yes	Yes
3c. Health technology assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives.[iv]	NA	2024		At least 2		At least 4	At least 7
3d. Approved 8 national guidelines for the provision of services at BHs A&B.[v]	NA	2024		Yes			
3e. Health human resource (i) databases adopting the national ID number (with sex disaggregated data) operational at MOHMM and provinces, and (ii) HRH unit functional at MOHMM	NA	2024			Yes		

Disbursement-Linked Indicators	Baseline Value	Baseline Year	Target Values				
			Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
DLI 4: Patient-centred secondary care services with quality, safety, and climate resilience measures enhanced.							
4a. % of BHs A&B implementing quality and safety measures[vi]	38% with 3 initiatives	2024		50% with 3 initiatives		50% with 5 initiatives	
4b. % BHs A&B providing identified services related to women, children, youth, elderly, and persons with disabilities.[vii]	0	2024			25%		50%
4c. % BHs A&B with facilities available for lipid profile, HBA1c and troponin I tests	28%	2024			At least 50%		
4d. % of BHs A&B with functional physiotherapy and/or rehabilitation unit[viii]	18%	2024				At least 40%	
4e. % of BHs A&B that have obtained environment protection license and scheduled waste management license from the Central Environmental Authority	12%	2024				At least 50%	
4f. % of identified BHs A&B that have renovated/ expanded/ repaired staff quarters.[ix]	0	2024				At least 20%	At least 40%
4g. % of secondary hospitals (BHs A&B) that provide day surgical services.[x]	0	2024				At least 20%	At least 40%
4h. Number of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province).[xi]	0	2024				At least 5 labs	At least 9 labs
4i. % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures.[xii]	6%	2024				20%	30%
DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized.							
5a. % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular.[xiii]	0	2024		At least 75%			
5b. % of clusters (with BHs A&B as Apex) with a functioning digital information [i]system[xiv]	0	2024		10%	At least 20%		
5c. % of BHs A&B that have a functional Patient Information Centre.[xv]	0	2024			At least 50%, 3 criteria		
5d. % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas.[xvi]	0	2024				At least 60%	
5e. The number of care pathways that have at least 1 circular and/or guideline defining the standard package of care that	0	2024					10

Disbursement-Linked Indicators	Baseline Value	Baseline Year	Target Values				
			Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
includes gender-sensitive care provision,[xvii] 1 referral and back referral guideline, and 1 training programme developed and uploaded to the continuous professional development (CPD) system.							
Output 2: Pandemic prevention, preparedness, and response enhanced							
DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved.							
6a. Sri Lanka Centre for Disease Control functional	NA	2024	Detailed design	10% constructed	Functional		
6b. Medical Research Institute (MRI) building renovations completed	NA	2024		Detailed cost estimates	100%		
6c. % of BHs A&B hospitals updating / reporting notifiable diseases via the GIS based early warning system[xviii]	0	2024		At least 30%	At least 60%		
6d. % of BHs A&B that use the external quality assurance system of the MRI at all 4 labs of the pathology, biochemistry, hematology and microbiology.	0	2024		At least 50%	At least 75%		
Output 3: Health sector technical capacity and pharmaceutical supply chain management improved							
DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced.							
7a. % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities	0	2024		Cost estimates available			At least 50%
7b. The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.	No	2024		Cost estimates available			Yes
7c. The % change of number of tests that can be performed by the NMRA (NMQAL) directly or via laboratories under MOUs and/or agreements in line with the established risk-based sampling and testing approach.	57 tests	2024				90% increase from baseline	
DLI 8: Procurement management capacity enhanced.							
8a. % of procurement entities of the MOHMM and 9 PDHS offices that complete all 3 of these steps: (i) has the master procurement plan updated in the e-GP system PROMISe.lk, (ii) has the annual procurement plan in the e-GP system	0	2024		At least 50% MOHMM PEs	At least 50% Provinces PEs		

Disbursement-Linked Indicators	Baseline Value	Baseline Year	Target Values				
			Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
PROMISe.lk, and (iii) utilizes PROMISe.lk for all RFQ contracts identified in the annual procurement plan.							
8b. No. of framework agreements signed for pharmaceuticals and medical supplies (excluding buy back)	0	2024			At least 10		
8c. Standard bidding documents (SBDs) for pharmaceuticals and medical equipment (i) developed; (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back).	0	2024		Developed			
8d. % change in the average time taken from request to initiation of repairs/service, etc. of a building or a medical equipment at centrally managed hospitals	90 days	2024		10% reduction from baseline		20% reduction from baseline	

A&B = type A and type B, BH = base hospital, CPD = continuous professional development, DGHS = district general hospitals, e-GP = electronic government procurement, FHB = Family Health Bureau, HAI = Hospital Acquired Infection, HBA1c = hemoglobin A1c test, HRH = human resource for health, ISO/IEC = International Organization for Standardization/International Electrotechnical Commission, MOHMM = Ministry of Health, MOU = memorandum of understanding, MRI = Medical Research Institute, MSD = medical supply division, NA = not applicable, NMRA = National Medicines Regulatory Authority, NMQAL = National Medicines Quality Assurance Laboratory, SBD = standard bidding documents.

[i] Secondary care hospitals, known as first referral hospitals, refer to health care facilities that provide four basic specialties (medicine, surgery, pediatric, obstetrics and gynecology) and other defined specialties such as psychiatry, orthopedic, ear, nose, throat (ENT) and eye care to manage patients needing specialist care that are not available in primary medical care institutions (PMCIs), while tertiary hospitals provide added specialties. Based on the treatment capacity, the secondary care hospitals are further classified by Based Hospital Type A and Type B. There are 82 Base Hospitals to be supported by the RBL program.

[ii] The baseline calculation for surgical site infections (defined as infections that develops at the site of a surgical site, within 30 days of the procedure, or within one year if an implant or foreign body is involved) reported from Base Hospitals were calculated using a few methods as there is large scale underreporting of this indicator due to both lack of resources and poor follow up of all cases of surgeries following discharge from hospitals up to 30 days following the surgery. The number reported from the hospitals was adjusted 20-fold to reflect the numbers from surveys carried out at tertiary and secondary care hospitals in Sri Lanka and in India and from the number of reported caesarian section related surgical site infections reported to the Quality unit of the MOHMM.

[iii] The progress report should indicate expenditure statement showing more than 80% allocation utilization and reporting of the relevant results achievement of the previous year and the completed safeguard checklist for proposed activities in the implementing year should be included.

[iv] Implementation achievement will be measured for at least 7 of the 8 areas: (i) approved organization structure,(ii) Technical expert panel appointed, (iii) a dedicated budget line in the MOHMM, (iv) Essential medicines List (EML) revised and updated, (v) Technical specifications of medical equipment uploaded in MOHMM website, (vi) use of the web-based Need Assessment and Prioritization Model (NAPM) for new medical equipment, (vii) mechanism identified to request new pharmaceuticals, and (viii) Cost accounting system in place.

[v] The guidelines include: (i) Elderly and women friendly services, (ii) Hospital laboratory quality enhancement, (iii) Provision of day surgical services, (iv) Mithuru Piyasa and Yowun Piyasa, (v) Guidelines on establishing Green, Healthy and Safe Hospitals, (vi) services as a cluster of hospitals linking with preventive services and population, (vii) Guideline on establishing norms for standardizing facilities at Base Hospitals, and (viii) Patient Information Centre.

[iv] Relates to five areas: (i) pharmaceutical labelling, (ii) good pharmaceutical storage practices, (iii) early warning score (Patient Observation Chart), (iv) adverse events submission box, and (v) antibiotic prescription chart.

[vii] Includes the provision of 7 areas guided by the relevant circulars issued by the MOHMM: (i) availability of male, female, disability access toilets in OPD, clinic waiting areas; (ii) holding bars in walking areas in OPD area, clinic area and corridors leading to wards and labs; (iii) access to drinking water in OPD and clinic waiting areas; (iv) adequate seating available at clinics and OPD; (v) special easy access options for people with special needs at registration, pharmacy, laboratory; (vi) provision of gender-based violence care services (Mithuru Piyasa) that includes, but not limited to, initial assessment of survivor's physical and mental condition, addressing her immediate medical needs, processing her intake, including referral services provided, especially to social workers, shelters, and police or local enforcement agencies tasked with supporting GBV survivors, all the while ensuring her privacy and safety from retaliation by her perpetrator; and (vii) Provision of adolescent health care services (Yowun Piyasa) with adequate privacy.

[viii] Functional physiotherapy or rehabilitation unit will have defined equipment for physiotherapy and for speech therapy and occupational therapy (as appropriate), physical space, patient friendly convenient access with mechanisms for integration with primary medical care institutions, and link to social service officers and assistive device providers.

[ix] The staff quarters renovated/expanded/repaired needs to be guided by the currently available staff facilities by staff category and should ensure that staff accommodation is available for minimum of 4 specialist consultants, for Intern medical officers (in relevant BHAs), for House officers, nurses, supplementary staff and support staff as guided by MOHMM and/or province circulars. New constructions for staff quarters will not be approved and only existing staff quarters can be renovated/expanded/repaired. Staff quarters will be designed with women's safety in mind.

[x] Definition of "Day surgical services" will be based on the new guideline and will include: availability of staffing arrangements, reporting arrangements with a new register in place, and facilities for day surgeries with patient admissions, pre-op, post-op and discharge occurring within the day for a surgical procedure (e.g. eye surgery/lump removal/wound toilet, etc.) and facilities for day surgical service theatre accessible for day procedures under Eye, ENT, General Surgery, Gyne and Obstetrics, and dental, with waiting area, recovery area, with access to the Central Sterile Supplies Department (CSSD), pre-op room, and changing rooms or staff resting rooms by gender.

[xi] Will be guided by the new Circular which will be based on the ISO 15189 standard managed via the Sri Lanka Accreditation Board, and the WHO Laboratory Quality Standard of 2011.

[xii] Climate resilience is defined as the process of integrating climate change adaptation and mitigation strategies into development plans to have hospitals defined as a green, healthy and safe by the MOHMM new guideline that will be issued. Initiatives are related to (i) reducing greenhouse gas emissions; (ii) improving water management; (iii) sourcing food locally and reducing food waste; (iv) improving water, sanitation and hygiene (WASH) measures; (v) improving energy efficiency by purchasing energy efficient appliances and lighting systems, utilizing renewable energy sources like solar power, conducting energy audits to identify inefficiencies, and investing in building renovations to enhance insulation, ventilation and thermal comfort; (vi) building stronger infrastructure to withstand extreme weather;(vii) relocating infrastructure from vulnerable areas are considered; (viii) availability of a Disaster Response Plan for activating during a climate related disaster situation affecting the hospital; and (ix) promoting behavioral changes among staff.

[xiii] The guideline to be issued by the MOHMM will give further guidance on defining clusters with empaneled populations linking BHs as the apex with lower referral facilities, MOHMM services for basic primary care and preventive services and inter sectoral services. This will include a laboratory cluster.

[xiv] The ongoing ADB financed HSEP is supporting the development of a software (OPEN MRs based) and a pilot of it in 2 clusters Thambuthegama and Dambulla clusters in Anuradhapura and Matale districts. The same software or another software should be adopted to interconnect the cluster hospitals to provide better continuity of care. A functioning system will be defined as a system that (i) links all feeder hospitals with the Apex hospital, (ii) is able to give a Patient health number to all registered patients, and (iii) allows a patient can go to any hospital in the cluster where all previous tests and records can be extracted via the digital system. This will be measured using the following five criteria. All hospitals in the cluster should adopt this system (i) for patient registration, (ii) to report notifiable disease to relevant medical officer of health area, (iii) for authorized health professionals to retrieve patient information, laboratory testing information and radiology related information (iv) use the OPD module and (v) use the Clinic modules.

[xv] A functional Patient Information Centre will be managed by a dedicated Development Officer/s and/or Nursing Officer/s and will have a hotline phone number. It will (i) provide appointment services to patients referred from PMCIs, other hospitals, Well Women Clinics, Healthy Life Style Centers (HLCs), family planning services, school medical inspections, dental inspections, sexually transmitted disease clinics, antenatal clinics, and medico legal units, (ii) link to other sectors for social services, legal services for women's medico legal issues, non-governmental organizations for key population services; (iii) provide disability support for special needs patients includes and (v) complaints and/or suggestions box or another mechanism to receive, review and act on complaints and suggestions.

[xvi] Care Pathways: (i) Accident and emergency care service package; (ii) Comprehensive emergency obstetric care facilities EMOC, Special Baby Care units, adolescent reproductive services; (iii) Medical care package for managing heart diseases and CVAs; (iv) Medical care package for managing lung diseases; (v) Medical, rehabilitative and palliative care package; (vi) Medical care package for managing diabetes mellitus; (vii) Medical care package for managing selected cancers; (viii) Comprehensive package of surgical services; (ix) Comprehensive package for Nephrology services; (x) Care Package for dental services; (xi) Care package for Eye and ENT services; (xii) Care package for Mental Health and Supporting services (xiii) Comprehensive package for laboratory and imaging services; (xiv) Antibiotic Stewardship Programme; and (xv) Comprehensive Medico legal services.

[xvii] Gender-sensitive care is an integral part of patient-centered care, where the biological and cultural context of a patient's needs are considered, to understand the medical interventions required for a patient, e.g., stigma/discrimination faced by women/adolescent girls in seeking reproductive health-related services, or blame experienced by married women for uncontrolled pregnancies, or social limitations of women in seeking health care, or refusal of some women to be seen by male doctors, among others

[xviii] The epidemiology unit of Sri Lanka monitors 28 notifiable diseases. Currently notification from hospital to the respective medical officer of health area is via the postal system for Group B diseases. A GIS based system that can manage disease surveillance is currently developed under TA funds and the disease surveillance module under OPEN MRs is available.

Sources: Annual Health Bulletin 2023, Completed Data collection tool for the baseline calculations developed by ADB staff and personal communications with relevant units, Directorate of the Provinces.

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[i] The ongoing ADB financed HSEP is supporting the development of a software (OPEN MRs based) and a pilot of it in 2 clusters Thambuthegama and Dambulla clusters in Anuradhapura and Matale districts. The same software or another software should be adopted to interconnect the cluster hospitals to provide better continuity of care. A functioning system will be defined as a system that links all feeder hospitals with the Apex hospital and is able to give a Patient health number to all registered patients and if a patient can go to any hospital in the cluster where all previous tests and records can be extracted via the digital system. This will be measured using the below 5 criteria. All hospitals in the cluster should adopt this system (i) for patient registration, (ii) to report notifiable disease to relevant medical officer of health area, (iii) for authorized health professionals to retrieve patient information, laboratory testing information and radiology related information (iv) use the OPD module and (v) use the Clinic modules.

2. Implementation Status (to be filled out during implementation)

Table 5: Status of Disbursement-Linked Indicators
(as of {date})

Disbursement-Linked Indicators[a]	Baseline Value	Baseline Year	Target Value {Year}	Actual Achievement {Year}
To be submitted annually in first week of April each year with the verified results report for previous years achievement.				
Outcome				
1.				
2.				
Outputs				
3.				
4.				

C. Disbursement-Linked Indicator Verification Protocols

1. Description of the Verification Protocols

11. Prior results of DLIs will be verified by ADB technical staff with support of independent consultants mobilized through TA. From 2026 onward, a verification firm will be engaged by the Department of Project Management and Monitoring (DPMM) of the Ministry of Finance, Planning, and Economic Development to serve as the independent verification agency (IVA) of the RBL program. The verification firm will report the findings to the DPMM, with recommendations for releasing total or proportionate funds as defined in the protocol. The funds required for the external firm will be borne by the Government of Sri Lanka. The verification findings of IVA will be considered final and reported directly to ADB.

12. Below Table 6 provides the detailed verification protocols of the DLIs of the RBL program.

Table 6: Disbursement-Linked Indicator Verification Protocols

(as of 4 April 2025)

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
Outcome: Efficiency and quality of secondary health services improved as first referral care				
DLI 1: Average waiting time of patients for 3 elective surgeries (cataract, hernia repair and hysterectomy) (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 30%	Definition: • % change is the reduction in the number of days that the patient needs to undergo the procedure from the day the procedure was recommended by the surgical, eye or gynecology clinic/ ward. • The selected elective surgeries are defined to include only (i) cataract surgeries, (ii) hernia repairs (iii) hysterectomies. • The average number of waiting days for the 3 surgical procedures will be calculated by getting the total number of waiting days for 9 base hospitals (1 base hospital randomly selected by the IVA in each province) for the 2 surgical procedures by male (for cataract and hernia) and female (for all 3 surgical types), for all age groups, divided by the total number of patients (separately for male and female) waiting for the procedure. Calculation: The average waiting time in 2024/2025: • The total number of waiting days for the 3 procedures (cataract surgery, hernia repairs and hysterectomy) separately by male and female from base hospitals during a selected day in quarter 1 of 2025 / total number of base hospitals that are reporting waiting time (separately for male and female). The average waiting time in 2030: The total number of waiting days for the 3 procedures (cataract surgery, hernia repairs and hysterectomies) separately by male and female from a randomly selected sample of 9 base hospitals during a randomly selected week in the Quarter 1 of 2030) (1 base hospital A&B from each province) / total number of base hospitals that are reporting waiting time in 2030 during the selected week in the selected 9 base hospitals (separately for male and female). The % change in the average waiting time: • The average number of waiting days for the 3 procedures in the base hospital sample in 2030 *minus* the average	Base Hospital Patient data. Frequency: Reporting to be carried out once on 15 January 2030.	The IVA will select during a randomly selected week in the Quarter 1 of 2030) of minimum 10 post op patients from each of the selected 9 BHs to calculate the waiting time for the selected surgeries by sex..	The results will be verified once at the end of February 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	number of waiting days for the 3 procedures in the base hospital sample in 2024/25 and/or the average waiting days for the 3 procedures in the base hospital sample in 2024/2025 x 100 (separately for male and female) Partial achievement: Yes, subject to achievement of a minimum of 60% of the targeted decrease (18% of decrease), ADB will disburse an amount proportional to the results achieved. For example, if instead of 30% reduction, only 25% then 83% of DLI will be disbursed.			
DLI 2: Surgical site hospital-acquired infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 40%	Definition: • The surgical site Hospital acquired infections (HAI) (disaggregated by sex) at base hospitals will be defined for this purpose by monitoring the number of surgical site infections reported by the Infection Control Nurse or Unit to the QMU at base hospitals. • The surgical site hospital acquired infections include infections from all surgery related infections and includes gynae and Obstetrics related surgical site infections. Calculation: Average Surgical site HAI rate of 2024 Baseline The total HAI reported by each of base hospitals (by sex) that report HAI / the number of patient admissions in 2024 of the base hospitals that report HAI (separately by sex) X 10,000 patient admissions by sex Average HAI Surgical site rate 2029 The total surgical site infection HAIs reported by base hospitals that report HAI for year 2029 by sex / the total number of patient admissions in 2029 of the base hospitals that report HAI (separately by sex) X 10,000 patient admissions. Partial achievement: Yes, subject to achievement of a minimum of 60% of the targeted reduction (24% reduction from baseline), ADB will disburse an amount proportional to the results achieved. For example, if instead of 40% reduction, only 35% reduction is verified reported then 88% of DLI amount will be disbursed (100/40x35).	Base hospital infection control unit data. Frequency: Reporting to be carried out once on 15 January 2030	The IVA will review the dataset at 9 BHs (one BHA or BHB randomly selected from each province)	The results will be verified once at the end of February 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
Output 1: First referral care services enhanced				
DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened				
3a. Concurrence by the Finance Commission and the DGHS of the costed 5-year action plan by each province and from MOHMM for BHs under MOHMM for first referral hospitals development (BHs A and B) for 2025–2029.	Definition: • A 5-year action plan needs to be developed defining the investments that will be made using the loan and grant proceeds that will be utilized to achieve the sector results agreed under the RBL program. • The plan format is attached as an annex to the Project Implementation Document (PID). • The 9 provincial plans will be endorsed by the Finance Commission. The plan needs to include climate proofing measures. • The annual plan from Year 2 (2027) will have a (i) completed Progress Review Report for the previous year's work along with (ii) the Fund Utilization sheet (the format will be in the PID) indicating that a minimum 80% of the allocation was used in the preceding year and a (iii) Safeguard checklist. Calculation: • The 5-year cost action plan should be in the agreed format and should be submitted following concurrence by the respective Chief Secretary and the Finance Commission for each of the 9 provinces to reflect the actions needed to achieve the results. Partial Achievement: No.	The Finance Commission for 9 province 5yr plans and DGHS for MOHMM plan. Frequency: Once on 15 August 2025.	IVA will verify if the activities are aligned with the results.	The results will be verified once by August 2025.
3b. Concurrence by the Finance Commission and DGHS of the 10 cost-detail annual plans for next year's investments in first referral hospitals (BHs A&B) under 9 provinces and MOHMM respectively.	Definition: • Each year before January 15, the MOHMM (MDPU and the Chief Secretaries of 9 provinces) will develop the respective annual action plans for the respective year, based on the 5-year plan, defining the investments that will be made using the loan proceeds and provincial allocations (fund source will be identified in the plan) to achieve the results agreed under the RBL loan.	The Finance Commission for 9 province annual plans and DGHS for MOHMM plan for Line Ministry units. Frequency: Reporting on 15 January every year.	IVA will verify the number of plans received and if the activities are in alignment with the results.	The results will be verified annually by 28 February of each year from 2026.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	• The plan format for the provinces is according to the Finance Commission and / or the version in the Project Implementation Document (PID) • The plan needs to include climate proofing measures. • The annual plan from Year 2 (2027) will have a (i) completed Progress Review Report for the previous year's work along with (ii) the Fund Utilization sheet (the format will be in the PID) indicating that a minimum 80% of the allocation was used in the preceding year and a (iii) Safeguard checklist. • The MOHMM annual plan will include sub-plans from each of the implementing units of the line ministry. Calculation: The annual costed action plan (with the Progress report and the fund utilization) should be in the agreed format and should be submitted by each of the 9 provinces along with the previous year's progress report and the fund utilization level and the completed Safeguard checklist to reflect the actions needed to achieve the results/DLIs. Partial Achievement: Yes, subject to a minimum achievement of 60% (minimum submission of endorsed plans from 6 of the 10 plans ADB will disburse an amount proportional to the number of plans submitted by FC and MOHMM. For example, if instead of 10 plans, only 7 plans are verified reported then 70% of DLI amount will be disbursed (100/10X7).			
3c. Health technology assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives	Definition: • The HTA system should be institutionalized. • Implementation achievement will be measured by reporting as available on the following for at least 7 of the 8 areas: (i) availability of an approved organization structure for carrying out HTAs for new medical equipment and pharmaceuticals. (Yes/No) (ii) a health technology assessment technical expert panel appointed. (Yes/No) (iii) a dedicated budget line in the MOHMM for carrying out assessments and related expenses required for a HTA. (Yes/No) (iv) Essential medicines list (EML) for Sri Lanka revised and updated. (Yes/No)	MOHMM data. Frequency: 3 reporting times on 15 January 2027, 2029, and 2030.	The IVA will verify the completeness if at least 2, 4 or 7 areas are carried out using a checklist of the 8 areas.	IVA will review before 28 February 2027, 2029, and 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	(v) Technical specifications of medical equipment required for hospitals developed and uploaded in MOHMM website (at least 75% of the high. value equipment specifications should be available) (vi) use of the web-based Need Assessment and Prioritization Model (NAPM) when requesting *new* medical equipment (at least 75% of the medical equipment requests from any hospital or MOHMM should have used this system) (vii) an electronic mechanism developed to request new pharmaceuticals. (Yes/No) (viii) The cost accounting analysis will be introduced to BHs A &B for at least clinic and OPD care in at least 50% of the BHs A&B. Calculation: For results reported on 15 January 2027; • The HTA Unit will report that at least 2 of the 8 initiatives mentioned above have been completed. For results reported in January 2029; • The HTA Unit will report that at least 4 of the 8 initiatives mentioned above have been completed. For results reported in January 2030; • The HTA Unit will report that at least 7 of the 8 initiatives mentioned above have been completed. Partial Achievement: No			
3d. Approved 8 national guidelines for the provision of services at BHs A&B	Definition: (i) The Directorate of Elderly Health of the MOHMM will develop a guideline to include provisions for base hospitals A & B to provide elderly friendly services. It will be issued as a circular by the DGHS. (ii) The DDG Laboratory Services of the MOHMM will develop guidelines to include standards for developing a laboratory in base hospitals. (iii) DDG MS2 will develop guidelines for carrying out day surgical procedures at base hospitals. (iv) The Director FHB will develop/ revise/ update guidelines on Mithuru Piyasa and Yowun Piyasa also applicable to base hospitals.	MOHMM data. Frequency: One time reporting on 15 January 2027	The IVA will review if the guidelines are approved.	Reviewed before 28 February 2027

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	(v) The DDG Env and Occupational Health will develop the Guideline on Green, Healthy and Safe Hospitals also applicable to base hospitals. (vi) The DDG MS2 will develop a guideline in consultation with the DDG MS1 and DDG PHS 1 and 2 for clustering services with base hospitals as the apex institution. (vii) The DDG MS2 will develop / revise / update guidelines for establishing norms for standardizing services and facilities at base hospitals. (viii) The DDG MS2 will develop guidelines for establishing a Patient Service Centre at base hospitals <u>Partial achievement /disbursement:</u> No.			
3e. Health human resource (i) databases adopting the national ID number (with sex disaggregated data) operational at MOHMM and provinces, (ii) HRH unit functional at MOHMM	<u>Definition:</u> • The MOHMM database for health human resources in the line ministry currently is managed by separate technical units for different staff categories. The database for each category is in the form of both papers based and electronic but not all databases are interoperable to ensure seamless information on HRH in the MOHMM. Some of the databases are linked to staff national ID card numbers while others are by name or other ID numbers. • In the provinces the health human resources with managed independently and they report information related to human resources (separately available the health sector staff) to the Finance Commission for annual budget estimation. This information is linked to the staff ID card number and is in Excel format. • For this indicator to be achieved, 2 aspects need to be completed. (a) it is agreed that all the databases available the health sector will be interoperable across all units that manage various categories of staff and will be linked to the national ID card number or a new HRH data base for the MOHMM is developed with access to all divisions managing the HRH in the health sector and the same database will need to be linked to the salary payment mechanism within the MOHMM and (b) a human resource for health unit will be operational based on the guidelines and circulars of the MOHMM.	MOHMM website and MOHMM data <u>Frequency:</u> Reporting on 15 January 2028.	IVA will visit MOHMM to observe HRH cell and websites for HRH databases.	Reviewed before 28 February 2028

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	Calculation: An interoperable HRH database with national ID number as the staff identifier will be available in the MOHMM and in each of the 9 provinces and a HRH Cell will be functional in the MOHMM. Partial achievement / disbursement: No			
DLI 4: Patient-centered secondary care services with quality, safety, and climate resilience measures enhanced.				
4a. % of BHs A&B implementing quality and safety measures	Definition: • The circulars referred to in this DLI are in footnote 2 and have been issued by the MOHMM in the recent past. • Implementation achievement will be measured by reporting on the following for at least 3 of the 5 areas: (i) For pharmaceutical labeling, at least 50% of the clinic pharmacy drugs issued should have the labeling as defined in the circular. (ii) Temperature and humidity monitors available in at least 50% of the hospital drug stores (iii) For the Early Warning Score (Patient Observation Chart), at least 50% of the post-surgical patients BHTs should have completed the Early Warning Score (Patient Observation Chart) attached in the BHT. (iv) For adverse events: At least 50% of base hospitals should have an adverse events submission box for anonymous and for signed submissions of adverse events at nurses station in each ward and emergency treatment unit (ETU) (v) For Antibiotic Prescription chart: At least 50% of patients on antibiotics in a medical ward should have a completed antibiotic prescription chart attached. Calculation: For 2027: • The total number of BHs A&B that have reported achieving 3 of the 5 quality and safety measures in 2026/2027 / Total number of BHs A&B x 100	BH Hospital Data • The QMU will assess for the above features in a (i) clinic pharmacy, (ii) hospital drug stores, (iii) post-surgical or surgical ward, (iv) nurses station in each ward and emergency treatment unit (ETU) and in a (v) medical ward if the (i to v) requirements have been reached. • If yes, for at least 3 of the 5 areas in year 2027 and all 5 areas in year 2029, (i to v) the QMU of the BH A&B will report to the PDHS via the respective RDHS as achieved. Frequency: 2 reporting times on 15 January 2027 and 2029	IVA will check on these 5 areas at 1 BH in each province. For areas (i) iii) and (v) take a 10-patient sample from the clinic pharmacy, post-surgical ward, and medical ward respectively and for (iv) observe the a few nurses stations and the ETU for adverse events submission box and for (i) will visit the drug store to observe if humidity and temperature monitors are in place.	Reviewed before 28 February 2027 and 2029.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	For 2028: • The total number of BHs A&B that have reported achievement of all 5 quality and safety measures in 2027/2028 / Total number of BHs A&B x 100 Partial Achievement: Yes, for 2027 and for 2029. Subject to a minimum achievement of 60%, ADB will disburse an amount proportional to the achievement. For example, if only 30% of the BHs A&B have reported achievement (instead of the agreed 50% for 3 and all 5 initiatives in 2027 and 2029), then only 60% of DLI amount will be disbursed. (100/50x30).			
4b. % BHs A&B providing identified services related to women, children, youth, elderly, and persons with disabilities.	Definition: • The BHs that have made efforts to introduce/provide the following 7 interventions guided by the relevant circulars issued by the MOHMM will be considered to have met the requirement of providing children, youth, gender, elderly, and disability care: (i) Have 3 toilets dedicated for males, females and for disabled persons in OPD and in clinic waiting areas. (ii) Have holding bars in walking areas in OPDs, clinic areas and corridors leading to wards, labs etc. (iii) Have access to drinking water in OPD and clinic waiting areas. (iv) Have at least 25 seats available at clinics and OPDs, (v) Have made arrangements for providing easy access options for elders who require assistance, disabled persons, key populations, women with small children, infectious diseases patients) at OPD registration, pharmacy and laboratory. (vi) Provide gender-based violence center services (Mithuru Piyasa) that includes, but not limited to, initial assessment of survivor's physical and mental condition, addressing her immediate medical needs, processing her intake, including referral services provided, especially to social workers, shelters, and police or local enforcement agencies tasked with supporting GBV survivors, all the while ensuring her privacy and safety from retaliation by her perpetrator. (vii) Provide Youth and Adolescent center services (Yowun Piyasa) with adequate privacy.	BH data. Frequency: This data will be collected twice - in 15 January 2028 and 2030.	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe the reported results.	Reviewed before 28 February 2028, and 28 February 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	• Implementation achievement will be measured by BHs reporting on the availability of the above 7 services: Calculation: For 2028: • The number of BHs that provide (as defined in the circulars) 7 services related to children, elderly, gender and disability mentioned above by 2027 / 2028 / Total number of BHs X 100 For 2030: • The number of BHs that provide (as defined in the circulars) 7 services related to children, elderly, gender and disability mentioned above by 2029/2030 / Total number of BHs A&B X 100 Partial Achievement: Subject to a minimum achievement of 60% of the target for 2028 and 2030, ADB will disburse an amount proportional to the achievement. For example, in 2028, if only 20% and in 2030 40% of the BHs have reported that they provide all 7 services (instead of the agreed 25% of BH by 2028 and 50% of BH by 2030 respectively), only 80% of the corresponding DLI amounts for years 2028 and 2030 will be disbursed. (100/25x20 and 100/50x40).			
4c. % BHs A&B with facilities available for lipid profile, HBA1c and troponin I tests	Definition: • The BHs that have facilities available will be interpreted as hospitals that have introduced all 3 blood tests – lipid profile, troponin I and glycosylated hemoglobin (HbA1c) for early detection of risk factors and management of hypercholesteremia, myocardial infarction and diabetes mellitus respectively). This is considered achieved when the hospital reports the number of these three tests carried out using a reporting mechanism. (if only one or two of the 3 tests are introduced then this is considered not achieved) Calculation: For 2028, • The number of BHs A&B that have reported carrying out all 3 tests of lipid profile, troponin I and HbA1c / Total number of BHs A&B X 100	BH Data. Frequency: Once on 15 January 2028	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe the reported results	Reviewed before 28 February 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	Partial Achievement: Yes, subject to a minimum achievement of 60% of yearly targets for 2028, ADB will disburse an amount proportional to the achievement. For example, in 2028, if only 40% of the BHs have reported that they provide all 3 tests (instead of the agreed 50% of BH by 2028), only 80% of the DLI amount for year 2028 will be disbursed. (100/25x20).			
4d. % of BHs A&B with functional physiotherapy and/or rehabilitation unit	Definition: • The functional physiotherapy / rehabilitation unit is defined in the relevant footnote below. • The Planning Unit and /or the QMU of each of the BHs will report if the hospital physiotherapy unit with the agreed functionalities are practiced. • Functional is defined as availability of (i) adequate physical space with disability access, (ii) established mechanisms for integration with divisional hospitals and primary medical care units, (iii) established linkage with social service officers and link to assistive device providers, and (iv) defined equipment for physiotherapy, for speech therapy, and for occupational therapy (if appropriate). Calculation: • The total number of BHs that have reported availability of a functional physiotherapy unit / Total number of BHs x 100 Partial Achievement: Subject to a minimum achievement of 60% of the target (40% of BHs), ADB will disburse an amount proportional to the achievement. For example, if only 20% of the BHs have reported achievement (instead of the agreed 40% target) of having a functional physiotherapy unit, only 50% of DLI amount will be disbursed. (100/40x20)	BH Data Frequency: Once on 15 January 2029	IVA will visit 1 randomly selected BH in each province and I randomly selected BH under the line ministry and will use check list.	Reviewed before 28 February 2029.
4e. % of BHs A&B that have obtained environment protection licence and scheduled waste management licence from the Central Environmental Authority	Definition: • The BH A&Bs that have received the environment protection license and scheduled waste management license from the Central Environmental Authority will be considered. Calculation: • The number of BHs that have received environment protection license and scheduled waste management	BH Data Frequency: To be reported once on 15 January 2029.	IVA will receive a copy of the certificates of BHs A&B that have received EPL certification from the CEA for the year 2028 (if not issued 2027 will be accepted) by 15 January 2029.	IVA will receive the reported results The IVA will verify the results before 28 February 2029.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	license from CEA for the year 2027 or 2028 / Total number of BHs X 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the target of 50% of BHs (30% of the identified BHs have received both environment protection licence and scheduled waste management licence) ADB will disburse an amount proportional to the achievement. For example, if only 35% BHs have received both environment protection licence and scheduled waste management licence then only 70% of DLI amount will be disbursed (100/50x35).			
4f. % of identified BHs A&B that have renovated / expanded / repaired staff quarters	Definition: • The BH that have repaired/ renovated/ expanded/staff quarters (for any one or combination of staff categories) will be included from the total number of BHs that required to repair staff quarters (baseline in the year 2024) Calculation: • The number of BHs that have repaired/renovated/expanded their staff quarters / Total number of BHs that identified a need for repairing staff quarters X 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (20% and 40% target, 60% will be 12% and 24%), ADB will disburse an amount proportional to the achievement. For example, if only 15% and 35% of the BHs have reported in 2029 and 2030 that they repaired staff quarters (instead of the agreed 20% and 40% targets by 2029 and 2030) only 75% and 88% of the DLI amounts will be disbursed in 2029 and 2030. (100/20x15 and 100/40x35).	BH Data. Frequency: Reported twice on 15 January 2029 and 2030.	IVA will select a sample of 9 BHs (1 BH from each province) selected randomly from the reported BHs and will observe the reported results.	The IVA will verify the results before 28 February 2029 and 2030.
4g. % of secondary hospitals (BHs A&B) that provide day surgical services (footnote on day surgical services above)	Definition: • A BH that provide day surgical services will be defined as a hospital with staffing arrangements, reporting arrangements with a new register in place, and facilities for day surgeries with patient admissions, pre-op, post-op and discharge occurring within the day for a surgical procedure (e.g. eye surgery/ lump removal / wound toilet/ etc.), pre-op room available, with facilities for day surgical service theatre accessible eye, ENT, general surgery, gynae and obstetrics, and dental, with waiting area, recovery area,	BH Data. Frequency: Twice on 15 January 2029 and 2030.	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe the reported results.	Reviewed before 28 February 2029 and 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	and with access to the Central Sterile Supplies Department (CSSD), and changing rooms / staff resting rooms by gender. Calculation: • The BHs that provide day surgical services / Total number of BHs X 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (20% and 40% target, 60% will be 12% and 24%), ADB will disburse an amount proportional to the achievement. For example, if only 15% and 35% of the BHs have reported in 2029 and 2030 that they provide day surgical services (instead of the agreed 20% and 40% targets by 2029 and 2030) only 75% and 88% of the DLI amounts will be disbursed in 2029 and 2030. (100/20x15 and 100/40x35).			
4h. Number of BHs A&B have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province)	Definition: • The BH that have received National Laboratory Quality Standard issued by MOHMM will be considered Calculation: • The number of BHs that have *received* National Laboratory Quality Standard issued by MOHMM Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (3 BHs have developed labs in 2029 and 6 labs developed in 2030) have received Lab certification out of the 9 BHs (1 per province), ADB will disburse an amount proportional to the achievement in 2029 and 2030. For example, if only 4 BHS in 2029 and 8 BHs in 2030 have received lab certification, (instead of the agreed 5 and 9 BHs given as targets in 2029 and 2030) only 80% in 2029 and 89% in 2030 of DLI amount will be disbursed. (100/5x4 and 100/9x8).	BH Data Frequency: Twice on 15 January 2029 and 2030.	IVA will visit the reported BHs (1 BH from each province) to observe the reported results.	Reviewed before 28 February 2029 and 2030
4i. % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures.	Definition: • The BH that have addressed measures on climate resilience of the premises, buildings, equipment or introduced processes will be considered. • Climate resilient measures is defined as - if any 8 or more of the following 9 aspects are addressed in selected BHs (i) reducing greenhouse gas emissions, (ii) improving water	BH Data Frequency: To be reported twice by 15 January 2029 and 2030.	IVA will select a sample of 9 BHs (1 from each province) from the reported BHs and will visit them to observe the reported results.	Reviewed before 28 February 2029 and 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	management, (iii) sourcing food locally and reducing food waste (iv) improving water, sanitation and hygiene (WASH) measures (v) improving energy efficiency by purchasing energy efficient appliances and lighting systems, utilizing renewable energy sources like solar power, conducting energy audits to identify inefficiencies, and investing in building renovations to enhance insulation and ventilation, (vi) building stronger infrastructure to withstand extreme weather, (vii) relocating infrastructure from vulnerable areas are considered, (viii) availability of a disaster response plan for activating during a climate related disaster situation affecting the hospital and (ix)promoting behavioral change among staff. Calculation: The total number of base hospitals that have addressed at least 8 of the above-mentioned 9 mitigation or adaptation measures (i) to (ix) in 2029 and 2030/ Total number of base hospitals X 100 Partial Achievement: Yes, Subject to a minimum achievement of 60% of the target (12% of the identified BHs A&B have addressed at least 8 of the above-mentioned 9 mitigation or adaptation measures: ADB will disburse an amount proportional to the achievement. For example, if only 15% and 25% BHs have developed climate resilient measures in 2029 and 2030, then only 75% in 2029 and 83% of DLI amount will be disbursed. (100/20x15 and 100/30x25).			
DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized.				
5a. % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular	Definition: • Based on the issued circular, preferably using GIS methodology, each province should demarcate the populations that belong to each of the BH A&B led clusters. • The clusters demarcated should at the minimum define a laboratory sharing mechanism within the cluster. Calculation:	PDHS data Frequency: One time reporting on 15 January 2027	IVA will be provided access to the demarcated cluster maps by the PDHSs and MOHMM before February15, 2027.	Reviewed by the IVA before February 28, 2027.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	• The number of BHs with a well-defined cluster based on the circular including a defined lab cluster /Total number of BHs x100 Partial achievement: Yes, subject to a minimum achievement of 60% of the target (45% of BHs have defined their clusters instead of the 75% of the BHs), ADB will disburse an amount proportional to the achievement. For example, if only (65%) BHs A&B have defined clusters then only 85% of DLI amount will be disbursed. (100/75x65).			
5b. % of clusters (with BH A &B as Apex) with a functioning digital information system	Definition: • The HIU of the MOHMM leads the development for a cluster IT system supported by the ongoing HSEP Project financed by ADB. It is being piloted in 1 pilot cluster as of early 2025. This will be measured using the below 5 criteria. All hospitals in the cluster should adopt this system (i) for patient registration, (ii) to report notifiable disease to relevant medical officer of health area, (iii) for authorized health professionals to retrieve patient information, laboratory testing information and radiology related information (iv) use the OPD module and (v) use the Clinic modules. Calculation: The number of base hospitals with a functioning cluster interlinked digital system (demonstrating ability to apply above 5 criteria) /Total number of base hospitals Apex clusters. Partial achievement: Yes subject to a minimum achievement of 60% of the target (6% of BHs have a functioning digital information system instead of the 10% of the BHs), ADB will disburse an amount proportional to the achievement. For example, if only (9%) BHs in 2027 and 16% of BHs in 2028 have a functional cluster information system then only 90% in 2027 and 80% in 2028 of DLI amount will be disbursed. (100/10x9 and 100/20x16)	PDHS data Frequency: One time reporting on 15 January 2027 and 2028.	IVA will be provided with access to the cluster digital system by the PDHSs and MOHMM before February15, 2027 and 2028.	Reviewed by the IVA before 28 February 2027 and 2028.
5c. % of BHs A&B that have a functional 'Patient Information Centre'	Definition: • A functional Patient Information Centre will be physically created with adequate space and responsible people identified by the BH A&B hospitals. The defined services	BHs records/self-reporting.	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit	Reviewed before 28 February 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
(guideline footnote in DLI table)	identified in the relevant foot note below will be provided at the desk and they will develop arrangements to update the information regularly. • The center will provide: (i) A dedicated development officer/s and/or nursing officer/s will have a hotline phone number. (ii) Appointment services a) patients referred to from PMCIs, other hospitals, b) Well Women clinics, c) Healthy Lifestyle Centers (HLCs), d) family planning services, e) school medical and dental inspections, f) STI clinics, and g) Medico legal units (iii) Links with other sectors a) For social services b) legal services for women's medico legal issues, c) NGOs for key population service (iv) Disability support for special needs patients includes having information of a) assistive device available outlets, b) list of legal support options, c) list of paid caregiver centers/ persons, d) elders' homes list (paid and free homes) with contact information, e) Link with the Police Department, Social service, Grama Niladhari, MOHMM, with contact information etc. (v) The Centre will have a complaints /suggestions box or another mechanism to receive, review (via a review committee) and act on complaints and suggestions. Calculation: The number of BHs that report a functional Patient Information Centre (based on the achieving 3 of the 5 criteria (a) to (e) above) in 2028/ Total number of BHs Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (if 30% of BHs have a functional patient	Frequency: Once on 15 January 2028	them to observe the reported results.	

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	information centre instead of the target 50% BHs have functional patient information center), ADB will disburse an amount proportional to the achievement. For example, if only (40%) BHs A&B have patient information center then only 80% of DLI amount will be disbursed. (100/50x40).			
5d. % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas	Definition: • The list of care pathways (15) is given in the respective footnote. The respective hospitals in consultation with the RDHS and PDHS, for each year, at the planning stage will determine the 5 or more care pathway areas that will be developed / during the RBL implementation period for each of the BHs under the PDHSs preview. The development will be guided by the MOHMM circulars of March 2020 defining health service facilities at BHs and other relevant MOHMM circulars / guidelines related to infrastructure expansion, renovation, equipment, and will identify the training needs and linkages that are required to provide the care pathway at BH levels and with linkages with higher and lower-level facilities. • The number of BHs that report development under a minimum of 5 care pathways (development in each care pathway in each BH will be defined if any one or more of the areas (a) to (d) given below were considered: (a) introduction of new / replacement equipment within MOHMM guidelines, (b) infrastructure development /enhancement / repairing/ expanding clinic areas, wards, OPD areas related to the care pathway,(c) staff training related to the care pathway has been caried out, (d) linkages relevant to the care pathway established with the community, NGOs, MOHMM, PMCIs and higher level facilities / Total number of BHs A&B Calculation: The no of BHs that have developed their services and facilities in at least 5 care pathways as described above) / Total Number of BHs x 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (36% BHs each have developed minimum of 5 care pathway areas), ADB will disburse an amount proportional to the achievement. For example, if only 40% BHs A&B have developed a minimum of 5 care pathway	BHs records/self-reporting. Frequency: Once on 15 January 2029	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe /verify the reported results.	Reviewed before 28 February 2029.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	areas then only 67% of DLI amount will be disbursed. (100/60x40).			
5e. The number of care pathways that have at least 1 circular/guideline defining the standard package of care that includes gender-sensitive care provision, 1 referral and back referral guideline, and 1 training program developed and uploaded to the continuous professional development (CPD) system.	Definition: • At the National MOHMM level, the Director Quality and Safety Unit and / or other relevant DDGs or Directorates will issue at least 1 circular/ guideline describing the standard package of care and the referral and back referral pathway that should be available / followed by the BH and by the feeder hospitals respectively for each of the 15 care pathways defined in relevant footnote. • For considering this indicator as achieved, at the minimum there should be (a) at least 1guideline defining the standard package for a respective care pathway area, (b) 1 referral and back referral pathway circular developed (as 2 documents or in the same document) and (c) 1 training program that can be uploaded to the CPD for at least 10 of the 15 care pathways. • Gender-sensitive care is an integral part of patient-centered care, where the biological and cultural context of a patient's needs are considered, to understand the medical interventions required for a patient, e.g., stigma/discrimination faced by women/adolescent girls in seeking reproductive health-related services, or blame experienced by married women for uncontrolled pregnancies, or social limitations of women in seeking health care, or refusal of some women to be seen by male doctors, among others. Calculation: • No of care pathways that have met all 3 of the above criteria ((a) at least 1guideline defining the standard package for a respective care pathway area, (b) 1 referral and back referral pathway circular developed (as 2 documents or in the same document) and (c) 1 training program that can be uploaded to the CPD) Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (at least 6 care pathways should have met the required 3 criteria instead of achieving the target 10 care pathways), ADB will disburse an amount proportional to	MOHMM Records. Frequency: Once on 15 January 2030	IVA will review the pathways/guidelines developed and verify them with the CPD system.	Reviewed before February 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	the achievement. For example, if only 7 care pathways have met the 3 criteria, then 70% of DLI amount will be disbursed. (100/10x7).			
DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved				
6a. Sri Lanka Centre for Disease Control functional	Definition: • The MOHMM will submit the costed detailed design including green building features for establishing a state-of-the-art CDC. • The designs and conceptual approval from the National Planning Department are expected prior to ADB submission. • The detailed design with the necessary approval will be considered acceptable for disbursement consideration. • 10% of construction is defined as the foundation of the building completed and first floor concrete completed. • 6% construction is foundation completed. • 7% construction is foundation completed and first floor construction ongoing. • Functional (100%) is defined as the building is fully completed, furnished and staff are operating out of the building. • 60% of functional is defined as 80% of the building constructed (building completed but internal construction work ongoing) • 80% of functional is construction of building completed but more than 50% of internal works remaining • 85% constructed means (building completed but less than 50% of internal construction work remaining) 3. Calculation: Submission of detailed designs,10% constructed and functional (100% completed, furnished, staff working from building). (2025 to 2028) Partial achievement: No for 2025. Partial achievement: Yes for 2027 and 2028 subject to a minimum achievement of 60% of the target (at least 6% of	Reports from Chief Epidemiologist. Frequency: Reporting on August 2025, 15 January 2027, and 15 January 2028.	The IVA will review and visit the CDC site and confirm that the CDC is functional.	Review before 15 August 2025, Feb 15, 2027, and Feb 15, 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	construction completed in 2027 and 80% of construction completed in 2028 as defined above), ADB will disburse an amount proportional to the achievement. For example, if only 7% of construction in 2027 and 85% of construction in 2028, then 70% of DLI amount will be disbursed in 2027 and 85% disbursed in 2028. (100/10x7) and 100/100x85).			
6b. Medical Research Institute (MRI) building renovations completed	Definition: • The MOHMM will submit the costed detailed design for renovations including green building features for MRI air quality and building renovations. • The detailed costed estimate with necessary approval will be considered acceptable for disbursement consideration. Calculation: Submission of detailed cost estimates, 100% constructed /renovated. The cost estimates will define the construction percentages. Partial achievement: No for 2027. Partial Yes. for 2028 subject to a minimum achievement of 60% of the target (at least 60% of construction completed in in 2028), ADB will disburse an amount proportional to the achievement. For example, if only 70% of construction in 2028, then 70% of DLI amount will be disbursed in 2028 (100/100x70)	Reports from Medical Research Institute. Frequency: Twice on 15 January 2027 and 2028.	The IVA will review and visit the MRI site and confirm progress in 2027 and that the MRI is renovated in 2028.	Review before 28 February 2027 and 2028.
6c. % of BHs A&B hospitals updating/reporting notifiable diseases via the GIS based early warning system	Definition: The Epidemiology Unit of the MOHMM in consultation with the 9 PDHSs will roll out a GIS based (spatial based to identify locations) electronic system for reporting/updating all notifiable diseases from hospital to the respective patients Medical Officer of Health area. Calculation: In 2027 and in 2028: No of hospitals that utilize an electronic GIS based early warning disease notification system to report suspected cases of notifiable diseases / Total number of BHs x 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the hospitals (18% in 2027 and 36% in 2028 of the BHs) ADB will disburse an amount proportional to the achievement. For example, if only 25% and 55% of BHs have introduced the disease notification system, then only 83%	Epid Unit records Frequency: Twice on 15 January 2027 and 2028.	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe the reported results.	IVA will review before 28 February 2027 and 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	and 92% of DLI amount will be disbursed in 2027 and 2028. (100/30%25 and 100/60x55).			
6d. % of BHs A that use the external quality assurance system of the MRI at all 4 labs of pathology, biochemistry, hematology and microbiology.	Definition: The MRI will introduce the external quality assurance system to all 4 labs of pathology, biochemistry, hematology and microbiology at BHs A, wherever the labs are available. The laboratories that will participate in the external quality assurance program will be either sending or receiving samples to / from the MRI at the requested frequency for validation. Calculation: No of BHs A that participates the external quality assurance program for the 4 labs of pathology, biochemistry, hematology and microbiology / Total No of BHs A with all 4 labs x 100 Partial Achievement: Yes, subject to a minimum achievement of 60% of the hospitals (30% and 45% of the BHs A instead of the 50% and 75% of BHs (target)), ADB will disburse an amount proportional to the achievement. For example, if only 65% of BHs A have participated in the external quality assurance system in 2028, then only 87% of DLI amounts will be disbursed in 2028. (100/75x65).	MRI records Frequency: Twice on 15 January 2027 and 2028.	IVA will select a sample of 9 BHs (1 BH from each province) from the reported BHs and will visit them to observe /verify the reported results.	IVA will review before 28 February 2027 and 2028.
Output 3: Health sector technical capacity and pharmaceutical supply chain management improved				
DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced				
7a. % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities	Definition: The MSD of the MOHMM will be responsible for this indicator and the pharmacy drug stores is 6. A summary report with detailed cost estimates for each of the sub store repairs will be submitted for consideration under this DLI. Calculation: • For 2027 deliverable: The detailed cost estimates for infrastructure changes will be submitted for 50% of the 6 stores (3 drug stores). • For 2030:	MSD data Frequency: Twice on 15 January 2027 and 2030.	The IVA will visit a 10% sample of the repaired drug stores for verification.	Reviewed before 28 February 2027 and before 28 February 2030.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	• No of MOHMM managed drug stores repaired / renovated / expanded / total number of MOHMM managed drug stores that need to be repaired / renovated / expanded x 100 Partial Achievement: Yes, but will only be considered only for the second delivery on the MOHMM Pharmacy drug stores. Subject to a minimum achievement of 60% of the MOHMM sub stores are developed, (if a minimum of 2 MOHMM managed drug stores are renovated) ADB will disburse an amount proportional to the achievement. For example, if only 2 of MOHMM drug stores are renovated then only 67% of DLI amount will be disbursed. (100/3x2) and if 3 or more are renovated 100% will be disbursed. (100/3x3)			
7b. The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.	Definition: • The NMQAL of the NMRA will be renovated and developed to meet the ISO/IEC 17025 standard. • The road map for developing the laboratory will be drafted by the NMQAL and the detailed designs will be completed by the NMQAL initially and the required renovations / repairs /expansion to the building and the equipment needs will be finalized while applying for the ISO 17025 certification. Calculation: • For 2027 deliverable: The detailed cost estimates for infrastructure changes will be submitted. • For 2030: the ISO/IEC 17025-certification received by NMRA but if the final comments have been addressed by NMQAL then partial achievement will be considered. Partial Achievement: Yes but will be considered only for the certification deliverable and only if the NMQAL has submitted the final revisions to the ISO team for certification with the final round of corrections/ suggestions. If this can be supported with documentary evidence, disbursement of 90% of the value of the DLI can be released pending the ISO certification.	NMRA data Frequency: Twice on 15 January 2027 and 2030.	The IVA will review cost estimates and visit an NMRA lab for verification.	Reviewed before the end of February 2027 and 2030.
7c. The % change of number of tests that can	Definition:	NMRA data	The IVA will	Reviewed by the end of February 2029.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
be performed by the NMRA (NMQAL) directly or via laboratories under MOUs and/or agreements in line with the established risk-based sampling and testing approach.	• The number of all types of tests that can be carried out at NMRA/NMQAL or at the designated laboratories of NMQAL will be collected and the risk-based sampling and testing approach should be defined as an SOP by NMRA. • Calculation: • At Baseline 2024: The number of all types of tests that can be carried out at NMRA/NMQAL or at the designated laboratories of NMQAL in the year 2024. • At endline 2029: The number of tests that can be performed at NMRA/NMQAL or at the designated laboratories of NMQAL in the year 2028. Calculation: • The number of types of tests that can be performed at NMRA/NMQAL or at the designated laboratories of NMQAL in the year 2028 *minus* the number of tests that can be performed at NMRA/NMQAL or at the designated laboratories of NMRA/NMQAL or at the designated laboratories of NMQAL in the year 2024 / The number of tests that can be performed at NMRA/NMQAL or at the designated laboratories of NMQALNMRA/NMQAL or at the designated laboratories of NMQAL in the year 2024 x 100 Partial achievement: Yes, subject to achievement of a minimum of 60% of the targeted increase (54% of increase), ADB will disburse an amount proportional to the results achieved. For example, if instead of 90% increase, only 75% increase is verified reported then 83% of DLI amount will be disbursed. (100/90x75)	Frequency: Once on 15 January 2029	will review the NMQAL records to confirm the types of tests that can be performed by the NMRA (NMQAL) along with the risk-based sampling and testing approach SOP.	
DLI 8: Procurement management capacity enhanced				
8a. % of procurement entities of the MOHMM and 9 PDHS offices that complete all *3 of these steps*: (i) has the master procurement plan updated in the eGP system PROMISe.lk, (ii)	Definition: E Procurement is recently introduced in Sri Lanka via the e-General Procurement system PROMISe.lk. Currently only RFQs are managed via the system but in 2025, the MOF will include NCB contracts to be managed via this system. Further, the MOHMM in consultation with the ADB and the Procurement Commission are drafting new RFQ, NCB, and ICB documents for pharmaceuticals and for medical	Data on MOHMM-managed procurement entities: Add Secretary Procurement records Data on Provincial-managed procurement entities: The Chief	IVA will observe if the 3 criteria are met at a randomly collected sample of 5 PEs under the MOHMM and in the 9 provinces by visiting each of the 9 PDHS Offices.	Review before 28 February 2027 and 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
has the annual procurement plan in the eGP system PROMISe.lk, and (iii) utilizes PROMISe.lk for all RFQ contracts identified in the annual procurement plan.	equipment. The line ministry and all 9 provinces are required to adopt the ePROMISe.lk system. MOHMM has 71 procurement entities 9 provinces will report from 9 PDHS offices and 26 Regional RDHS offices (total 35) Calculation: In 2027: The number of procurement entities (PEs) of the MOHMM (i) has the master procurement plan updated in the eGP system PROMISe.lk (ii) annual procurement plan in the eGP system PROMISe.lk, (ii) utilizes PROMISe.lk for all RFQ contracts in the annual Procurement Plan. / Total number of PEs in the MOHMM (71) In 2028: The number of procurement entities (PEs) of the Provinces (i) has the master procurement plan updated in the eGP system PROMISe.lk (ii) annual procurement plan in the eGP system PROMISe.lk, (ii) utilizes PROMISe.lk for all RFQ contracts in the annual Procurement Plan. / Total number of PEs in the PDHS offices (35) Partial Achievement: Yes, For 2027, subject to a minimum achievement of 60% of the target (30% of the 71 PEs (21 PEs) of the PEs have met all 3 criteria), ADB will disburse an amount proportional to the achievement. For example, if only 40% (28 PEs) of PEs have met all 3 criteria, then 80% of DLI amount will be disbursed. (100/50x40).	Secretaries Finance / Eng records Frequency: by 15 January 2027 and 2028.		
8b. No of framework agreements signed for pharmaceuticals and medical supplies (excluding buy back)	Definition: Framework agreements are newly introduced under the SL Pharmaceutical Procurement Guidelines. Calculation: The number of framework agreements signed by the SPC (excludes buy back) Partial Achievement: Yes, subject to a minimum achievement of 60% of the target (6 contracts), ADB will disburse an	Add Sec Procurement records. Frequency: One time by 15 January 2028.	IVA will observe the use of the framework agreement.	Reviewed before 28 February, 2028.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	amount proportional to the achievement. For example, if only 7 procurement entities have managed to utilize procurement monitoring system, then 70% of DLI amount will be disbursed. (100/10x7).			
8c. Standard bidding documents (SBDs) for pharmaceuticals and medical equipment (i) developed; and (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back).	Definition: For this indicator to be achieved, two criteria need to be met: (a) SBDs for medical equipment and pharmaceuticals need to be developed and (b) 50% of pharmaceutical contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back). Calculation: For deliverable 1: The SBDs for pharmaceuticals and medical equipment should be developed, approved and authorized for use. For deliverable 2: 50% of pharmaceutical contracts awarded by SPC should have been used the pharmaceutical and medical equipment SBDs (excluding buy back). Partial Achievement for Deliverable1: No Partial Achievement for Deliverable 2: Yes, subject to a minimum achievement of 60% of the target (30% of the pharmaceutical contracts), ADB will disburse an amount proportional to the achievement. For example, if only 35% of the pharmaceutical contracts have used framework agreements, then 70% of DLI amount will be disbursed. (100/50x35).	The Add Secretary Procurement records Frequency: One time reporting on 15 January 2027 for deliverable 1 and 15 January 2030 reporting for deliverable 2.	IVA will observe the use of the new SBDs.	Reviewed before 28 February 2027 and 28 February 2030.
8d. % change in the average time taken from request to initiation of repairs/service etc. of a building or a medical equipment at centrally managed hospitals	Calculation: For 2027: The number of days taken from the date of the request for a maintenance task to be initiated in year 2026 minus the number of days taken from the date of the request for a maintenance task to be initiated in year 2024/ The number of days taken from the date of the request for a maintenance task to be initiated in year 2024 x 100 For 2029: The number of days taken from the date of the request for a maintenance task to be initiated in year 2028 minus the number of days taken from the date of the request for a maintenance task to be initiated in year 2024/ The number of	Building request: Add Secretary Engineering office records Medical equipment request: DDG Biomedical engineering unit records. Frequency: Reported on 15 January 2027 and 2029.	IVA will verify the results by taking a sample from each entity (BME and Add Sec Eng units) of 5 cases received at each of the 2 entities in 2027 and 2029.	Reviewed by 28 February 2027 and 2029.

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
	days taken from the date of the request for a maintenance task to be initiated in year 2024 x 100 Partial achievement: Yes, subject to a minimum achievement of 60% of the target (6% reduction from baseline in 2027 and 12% reduction from baseline in 2029), ADB will disburse an amount proportional to the achievement. For example, if only 8% reduction in 2027 15% reduction of the time taken then 80% in 2027 and 75% in 2029 of DLI amount will be disbursed. (100/10x8 and 100/20x15).			

BH = base hospital, A&B = type A and type B, DGHs = district general hospitals, eGP = electronic government procurement, FHB = Family Health Bureau, HBA1c = hemoglobin A1c test, HRH = human resource for health, ISO/IEC = International Organization for Standardization/International Electrotechnical Commission, MOHMM = Ministry of Health and Mass Media, MRI = Medical Research Institute, MSD = medical supply division, NMRA = National Medicines Regulatory Authority, NMQAL = National Medicines Quality Assurance Laboratory, SBD = standard bidding documents.
Source: Asian Development Bank.

D. Disbursement Allocation and Status

14. **Disbursement arrangements.** The loan and grant proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2022, as amended from time to time),[9] and detailed arrangements agreed between the borrower and ADB.

15. Disbursement of loan and grant proceeds will be made to the Account of Deputy Secretary Treasury under the Central Bank based on the verification of achievement of DLIs for which disbursement is requested. A combined withdrawal application for all implementing agencies will be submitted to ADB by the Program Coordination Office (PCO) under the executing agency via External Resource Department (ERD) of MOF together with the verification report from IVA upon loan and grant effectiveness in 2025 for reporting prior results achieved and also in the first week of April of each of following implementing years from 2026 for reporting the previous calendar years achievements. Disbursement will follow the agreed disbursement schedule, including partial disbursements. The RBL program includes a provision for financing for prior results of $4.1 million ($3.6 million loan and $0.5 million grant proceeds). The prior results include approval of costed 5-year action plan and annual plans and detailed design for center for disease control, which are prerequisite for timely implementation of the program.

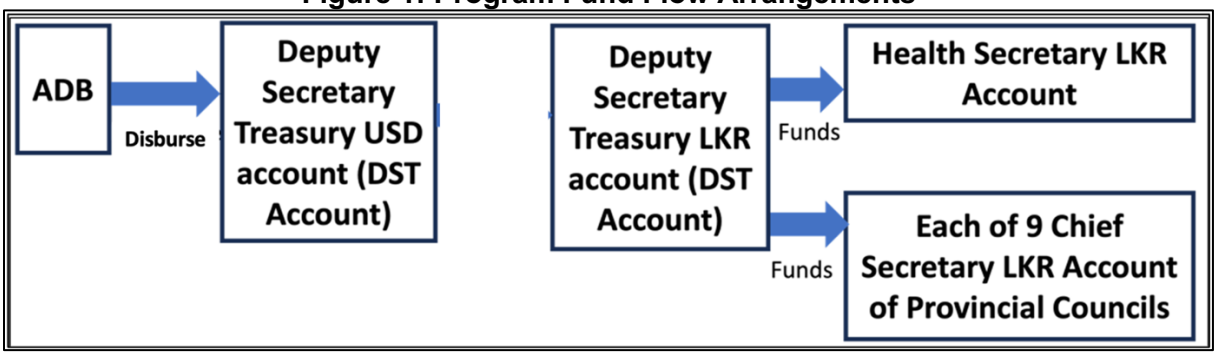
16. The borrower requested advance financing up to 10% of loan and 10% of the grant to achieve the initial set of DLIs. The amount of advances will be recovered from subsequent disbursements when DLIs are achieved. The recovered advance is then available, as needed, for additional advances ("revolving advances"), but the outstanding advance should not at any time exceed the ceiling of 10% of the respective ADB financing. When the borrower submits a withdrawal application for the achieved DLIs, any outstanding advances must be liquidated before any disbursements are made.[10] The borrower must refund any unliquidated advances within 2 months after the winding-up period.

17. **Fund flow.** The loan and grant proceeds will be disbursed to the government's general account. Disbursements will not depend on evidence of expenditure or transactions. The Deputy Secretary Treasury Account will transfer funds to Health Secretary account for achieving MOHMM-level results and to the 9 Chief Secretary accounts for achieving provincial-level results. Upon receiving the request for releasing the loan and grant proceeds with the corresponding achievement of results certified or upon receiving the request for advance, the funds will be disbursed by ADB to the Deputy Secretary Treasury Account. The fund release from the ADB to the government will be done annually based on the verified result reports along with the withdrawal applications submitted by the executing agency through ERD. The withdrawal applications and other associated tasks for 9 provincial councils and MOHMM will be collected, summarized, and prepared by the PCO and signed by DGHS as the Program Director and submitted by DGHS to ADB through ERD. The program fund flow and withdrawal application procedure are summarized in the below Figure 1 and Figure 2, respectively.

[9] The handbook is available electronically from the ADB website. ADB. Loan Disbursement Handbook.

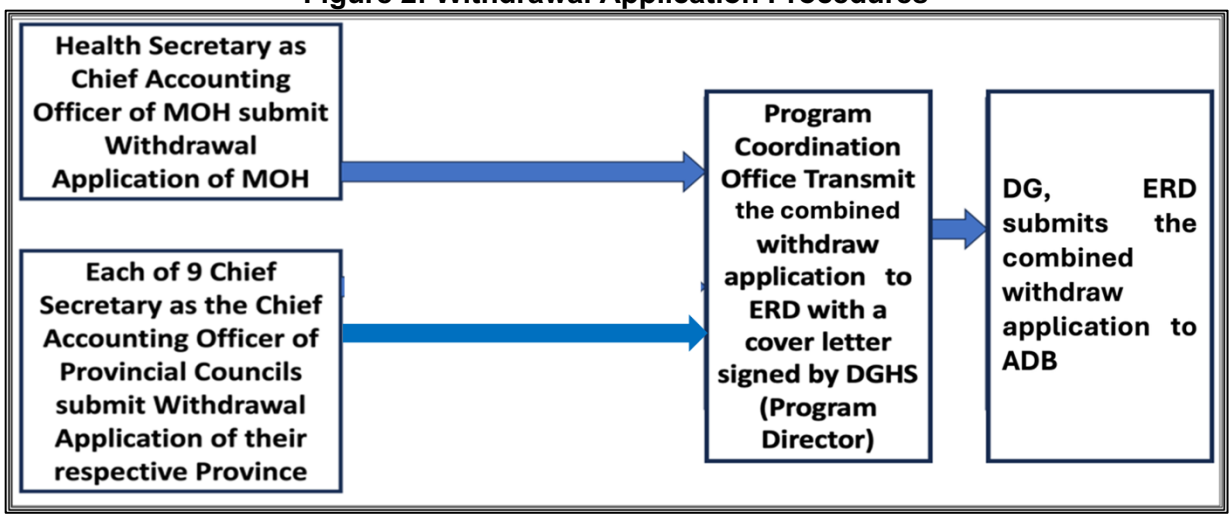
[10] If the amount(s) of the achieved DLI(s) submitted in the withdrawal application exceeds the amount of the outstanding advance, the excess will be treated as reimbursement to the government.

Figure 1: Program Fund Flow Arrangements



ADB = Asian Development Bank, DST = Deputy Secretary Treasury, LKR = Sri Lankan rupee, MOF = Ministry of Finance, Planning, and Economic Development.
Source: ADB.

Figure 2: Withdrawal Application Procedures



ADB = Asian Development Bank, DG = Director General, ERD = Department of External Resources, MOH = Ministry of Health and Mass Media.
Source: ADB.

18. All DLIs must be achieved on or before the RBL program's completion date.[11] If a DLI is not achieved or not fully achieved by the RBL program completion date, the amount allocated to the portion of the DLI not achieved or not fully achieved will be canceled. Evidence of achievement of DLIs must be submitted with the withdrawal applications. The borrower will have a winding-up period, which ends 4 months after the RBL program's completion date, for submitting withdrawal applications to ADB. If the amount of ADB financing disbursed exceeds the total amount of the government-owned program's expenditures after the winding-up period and final disbursement has been made, the borrower should refund the difference to ADB within 6 months after the RBL program completion date.

19. Before the submission of the first withdrawal application, the borrower will submit to ADB the evidence of the authority of the person(s) who will sign the withdrawal applications on behalf of the borrower, together with the authenticated specimen signatures of each authorized person.

[11] Under RBL, the program completion date is the same as the loan closing date.

Use of ADB's Client Portal for Disbursements[12] system is **mandatory** for submitting withdrawal applications to ADB.

20. The standard withdrawal application form is provided in Appendix 2.

[12] The portal facilitates the online submission of withdrawal applications to ADB, resulting in faster disbursement. The forms the borrower needs to complete are available in ADB. Guide to the Client Portal for Disbursements.

1. Expected Disbursement Allocation and Schedule

Table 8: Expected Disbursement Schedule
($ million, as of 18 March 2025)

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
Outcome: Efficiency and quality of secondary health services improved as first referral care ($12 million) (100% provinces)										
DLI 1: Average waiting time of patients for 3 elective surgeries (cataract, hernia repair and hysterectomy) (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 30%		6.0	6%							6
DLI 2: Surgical site hospital-acquired infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (type A and B base hospitals) reduced by 40%		6.0	6%							6
Outputs										
Output 1: First referral care services enhanced ($69.50 million)										
DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened ($17.50 million) (35% MOHMM,65% Provinces)										
3a. Concurrence by the Finance Commission and the DGHS of the costed 5-year action plan by each province and from MOHMM for BHs under MOHMM respectively for first referral hospitals development (BHs A&B) for 2025–2029.	0.25	1.75	2%			2				
3b. Concurrence by the Finance Commission and DGHS of the 10 costed detailed annual plans for next year's investments in first referral hospitals (BHs A&B) under 9 provinces and MOHMM respectively.	3	9	12%			1.6	2.6	2.6	2.6	2.6
3c. Health technology assessment process for new medical equipment and new	1		1%				0.2		0.4	0.4

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives										
3d. Approved 8 national guidelines for the provision of services at BHs A&B.	0.5		0.5%				0.5			
3e. Health human resource (i) databases adopting the national ID number (with sex disaggregated data) operational at MOHMM and provinces, and (ii) HRH unit functional at MOHMM	1	1	2%					2		
DLI 4: Patient-centred secondary care services with quality, safety, and climate resilience measures enhanced ($29 million) (100% provinces)										
4a. % of BHs A&B implementing quality and safety measures		2	2%				1		1	
4b. % BHs A&B providing identified services related to women, children, youth, elderly, and persons with disabilities.		3	3%					2		1
4c. % BHs A&B with facilities available for lipid profile, HBA1c and troponin I tests		3	3%					3		
4d. % of BHs A and B with functional physiotherapy and/or rehabilitation unit		3	3%						3	
4e. % of BHs A&B that have obtained environment protection licence and scheduled waste management licence from the Central Environmental Authority		4	4%						4	
4f. % of identified BHs A&B that have renovated/expanded/ repaired staff quarters		4	4%						3	1
4g. % of secondary hospitals (BHs A&B) that provide day surgical services		4	4%						3	1
4h. Number of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province)		2	2%						1	1
4i. % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures		4	4%						3	1

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized. ($23 million) (96% Provinces, 4% MOHMM)										
5a. % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular		6	6%				6			
5b. % of clusters (with BHs A&B as Apex) with a functioning digital information system		7	7%				4	3		
5c. % of BHs A&B that have a functional Patient Information Centre.		3	3%					3		
5d. % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas.		6	6%						6	
5e. The number of care pathways that have at least 1 circular and/or guideline defining the standard package of care, 1 referral and back referral guideline and 1 training programme developed and uploaded to the continuous professional development (CPD) system.	1		1%							1
Output 2: Pandemic prevention, preparedness, and response enhanced ($6.9 million Pandemic Prevention, Preparedness and Response Trust Fund Grant) (100% MOHMM)										
DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved. ($6.9 million Pandemic Prevention, Preparedness and Response Trust Fund Grant) (100% MOHMM)										
6a. Sri Lanka Centre for Disease Control functional				3.1	44.9%	0.5	1.6	1		
6b. Medical Research Institute (MRI) building renovations completed				2.75	39.9%		1.5	1.25		
6c. % of BHs A&B hospitals updating / reporting notifiable diseases via the GIS based early warning system				0.5	7.2%		0.25	0.25		
6d. % of BHs A&B that use the external quality assurance system of the MRI at all				0.55	8.0%		0.3	0.25		

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
4 labs of pathology, biochemistry, hematology and microbiology.										

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
Output 3: Health sector technical capacity and pharmaceutical supply chain management improved ($18.5 million) (65% MOHMM, 35% Provinces)										
DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced ($9 million) (100% MOHMM)										
7a. % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities	4		4%				1			3
7b. The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.	4		4%				1			3
7c. The % change of number of tests that can be performed by the NMRA (NMQAL) directly or via laboratories under MOUs and/or agreements in line with the established risk-based sampling and testing approach.	1		1%						1	
DLI 8: Procurement management capacity enhanced ($9.5 million) (30% MOHMM, 70% Provinces)										
8a. % of procurement entities of the MOHMM and 9 PDHS offices that complete all *3 of these steps*: (i) has the master procurement plan updated in the eGP system PROMISe.lk, (ii) has the annual procurement plan in the eGP system PROMISe.lk, and (iii) utilizes PROMISe.lk for all RFQ contracts identified in the annual procurement plan.	0.75	6.25	7%				0.75	6.25		
8b. No of framework agreements signed for pharmaceuticals and medical supplies (excluding buy back)	0.50		0.5%					0.50		
8c. Standard bidding documents (SBDs) for pharmaceuticals and medical equipment (i) developed; (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back).	0.50		0.5%				0.25			0.25

Disbursement-Linked Indicators	Total ADB Loan Financing Allocation ($ million)		Share of Total ADB Loan Financing (%)	Total PPPR Fund Grant Financing Allocation ($ million)	Share of Total PPPR Fund Grant Financing (%)	Prior Results	Period 1 (effective date to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)
	Allocation to MOHMM	Allocation to 9 Provinces								
8d. % change in the average time taken from request to initiation of repairs/service etc. of a building or a medical equipment at centrally managed hospitals	1.50		1.5%				1		0.5	
Total	**19.00**	**81.00**	**100.00%**	**6.90**	**100.00%**	**4.10**	**21.95**	**25.10**	**28.50**	**27.25**

BH = Base Hospital, A&B = type A and type B, DGHs = district general hospitals, eGP = electronic government procurement, FHB = Family Health Bureau, HBA1c = hemoglobin A1c test, HRH = human resource for health, ISO/IEC = International Organization for Standardization/International Electrotechnical Commission, MOHMM = Ministry of Health and Mass Media, MRI = Medical Research Institute, MSD = medical supply division, NMRA = National Medicines Regulatory Authority, NMQAL = National Medicines Quality Assurance Laboratory, PPPR Fund = Pandemic Prevention, Preparedness and Response Trust Fund, SBD = standard bidding documents.
Source: Asian Development Bank.

Table 9: Disbursement Schedule ($ million) by Provinces and MOHMM by Year

Allocation	Prior results (12 months prior to effective date of loan and grant)	Period 1 (effective date of loan and grant to March 2027)	Period 2 (April 2027 to March 2028)	Period 3 (April 2028 to March 2029)	Period 4 (April 2029 to March 2030)	Total
9 Provincial Councils for Health	2.75	13.00	20.25	26.00	19.00	**81.00**
Ministry of Health and Mass Media Loan	0.85	5.30	2.10	2.50	8.25	**19.00**
Ministry of Health and Mass Media Pandemic Prevention, Preparedness and Response Trust Fund Grant	0.50	3.65	2.75	0	0	**6.90**
Total	**4.10**	**21.95**	**25.10**	**28.50**	**27.25**	**106.90**

Table 10: Disbursement Timeline and Link to Verified Results for the RBL Program 2025 to 2030

Time Period	Description	Disbursement (US$ million)
Prior results (12 months prior to effective date of loan and grant	***August 2025**:* GOSL to ADB fund release request: Upon effectiveness of project	*MOHMM Loan 0.85* *MOHMM PF Grant 0.50* *9 Provinces 2.75*
	Amount: US$ 1.35 to MOHMM (Loan 0.85, PF Grant 0.5) and USD 2.75 million to the 9 Provincial accounts (at USD 305,555.00 per province) equal distribution for first year), with the reporting of achievement of verified results of prior year. If verified results achievement is less than 100% but more than 60%, for partial achievement approved DLIs (given in Verification protocol) the reimbursement fund release will be (reduced) pro-rated against each of the partly completed indicators. These results include:	
	DLI 3a: (***Yes)*** Concurrence by the Finance Commission and the DGHS of the costed *5-year action plan by each province and from MOHMM for BHs under MOHMM respectively* for *first referral hospitals development (BHs A and B) for* 2025 – 2029	
	DLI 3b: ***(Yes)*** Concurrence by the Finance Commission and DGHS of the 10 costed detail *annual plans* for next year's investments in first referral hospitals *(BHs A and B) under provinces (9) and MOHMM (1) respectively*	
	DLI 6a: (***Detailed design)*** Sri Lanka Centre for Disease Control functional	
Period 1 (effective date of loan and grant to March 2027)	***January / February 2026**:* GOSL to ADB fund release request: Advance financing of 45% of 2026 Allocation of US$ 21.95 million	MOHMM Loan: 2.39 *MOHMM PF Grant 1.64* 9 Provinces: 5.85
	April 2027: GOSL to ADB fund release request: Balance of 2026 allocation	*MOHMM Loan* 2.92 MOHMM PF Grant 2.01 9 Provinces:7.15
	Total US$ 21.95 million: US$ 8.95 million to MOHMM account and US$ 13.00 to the 9 Provincial Accounts based on the Finance Commission approved resource allocation formula with the reporting of achievement of verified results of year from effective date in 2025 to December 2026. If verified results achievement is less than 100% but more than 60%, the reimbursement fund release will be (reduced) pro-rated against each of the partly completed indicators for the implementing year July to December 2025.	

<table>
<tr><td></td><td colspan="2">45% Advance financing of the Period 1 allocation can be requested as an advance in January / February 2026.

If incomplete results of the previous year (Period: prior year) is reported as verified and complete along with the 2025/2026 results in February 2027, the balance due payments of the 2025 prior year results allocation will also be reimbursed to the MOHMM or the 9 Provinces as relevant.

The results that are verified in include the following:</td></tr>
<tr><td></td><td colspan="2">DLI3b: (Yes) Concurrence by the Finance Commission and DGHS of the 10 costed detail <u>annual plans</u> for next year's investments in first referral hospitals (BHs A and B) under provinces (9) and MOHMM (1) respectively</td></tr>
<tr><td></td><td colspan="2">DLI 3c: (At least 2 of the 8) Health Technology Assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives</td></tr>
<tr><td></td><td colspan="2">DLI 3d: (all 8 plans) Approved 8 national guidelines for the provision of services at BHs A&B.</td></tr>
<tr><td></td><td colspan="2">DLI 4a: (50% of BHs with 3 initiatives introduced) % of BHs A&B implements quality and safety measures</td></tr>
<tr><td></td><td colspan="2">DLI 5a: (At least 75% of clusters) % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular</td></tr>
<tr><td></td><td colspan="2">DLI 5b: (At least 10% of clusters) % of clusters (with BH A or Bs as Apex) with a functioning digital information system</td></tr>
<tr><td></td><td colspan="2">DLI 6a: (10% constructed) Sri Lanka Centre for Disease Control functional</td></tr>
<tr><td></td><td colspan="2">DLI 6b: (Detailed cost estimate submitted) Medical Research Institute MRI building renovations completed</td></tr>
<tr><td></td><td colspan="2">DLI 6c: (at least 30% of clusters) % of hospitals updating / reporting notifiable diseases via the GIS based early warning system</td></tr>
<tr><td></td><td colspan="2">DLI 6d: (at least 50% of BHs) % of BHs A&B that use the External Quality Assurance system of the MRI at all 4 labs of the Pathology, Biochemistry, Haematology and Microbiology.</td></tr>
<tr><td></td><td colspan="2">DLI 7a: (Cost estimates available) % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities</td></tr>
<tr><td></td><td colspan="2">DLI 7b: (Cost estimates available) The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.</td></tr>
<tr><td></td><td colspan="2">DLI 8a: (At least 50% MOHMM PEs) % of procurement entities of the MOHMM and 9 PDHS offices that complete all 3 of these steps: (i) has the master procurement plan updated in th eGP system PROMISe.lk (ii) has the annual procurement plan in the eGP system PROMISe.lk (ii) utilizes PROMISe.lk for all RFQ contracts identified in the annual Procurement Plan. (MOHMM activities)</td></tr>
<tr><td></td><td colspan="2">DLI 8c: (Developed) Standard Bidding Documents (SBDs) for Pharmaceuticals and Medical equipment (i) developed (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy-back).</td></tr>
<tr><td></td><td colspan="2">DLI 8d: (10% reduction) % change in the average time taken from request to initiation of repairs/service etc. of a building or a medical equipment at centrally managed hospitals</td></tr>
<tr><td rowspan="5">Period 2 (April 2027 to March 2028)</td><td rowspan="2"><u>January 2028: GOSL to ADB 20% advance of Allocation for 2028</u></td><td>MOHMM (Loan) : 0.5</td></tr>
<tr><td>9 Provinces: 5.20</td></tr>
<tr><td rowspan="3"><u>April 2028:</u> GOSL to ADB fund release request: Total of allocation of 2027</td><td>MOHMM (Loan) : 2.10</td></tr>
<tr><td>MOHMM (PF Grant) 2.75</td></tr>
<tr><td>9 Provinces: 20.25</td></tr>
<tr><td colspan="2">US$ 4.85 million to MOHMM account and US$ 20.25 million to the 9 Provincial Accounts release based on the Finance Commission approved resource allocation formula.

Any incomplete results of the previous year 2025/2026 is reported as verified and complete, the balance due payments of the 2025 allocations (prior year or 2025/2026 Period 1) will also be reimbursed to the MOHMM or the 9 Provinces as relevant.

If verified results achievement is less than 100% but more than 60%, the reimbursement fund release will be pro-rated against each of the partly completed indicators for the implementation year 2027.</td></tr>
</table>

	DLI 3b: ***(10 annual plans for Provinces and MOHMM)*** Concurrence by the Finance Commission and DGHS of the 10 costed detail *annual plans* for next year's investments in first referral hospitals *(BHs A and B) under provinces (9) and MOHMM (1) respectively.*	
	DLI 3e: ***(Yes)*** Health human resource (i) databases adopting the National ID number operational at MOHMM and Provinces, (ii) HRH unit functional at MOHMM	
	DLI 4b: ***(40% with all initiatives)*** % BHs A&B provide all identified services related to women, children, youth, elderly, and persons with disabilities	
	DLI 4c: (***At least 50%)*** % BHs A&B with facilities available for Lipid Profile, HBA1c and Troponin I tests	
	DLI 5b: ***(at least 20%)*** % of clusters (with BH A or Bs as Apex) with a functioning digital information system	
	DLI 5c: ***(At least 50%, 3 criteria)*** % of BHs A&B that have a functional Patient Information Centre	
	DLI 6a: (Functional) Sri Lanka Centre for Disease Control functional	
	DLI 6b: (100%) Medical Research Institute MRI building renovations completed	
	DLI 6c: (*At least 60%)* % of hospitals updating / reporting notifiable diseases via the GIS based early warning system	
	DLI 6d: (***At least 75%)*** % of BHs A&B that use the External Quality Assurance system of the MRI at all 4 labs of the Pathology, Biochemistry, Haematology and Microbiology	
	DLI 8a: (***At least 50% Provinces PEs***) % of procurement entities of the MOHMM and 9 PDHS offices that complete all *3 of these steps*: (i) has the master procurement plan updated in th eGP system PROMISe.lk (ii) has the annual procurement plan in the eGP system PROMISe.lk (ii) utilizes PROMISe.lk for all RFQ contracts identified in the annual Procurement Plan.	
	DLI 8b: (at least 10) No. of Framework Agreements signed for pharmaceuticals and medical supplies (excluding buy back)	
Period 3 (April 2028 to March 2029)	**January/February 2029:** Advance financing of 20% of 2028 Allocation of US$ 23.85 million	MOHMM (Loan) 1.65 Provinces 3.80
	April 2029: GOSL to ADB fund release request: Balance of allocation of 2028	MOHMM: 2.00 9 Provinces: 20.80
	US$ 2.50 million to MOHMM account and US$ 26.00 million to the 9 Provincial Accounts release based on the Finance Commission approved resource allocation formula. 20% Advance of the Period 2 allocation can be requested as an advance in January / February 2028. Any incomplete results of the previous year 2025, 2026,2027 are reported as verified and complete, the balance due payments of the 2025,2026,2027 allocation will also be reimbursed to the MOHMM or the 9 Provinces as relevant. If verified results achievement is less than 100% but more than 60%, the reimbursement fund release will be pro-rated against each of the partly completed indicators for the reporting year 2028.	
	DLI 3b: (***Yes)*** Concurrence by the Finance Commission and DGHS of the 10 costed detail *annual plans* for next year's investments in first referral hospitals *(BHs A and B) under provinces (9) and MOHMM (1) respectively*	
	DLI 3c: (*At least 4 of the 8 initiatives achieved)* Health Technology Assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives	
	DLI 4a: (***50% with 5 initiatives***) % of BHs A&B implements quality and safety measures	
	DLI 4d: ***(At least 40%)*** % of BHs A and B with functional physiotherapy / rehabilitation unit	
	DLI 4e: ***(At least 50%)*** % of BHs A&B that have obtained Environment Protection Licence and and Scheduled Waste Management Licence from the Central Environmental Authority	
	DLI 4f: ***(At least 20%)*** % of identified BHs A & B have renovated /expanded/ repaired staff quarters	
	DLI 4g: (At least 20%) % of secondary hospitals (BHs A&B) that provide day surgical services	
	DLI 4h: (***At least 5 labs***) No of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province	

	DLI 4i: (***At least 10% of 5 initiatives)*** % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures	
	DLI 5d: (***At least 60%)*** % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas	
	DLI 7c: ***(90% increase from base line)*** The % change of number of tests that can be performed by the NMRA (NMQAL) directly or via laboratories under MOUs/Agreements in line with the established risk-based sampling and testing approach.	
	DLI 8d: (***20% reduction)*** % change in the average time taken from request to initiation of repairs/service etc. of a building or a medical equipment at centrally managed hospitals	
Period 4 (April 2029 to March 2030)	***April 2030:*** GOSL to ADB fund release request: Balance of allocation of 2029	MOHMM: 6.60 9 Provinces: 15.20
	US$ 8.25 million to MOHMM account and US$ 19.00 million to the 9 Provincial Accounts release based on the Finance Commission approved resource allocation formula. 20% Advance of the Period 4 allocation can be requested as an advance in January / February 2029. Any incomplete results of the previous year 2025, 2026, 2027 are reported as verified and complete, the balance due payments of the 2025 allocation and the 2026 allocation and the 2027 allocation will also be reimbursed to the MOHMM or the 9 Provinces as relevant. If verified results achievement is less than 100% but more than 60%, the reimbursement fund release will be pro-rated against each of the partly completed indicators for the reporting year 2028.	
	DLI 1: ***(30% reduction from baseline)*** The average waiting time of patients for 3 elective surgeries (cataract, hernia by sex) and hysterectomy) at first referral hospitals (BHs A&B) reduced by 30%	
	DLI 2: ***(40% reduction from baseline)*** IV cannula and surgical site Hospital Acquired Infections per 10,000 admissions (disaggregated by sex) at first referral hospitals (BHs A&B) reduced by 40%	
	DLI 3b: ***(Yes)*** Concurrence by the Finance Commission and DGHS of the 10 costed detail *annual plans* for next year's investments in first referral hospitals *(BHs A and B) under provinces (9) and MOHMM (1) respectively*	
	DLI 3c: ***(At least 7 of the 8 initiatives achieved)*** Health Technology Assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives	
	DLI 4b: ***(at least 60% with all initiatives)*** % BHs A&B provide all identified services related to women, children, youth, elderly, and persons with disabilities	
	DLI 4f: (***At least 40%)*** % of identified BHs A & B have renovated /expanded/ repaired staff quarters	
	DLI 4g: ***(At least 40%)*** % of secondary hospitals (BHs A&B) that provide day surgical services	
	DLI 4h: ***(At least 9 labs)*** No of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (1 per province)	
	DLI 4i: ***(At least 20% of 5 initiatives)*** % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures	
	DLI 5e: ***(10 number of pathways)*** The number of care pathways that have at least 1 circular/guideline defining the standard package of care, 1 referral and back referral guideline and 1 training programme developed and uploaded to the Continuous Professional Development (CPD) system.	
	DLI 7a: ***(at least 50%)*** % of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities	
	DLI 7b: ***(Yes)*** The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025.	
	DLI 8c: ***(50%)*** Standard Bidding Documents (SBDs) for Pharmaceuticals and Medical equipment (i) developed (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy-back).	

Table 11: Disbursement Timeline and Allocations by MOHMM and Provinces

Description	Timeline	MOHMM (Loan)	MOHMM (PF Grant)	Provinces	Total
GOSL to ADB fund release request: Upon effectiveness of project	August 2025	0.85	0.50	2.75	4.10
GOSL to ADB fund release request: Advance financing of 45% of 2026 Allocation	January/February 2026	2.38	1.64	5.85	9.88
GOSL to ADB fund release request: Total of allocation of 2026	March 2027	2.92	2.01	7.15	12.07
GOSL to ADB fund release request: Advance financing of 20% of 2028 Allocation	January/February 2028	0.50	0	5.20	5.70
GOSL to ADB fund release request: Total allocation of 2027	March 2028	2.10	2.75	20.25	25.10
GOSL to ADB fund release request: Advance financing of 20% of 2029 Allocation	January/February 2029	1.65	0	3.80	5.45
GOSL to ADB fund release request: Balance of allocation of 2028	March 2029	2.00	0	20.80	22.80
GOSL to ADB fund release request: Balance of allocation of 2029	March 2030	6.60	0	15.20	21.80
Total		19.00	6.90	81.00	106.90

2. Disbursement Status

Table 12: Disbursement Status[a]

(as of {date})

Disbursement-Linked Indicator[b]	ADB Financing Allocation ($ million)	Share of Total ADB Financing (%)	Expected Disbursement by {month and year} ($ million)	Actual Disbursement by {month and year} ($ million)	Share of Total ADB Financing Disbursed (%)
			Not applicable at this stage.		
Total					**100.0**

Source: Asian Development Bank.

III. EXPENDITURE FRAMEWORK AND FINANCING

A. Expenditure Framework

1. Expected Expenditure Framework

Table 13: Summary of Program Expenditure Framework, FY2025–FY2030
(2024 prices) ($ million)[1]

Sl No	Items	Broader Program		Expenditure Program[2]	
		Amount	Share of Total (%)	Amount	Share of Total (%)
1	**Ministry of Health and Mass Media**				
	Recurrent expenditure	8,323.2	71.0%	49.5	0.4%
	Capital expenditure	1,428.8	12.2%	55.8	0.5%
2	**Central Province**				
	Recurrent expenditure	190.1	1.6%	29.2	0.2%
	Capital expenditure	6.1	0.1%	6.1	0.1%
3	**Eastern Province**				
	Recurrent expenditure	168.1	1.4%	31.4	0.3%
	Capital expenditure	14.6	0.1%	14.6	0.1%
4	**Northern Province**				
	Recurrent expenditure	177.6	1.5%	38.3	0.3%
	Capital expenditure	15.8	0.1%	15.8	0.1%
5	**North-Central Province**				
	Recurrent expenditure	135.0	1.2%	27.4	0.2%
	Capital expenditure	15.9	0.1%	15.9	0.1%
6	**North-Western Province**				
	Recurrent expenditure	196.6	1.7%	36.9	0.3%
	Capital expenditure	0.3	0.0%	0.3	0.0%
7	**Sabaragamuwa Province**				
	Recurrent expenditure	229.4	2.0%	50.1	0.4%
	Capital expenditure	14.2	0.1%	14.2	0.1%
8	**Southern Province**				
	Recurrent expenditure	258.7	2.2%	45.7	0.4%
	Capital expenditure	1.1	0.0%	1.1	0.0%
9	**Uva Province**				
	Recurrent expenditure	158.5	1.4%	29.1	0.2%
	Capital expenditure	14.3	0.1%	14.3	0.1%
10	**Western Province**				
	Recurrent expenditure	357.0	3.0%	57.7	0.5%
	Capital expenditure	19.8	0.2%	19.8	0.2%
	Total	**11,725.0**	**100.0%**	**553.1**	**4.7%**
	ADB Loan Proceeds for the RBL Program			**100.0**	
	Pandemic Prevention, Preparedness and Response Trust Fund Grant			**6.9**	
	TOTAL RBL PROGRAM FINANCING			**660.0**	

Note: Numbers may not sum precisely because of rounding.
[1] US$ 1 = LKR 295.
[2] The eligible budget codes for RBL program are (i) MOHMM: 111-01-05, 111-02-13, 111-02-17, 111-02-20, 111-02-25, and 111-02-26 (the expenditure is further categorized under object codes 11–17 and 20–25 for each of above identified project codes/ subproject codes); and (ii) for Provincial Councils (PMOHMM and PDHS) : Western : 105-03-01, 105-71-01, 113-70-01, 113-71-01, 113-72-01; Sabaragamuwa: 810-71-03, 810-72-01, 811-70-01, 811-71-01, 811-72-01; Southern: 304-03-01, 304-03-01, 305-70-02, 305-70-03, 305-71-02, 305-72-02, 305-72-03; Northen: 450-03-08, 450-09-03, 450-70-04, 450-72-05, 450-72-06; Eastern: 950-03-02, 951-03-02, 951-70-01, 951-70-01, 951-71-01, 951-72-01; Uva: 710-03-02, 710-03-03, 710-03-04, 710-71-03, 710-72-04, North-Central: 630-72-05, 630-70-06, 630-71-07, 811-72-01, 811-72-01, 811-72-01, Central: 561-02-04, 561-74-01, 561-71-01, 811-74-01, 811-72-06; and North-Western: 811-70-01, 811-71-01, 811-72-01. (include capital and recurrent expenditure incurred under object codes and 11–17 and 20–25 for each of above identified project code/subproject code).
Source: Asian Development Bank estimates based on 2024 budgets of MOHMM and nine Provinces.

2. Expenditure Status

Table 14: Estimated Program Expenditure
(as of {date})

Items	Estimated Expenditures in {Previous Year} ($ million)	Share of Total Expenditures in {Previous Year} (%)	Cumulative Expenditures to Date {Year–Year} ($ million)	Share of Total Cumulative Expenditures to Date (%)
1. Item A	0.0		0.0	
2. Item B	0.0		0.0	
3. Item C	0.0		0.0	
Total	**0.0**	**100.0**	**0.0**	**100.0**

Either define abbreviations within the table or list them alphabetically and define them below the table. Use a consistent approach and do not define some in the table and others below the table.
Source(s): List table source(s).

B. Program Financing

1. Expected Financing Plan

Table 15: Program Financing Plan
($ million)

Source	Amount	Share of Total (%)
Government of Sri Lanka	553.1	83.8
Asian Development Bank		
Ordinary capital resources (loan)	100.0	15.2
Pandemic Prevention, Preparedness and Response Trust Fund (grant)	6.9	1.0
Total	**660.0**	**100.0**

Source: Asian Development Bank.

2. Financing Status

Table 16: Status of Program Financing Plan
(as of {date})

Source[a]	Financing in {Previous Year} ($ million)	Share of Total Financing in {Previous Year} (%)	Cumulative Amount of Financing to Date (Year–Year) ($ million)	Share of Total Cumulative Financing to Date (%)
Government	0.0	0.0	0.0	0.0
Private sector[b]	0.0	0.0	0.0	0.0

Source[a]	Financing in {Previous Year} ($ million)	Share of Total Financing in {Previous Year} (%)	Cumulative Amount of Financing to Date (Year–Year) ($ million)	Share of Total Cumulative Financing to Date (%)
Development partners	0.0	0.0	0.0	0.0
Asian Development Bank	0.0	0.0	0.0	0.0
{Ordinary capital resources (loan)}	0.0	0.0	0.0	0.0
{Special Funds resources (loan)}	0.0	0.0	0.0	0.0
{Special Funds resources (grant)}	0.0	0.0	0.0	0.0
Other development partner 1[c]	0.0	0.0	0.0	0.0
Other development partner 2[c]	0.0	0.0	0.0	0.0
Name of cofinancier(s) (loan or grant)[d]	0.0	0.0	0.0	0.0
Total	**0.0**	**100.0**	**0.0**	**100.0**

Either define abbreviations within the table or list them alphabetically and define them below the table. Use a consistent approach and do not define some in the table and others below the table.

[a] Add or delete rows, as appropriate.
[b] Indicate name of private sector entity.
[c] Indicate name of development partner.
[d] For ADB-administered cofinancing, indicate if the loan or grant amount includes administration fees and other charges as may be deducted pursuant to the cofinancing agreement.

Source(s): List table source(s).

IV. PROGRAM SYSTEMS AND IMPLEMENTATION ARRANGEMENTS

21. **Program implementation.** The RBL program will be implemented from September 2025 to June 2030. The program implementation will follow the existing government structure of the health sector; no special arrangements are envisaged to be put in place for the program except for providing a few experts and coordinating officers as a PCO under the Director General of Health Services (DGHS). The executing agency of the program will be MOHMM, and the implementing agencies will be the MOHMM and the 9 provincial councils. Finance Commission, as the government entity that is mandated for ensuring equitable resource allocation across provinces, will coordinate with 9 provincial councils on program implementation.

22. **RBL program oversight mechanism.** The RBL program will be steered by a committee at national level, which will be co-chaired by Secretary of Health and the Secretary of Finance Commission. The steering committee will have Chief Secretaries of all 9 provinces, representatives of Ministry of Provincial Councils and Local Government, Ministry of Finance, Planning, and Economic Development (Departments of National planning, External Resources, Budget, Treasury Operations and Project Management and Monitoring), the DGHS, relevant DDGs, CFOs, Director Budget as its members. The steering committee will review the implementation progress of all DLIs and the DMF indicators of the RBL Program on a quarterly basis in the first month of each quarter. An integrated secondary health care and governance strengthening program coordination committee will also be established at each province. The provincial committee will be chaired by Chief Secretary of each Provinces with relevant provincial level officers as its members.

23. **For MOHMM/central-level-implemented program activities**. Director General of Health Services (DGHS) will provide overall stewardship on MOHMM program activity implementation. Concerned MOHMM units responsible for implementing MOHMM-level activities will submit their annual costed action plans for DGHS' approval before 31 August 2025 for 2025 activities, and thereafter, before 15 February of each implementing year. At the Ministry of Health and Mass Media, Additional Secretary Procurement, Medical Services, Engineering, CFOs and DDGs will

develop their respective annual costed RBL action plans in consultation with relevant stakeholders and will submit to DGHS for approval prior to implementation each year.

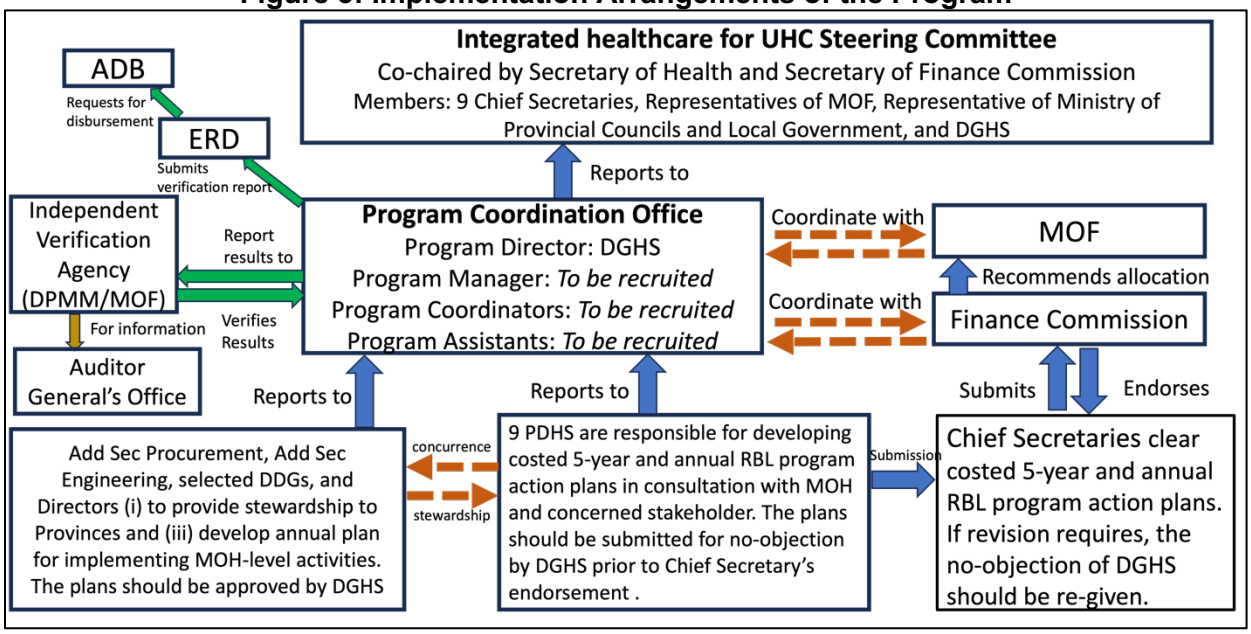
24. **For the 9 province-implemented program activities,** at each Provincial Director Health Services level, an RBL program planning and implementation technical committee will be established (i) to lead the development of the 5 year and the annual costed plans in collaboration with the MOHMM and other province level stakeholders and (ii) to direct implementation of the approved plans. The Provincial Director of Health Services of each province will submit a costed 5-year (2025-2030) action plan as well as an annual costed RBL program action plan for investments in secondary hospital development (base hospitals Type A and B) in following consultation with DGHS, all relevant DDGs and Directors of MOHMM, and other relevant stakeholders in provinces. The 5-year plan as well as the annual plan for 2025 will be submitted to DGHS by 31 August 2025, and thereafter, by 15 February of each implementing year, for no-objection by DGHS before proceeding to submission to Provincial Health Secretary and Chief Secretary for concurrence. The endorsed plans will be submitted by Chief Secretary to Finance Commission for concurrence and budget recommendation. Annual inter-provincial fund allocation will be determined by a resource allocation formula issued by Finance Commission prior to loan effectiveness.

25. **Planning guideline**. A planning guideline for MOHMM's and 9 provinces' reference when preparing the 5-year and annual RBL program implementation plan is provided in **Appendix 3**.

26. **Program coordination.** The DGHS will be the Program Director of the RBL program. A PCO comprising of a hired program manager, a hired program coordinator, and two-three hired program assistants (safeguards, finance, monitoring) will be established under DGHS. PCO will facilitate overall coordination with the Finance Commission and via them with the 9 provincial councils and within the MOHMM directorates and with the MOF. The PCO will annually arrange a two-day residential Central–Provincial Technical Dialogue each year during the month of August starting from 2025 to 2029. The objectives of the consultation would be to (i) share best practices of efficiency and quality enhancement measures carried out by the provinces in the secondary health level, (ii) to update provinces on relevant new/revised policies, plans, guidelines related to RBL program, (iii) discuss governance strengthening measures, (iv) review RBL program implementation program. The PCO will consolidate reports, review program implementation progress, monitor fund flow, disbursement, DMF and DLI results reporting and safeguard issues.

27. The program implementation arrangements are summarized in Figure 3.

Figure 3: Implementation Arrangements of the Program



ADB = Asian Development Bank, Add Sec = Additional Secretary, DDG = deputy director general, DGHS = Director General of Health Services, DPMM = Department of Project Management and Monitoring, DST = Deputy Secretary Treasury, ERD = Department of External Resources, MOF = Ministry of Finance, Planning, and Economic Development, MOHMM = Ministry of Health and Mass Media, PDHS = Provincial Department of Health Services, UHC = universal health coverage.
Source: ADB.

A. Monitoring and Evaluation System

1. Summary of Monitoring and Evaluation System (and Actions)

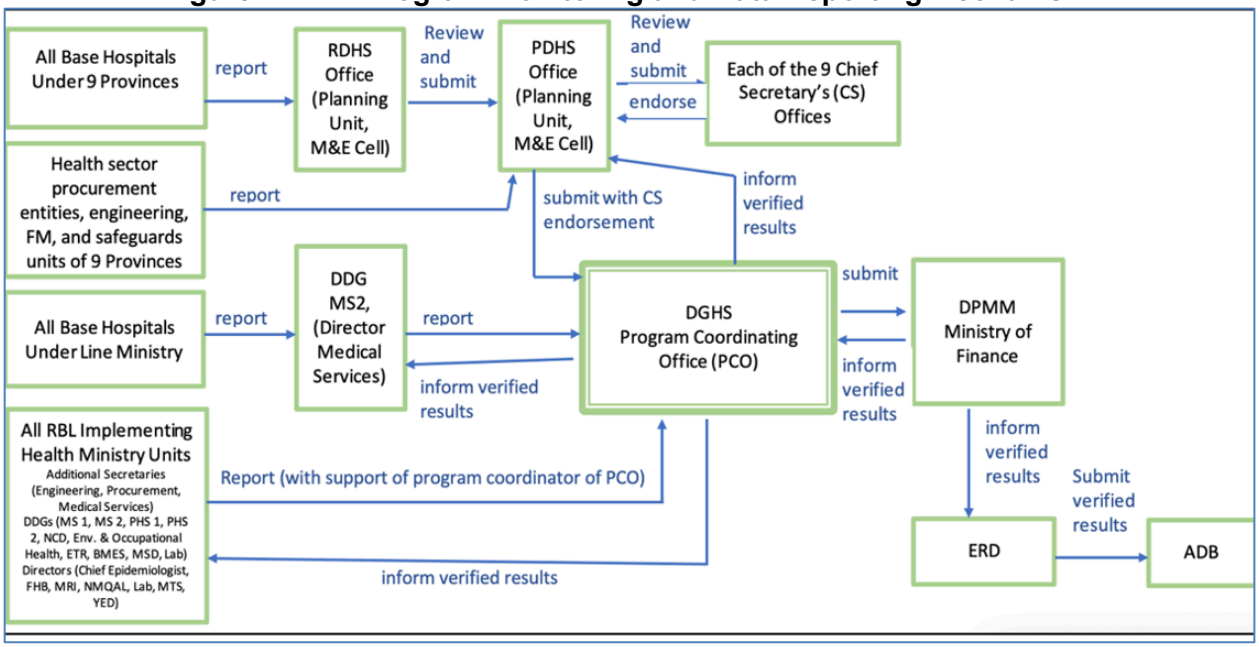
28. **Monitoring and evaluation system.** Availability of a timely, standard, continuous and consistent monitoring and evaluation mechanism is key to successful RBL program planning and implementation. The MOHMM has a routine data monitoring system which uses both digital systems and paper-based systems for reporting preventive sector related results, but hospital-based data systems are largely manual with annual reporting. The data systems are based on technical areas like maternal and child health, health care quality, nutrition, immunization, notifiable diseases and NCDs, and single disease reporting systems via the campaigns for sexually transmitted infections and HIV/AIDS, dengue, tuberculosis, rabies, malaria, filaria, leprosy etc. and data reporting systems across hospitals are established as a digital system for anti-microbial resistance (AMR) monitoring, but the hospital-based information data reporting system via medical statistics unit is paper-based. An electronic real time system reports all inpatient and death data across all government hospitals via the eIMMR system. Annually, the MOHMM releases the Annual Health Bulletin providing all health-related results. The latest available report is for 2023. In addition, each province also publishes an annual health statistics bulletin which gives monitoring statistics relevant to the province. The planning units and quality management units in respective provinces, districts, hospitals, campaigns and programs have data that can be extracted for specific purposes within the health sector. The MOHMM's routine reporting system via respective directorates at MOHMM level and at provincial level will report on all 6 output DLIs while the 2-outcome related DLIs data will be extracted from each of the secondary health care hospitals for baseline calculation and twice during project implementation.

29. The DGHS will be the Program Director of the RBL program which will work at both provincial and national levels. At the provincial level, data will derive from two sources: (i) base hospitals and (ii) health sector procurement entities, engineering departments charged with health sector works, financial management, and safeguards units in the provinces. This data will flow from Provincial Department of Health Services (PDHS) office to the national level after endorsement by the Chief Secretary of the provinces. Data from the national level will also flow from two sources: (i) the 7 base hospitals that report directly to the line ministry and (ii) implementing Health Ministry units. Both provincial and central data will pass to a PCO established in the office of the DGHS where it shall be scrutinized for veracity and completeness. Once approved by the DGHS, the reports shall be sent to the Department of Project Management and Monitoring (DPMM), MOF and thereon to the Department of External Resources (ERD), Government of Sri Lanka. Thence, the reports shall be shared with the ADB.

30. Feedback on performance is proposed to be shared regularly with the reporting units. This role shall belong to the DPMM, MOF which will share verified results with the DGHS and PCO. They in turn, will dialogue with provincial and national units in order to ensure that all units are aware of their own performance achievement as well as overall, so that they can factor that into future planning and budgeting. Another key opportunity at which results will be discussed is a two-day residential Central–Provincial Technical Dialogue will be held each year to capture learnings from the RBL program, share best practices, ensure that guidelines and new/revised policies are well understood, and review RBL program implementation.

31. The below Figure 4 summarizes the monitoring and evaluation arrangements of the RBL Program.

Figure 4: RBL Program Monitoring and Data Reporting Mechanism



ADB = Asian Development Bank, BMES = Division of Biomedical Engineering Services, DDG = deputy director general, DGHS = Director General of Health Services, DPMM = Department of Project Management and Monitoring, ERD = Department of External Resources, ETR = education, training, and research, FHB = Family Health Bureau, FM = financial management, M&E = monitoring and evaluation, MOHMM = Ministry of Health and Mass Media, MRI = Medical Research Institute, MS = medical services, MSD = medical supply division, NMQAL = National Medicines Quality Assurance Laboratory, PCO = program coordination office, PDHS = Provincial Department of Health Services, PHS =

public health services, RBL = result-based lending, RDHS = Regional Department of Health Services, UHC = universal health coverage, YED = youth, elderly, disabled and displaced.
Source: Asian Development Bank.

2. Monitoring and Evaluation System-Related Program Actions Status

32. Based on the assessment, the following program action plan has been prepared for monitoring and evaluation:

Table 17: Monitoring and Evaluation System-Related Program Actions

Actions	Responsible Agency	Time Frame for Implementation
Monitoring and Evaluation		
Assign focal person for the monitoring and evaluation of the RBL Program results at PDHS, RDHS, DDG MS2, PCO, and other concerned MOHMM offices	All PDHS, all RDHS, DDG MS2, PCO and other concerned MOHMM offices	Before loan and grant effectiveness, PDHS, RDHS, DDG MS2, PCO,
Ensure all base hospitals A&B have either a functional QMU or an dedicated focal for serving the same role and responsibility.	All Base Hospital A&B	By end of 2026
Introduce digital information systems to improve the timeliness and accuracy of hospital data collection and reporting	Director HIU and 9 PDHS	Continuous from loan effectiveness,
Provide training on the use of digital information systems to base hospital staff	Director HIU and 9 PDHS	Annually from 2026 onwards,

DDG = deputy director general, HIU = health information unit, MS = medical services, PCO = program coordination office, PDHS = provincial director of health services, RBL = result=based lending, RDHS = regional director of health services, QMU = quality management unit.
Source: Asian Development Bank.

33. The status of any M&E-related program action will be updated during implementation.

B. Fiduciary Systems

1. Financial Management System

a) Summary of the Financial Management System (and Actions)

34. The RBL program financial management arrangements will follow the government's financial management system for planning, budgeting, execution, accounting and internal control, internal audit, financial reporting, and external audit. The program fiduciary systems assessment rates the program financial management risk *substantial* and highlights the (i) complex implementation arrangement with the involvement of multiple agencies, (ii) varying level of staff capacity for financial reporting and accounting, (iii) recurring audit observations across MOHMM and PDHS levels, and (iv) weak monitoring mechanism for tracking and solving repeatedly noted audit observations**.** To mitigate the actions, GOSL, MOHMM and all provincial councils agreed to include strengthening of financial management systems including (i) PSC will be formed chaired Secretary of Health and co-chaired by the Secretary of Finance Commission with members including the Chief Secretaries of all 9 provinces, representatives of MOF, and Ministry of Local Government and Provincial Council; (ii) MOHMM at the central level will be the lead agency for the program. A PCO will be established in MOHMM for overall coordination, monitoring and supervision of program implementation; (iii) a qualified accountants and support staff to be

mobilized at MOHMM and each Province before loan effectiveness; (iv) the RBL program to be included in the audit plan of the internal auditors within first quarter of effectiveness; and (v) the internal audit will report its findings to the PSC. Findings and status of implementation of the recommendations will be included in the semi-annual progress report and shared with ADB.

b) Accounting and Financial Reporting

35. The MOHMM and PDHSs will maintain their accounts under the RBL program, in accordance with Sri Lanka Public Sector Accounting Standards and government regulations. Expenditure at the MOHMM and provinces will be managed through CIGAS. The RBL program will use the MOHMM, Provincial Ministry of Health (PMOH) and PDHSs budget codes focusing on budget codes relevant for secondary care development and governance improvement. The RBL program, will be funded under the following budget heads (and as amended from time to time):

(i) Central level institution:
MOHMM: the eligible recurrent and capital expenditure incurred under object codes 11–17 and 20–25 respectively, for each of identified project code/subproject code as below:

- MOHMM: Budget head 111: (i) Program code 01- Operational activities; Project Code 05- Hospital Operations; (ii) Program Code 02 – Development Activities; Project Code 13 - Hospital Development Projects, (iii) Program Code 02 – Development Activities; 17 - Medical Research, (iv) Program Code 02 – Development Activities; 20 - Human Resource Development, (v) Program Code 02 – Development Activities; 25 - Medical Supplies, (vi) Program Code 02 – Development Activities; 26 - Prevention and Control of Communicable & Non-Communicable Diseases.

(ii) Provincial level institutions:
Provincial Ministry of Health (PMOH) and PDHS Budget heads: The eligible recurrent and capital expenditure incurred under object codes 11–17 and 20–25 respectively, for each of identified project code/subproject code as below:

- Western Province:
  b) PMOH: Budget head 105: (i) Program code 03 - Provincial Administration, Project code 01 - General Administration & Establishment Services - Minister's Office; (ii) Program code 71 - Hospital Services, Project code 01 - Patient care Services;
  c) PDHS: Budget Head: 113: (i) Program Code 70 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; (iii) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

- Sabaragamuwa Province:
  a) PMOH: Budget Head 810: (i) Program code 71 - Public Health Services, Project code 03 - Patient care Services; (ii) Program code 72 - Public Health Services, Project code 01 - Community Health Services.
  b) PDHS: Budget Head 811: (i) Program Code 70 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; (iii) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services.

- Southern Province:
  a) PMOH: Budget Head 304: (i) Program code 03 - Provincial Administration, Project code 01 - Health Development; (ii) Program code 03 - Provincial Administration, Project code 02 Primary health Development Project
  b) PDHS: Budget Head 305: (i) Program Code 70 - Provincial Services, Project Code 02 - General Administration & Establishment Services; (ii) Program Code 70 - Provincial Services, Project Code 03 - Bio Medical Engineering Service; (iii) Program Code 71 - Hospital Services, Project Code 02 - Patient care Services; (iv) Program Code 72 - Public Health Services, Project Code 02 - Community Health Services (Preventive); (v) Program Code 72 - Public Health Services, Project Code 03 - Management of Information & Health Education

- Northen Province
  a) PMOH: Budget Head 413: Program code 03 - Provincial Administration, Project code 08 - General Administration & Finance;
  b) PDHS: Budget Head 450: (i) Program Code 03 - Provincial Administration, Project Code 08 - General Administration & Finance; (ii) Program Code 09 - Human Resources Management , Project Code 03 - Health and Training; (iii) Program Code 70 - Hospital Services, Project Code 04 - General Health Services; (iv) Program Code 72 - Public Health Services, Project Code 05 - Patient Care Services - Curative; (v) Program Code 72 - Public Health Services, Project Code 06 - Patient Care Services - Cancer Unit

- Eastern Province
  a) PMOH: Budget Head 950: Program code 03 - Provincial Administration, Project code 02 - General Administration & Finance
  b) PDHS: Budget Head 951: (i) Program Code 03 - Provincial Administration, Project Code 02 - General Administration & Finance; (ii) Program Code 70 - Hospital Services, Project Code 01 - General Health Service; (iii) Program Code 71 - Public Health Services, Project Code 01 - Patient Care Services (Curative); (iv) Program Code 72 -General Health Services, Project Code 01 - Community Health Services (Preventive)

- Uva Province
  a) PMOH: Budget Head 707: Program code 72 - Public Health Services, Project code 07 24 - PSDG
  b) PDHS: Budget Head 710: (i) Program Code 03 - Provincial Council Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Public Health Services, Project Code PSDG; (iii) Program Code 71 - Public Health Services, Project Code 03 - Patient care Services; (iv) Program Code 72 - General Health Service, Project Code 01 - General Health Services

- North-Central Province
  a) PMOH: Budget Head 630: (i) Program code 03 -Provincial Council Administration, Project code 02 - General Administration & Establishment Services (Ministry Staff); (ii) Program code 72 - General Health Services, Project code 05 - Health Service; Budget Head 630: Program code 70 - Hospital Services, Project code 06 - Patient Care Services; (iii) Program code 71 - Public Health Services, Project code 07 - Public Health & Prevention of Diseases

b) PDHS: Budget Head 811: (i) Program Code 72 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 72 - General Health Services, Project Code Health Service (Ministry Interventions); (iii) Program Code 70 - Hospital Services, Project Code 01 - Patient care Services; (iv) Program Code 72 - Public Health Services, Project Code Public Health & Prevention of Diseases; (v) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

- Central Province
  a) PMOH: Budget Head 561: (i) Program code 02 - General Administration, Project code 04 - Ministry Secretariat Office; (ii) Program code 74 - Research & Development Activities, Project code 01 - Health Services
  b) PDHS: Budget Head 561: (i) Program Code 01 - General Administration, Project Code 04 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services (Curative); (iii) Program Code 74 - Research & Development Activities, Project Code 01 - Health Services; (iv) Program Code 72 - Public Health Services, Project Code 06 - Community Health Services.

- North-Western Province
  a) PMOH: Budget Head 811: (i) Program code 70 - Provincial Administration, Project code 02 - General Administration - Ministry Administration; (ii) Program code 70 - Hospital Services, Project code 01 - Patient care Services; (iii) Program code 72 - Public Health Services, Project code 01 - Community Health Services.
  b) PDHS: Budget Head 811: Program Code 70 - Provincial Administration, Project Code 01 - General Budget Head 811: Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; Budget Head 811: Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

c. Auditing and Public Disclosure

36. MOHMM and the nine PDHSs will prepare annual financial statements covering the RBL program (hereafter called program financial statements) within two months after the end of the fiscal year. The sample audited program financial statement form is provided in **Appendix 4**, and the sample note of disclosure required by ADB to be included in program financial statements is provided in **Appendix 5**. The program financial statements will reflect the expenditures incurred under the agreed budget codes. The respective program financial statements shall include: (i) statement of program expenditure by major budget heads and program and project codes for the fiscal year, previous year and cumulative; (ii) statement of budgeted vs. actual expenditures by major budget heads and program and project codes for the fiscal year with significant variance explained in the notes; (iii) statement of disbursement (statement of amount claimed under the ADB loan and funds disbursed by ADB for the fiscal year, previous year and cumulative), (iv) statement of appropriation accounts/ budgeted vs. actual expenditures by major budget heads and program and project codes for each central or provincial level entity , as well as (v) detailed notes to the financial statements including significant accounting policies and breakdowns on the amount of expenditures incurred under the selected budget heads as well as program and project code.

37. The audited program financial statements of the MOHMM and the audited program financial statements of all nine PDHSs in the format described above will be audited annually by NAO in accordance statement of audit needs agreed between ADB, NAO, and the government

(see related para. below and Appendix **4**). Based on the ten audit reports, its own records, MOF records, and other sources, the PCO will prepare the following unaudited financial information: (i) Funds received from the government – Treasury released funds for the program according to the budgeted allocations during the current and previous years, and cumulative to date; (ii) list of withdrawal applications claimed from ADB under the DLI procedure during the current and previous years, and cumulative to date, including details by withdrawal applications on the amount, currency, DLIs met, date of submission and amount disbursed by ADB to the government treasury account. The information should be supported with statement from MOF showing receipt of the amounts as disbursed by ADB to the Treasury account; (iii) comparison of aggregate amount of proceeds disbursed under the ADB RBL and aggregate expenditures incurred under the program by MOHMM and the nine Provinces (formula to be used: total program expenditures under the agreed budget heads and codes); and (iv) interest expenses and financial charges incurred as part of the ADB loan during the current and previous years, and cumulative to date.

38. The PCO will submit the entire package; that is, the audited program financial statements of MOHMM, audited program financial statement of the each nine PDHSs, and the additional information listed above, to ADB within ***nine months*** after the end of the fiscal year. Furthermore, in order to provide timely information on the program's financial progress and financial management status to the executing agency, the government, and ADB, MOHMM through its PCO will ensure that comprehensive financial information is included in the semi-annual progress reports to be submitted to ADB within 60 days after the end of each reporting period. The financial information will include at least the following: (i) overall financial progress of the program including an analysis of the adequacy and timeliness of government funding allocated and released to the program; (ii) progress against DLIs achieved in the reporting period, and cumulative year to date; (iii) disbursement information for the reporting period, and cumulative year to date including a reconciliation with ADB's disbursement data found in the Loan Financial Information System (LFIS); (iv) status of implementation of each action included in the PAP; (v) status of actions agreed and recorded in mission aide memoires; and (vi) status of compliance with past audit observations from external audit. An indicative template for the financial information to be included in the semi-annual progress reports is included in Appendix **5**.

39. The program financial statements will be audited by the NAO in accordance with Sri Lankan Auditing Standards, which follow the International Standards of Supreme Audit Institutions (ISSAI). In this regard, the NAO will audit: (i) the program financial statements of the MOHMM; and (ii) the program financial statements of each of nine Provinces (combined statement of PDHSs and PMOHMMs). The objective of the audit is to provide assurances to ADB that the program financial statements covering the government's strengthening integrated health care and governance for universal health coverage program, present a true and fair view and are free from misstatements. Each audit report will include the following separate audit opinions: (i) whether the program financial statements are presented fairly, in all material respects, in accordance with the applicable financial reporting framework; and (ii) the level of compliance for each financial covenant contained in the legal agreements for the project (if any). The indicative statement of audit needs is included in Appendix **4 and Appendix 5**. The first audit will include prior results achieved 12 months prior to the loan signing date and the first APFS will cover the date from when eligible expenditure is permitted under retroactive financing and end on 31 December of a loan signing year. ADB will disclose on its website the program financial statements and the auditors' report thereon within 14 days of their acceptance, following ADB's Access to Information Policy[13]

[13] ADB. 2018. *Access to Information Policy*.

40. The audited program financial statements and the auditors' report will be submitted in English language to ADB within 9 months after the close of the DMC's fiscal year. ADB reserves the right to require a change in the auditor (in a manner consistent with the laws and regulation of the Sri Lanka) or require additional support to be provided to the auditor, if the audits required are not conducted in a manner satisfactory to ADB or if the audits are substantially delayed.

d. Financial Management System-Related Program Actions Status

41. Based on the assessment, the following program action plan has been prepared for financial management:

Table 18: Financial Management Action Plan

Actions	Responsible Agency	Time Frame for Implementation
Monitor (i) the timely and adequate budget release, (ii) the actual utilization of funds against approved requests, (iii) the findings and status of implementation of internal and external audit recommendations and report them to ADB in the semi-annual program performance reports.	PCO, PSC	By 28 February and 31 August every year.
PCO and concerned financial and accounts staff of MOHMM, Finance Commission, and 9 provincial councils to be trained on ADB's disbursement procedures and financial management requirements by completing e-learning and attending trainings.	ADB	Annually.
Submit annual PFS to NAO with copies shared with ADB. PCO to monitor and track the compliance.	CFO of MOHMM and DCSF of 9 provincial councils	By 30 June every year
The RBL program to be included in the audit plan of the internal auditors within first quarter of loan effectiveness. The RBL program is to be audited by internal auditors at least annually and internal audit findings will be implemented by the MOHMM and 9 provinces within 12 months of internal audit reports. Internal audit findings will be shared with ADB and status of implementation of internal audit findings.	PCO in coordination with MOHMM and 9 provincial councils	Within first quarter of loan effectiveness By 30 September every year
Coordinate with NAO to finalize the statement of audit needs and audit opinion letters, management letters and to ensure the RBL program is included in the audit plan of NAO. The audit report are prepared and APFS to be submitted in a timely manner.	CFO of MOHMM and DCSF of 9 provincial councils	Within one quarter of loan effectiveness By 30 September every year

ADB = Asian Development Bank, APFS = audited program financial statement, CFO = chief financial officer, DSCF = deputy chief secretary finance, MOHMM = Ministry of Health and Mass Media, NAO= national audit office, PCO = program coordination office, PFM = Public Financial Management, PFS = program financial statements, PPCC = provincial program coordination committee, RBL = result-based lending.
Source: Asian Development Bank.

42. The status of any financial management-related program actions will be updated during implementation.

2. Procurement System

a. Summary of the Procurement System (and Actions)

43. The proposed RBL will primarily finance minor civil works for secondary care hospitals, new constructions at the Sri Lanka Centre for Disease Control, medical equipment, consumables as well as consulting and nonconsulting services, including for the development, deployment and integration of electronic information systems, across all provinces in Sri Lanka. High-value contracts and pharmaceutical procurement are excluded.

44. The procurement system, governed by the 2024 Procurement Guidelines (PGL 2024), mandates competitive bidding as the primary method, supplemented by detailed manuals, standard bidding documents, and specific financial thresholds for procurement methods. Central and provincial authorities have structured finance divisions supported by dedicated procurement committees, bid evaluation committees, internal auditors, and technical specialists, coordinated by the MOHMM and provincial administrations. Procurement activities at national and provincial levels are overseen by designated authorities responsible for civil works and medical equipment procurement, though inconsistencies exist in procurement planning, transparency, and contract management systems, with limited usage of electronic platforms except in select provinces. An established appeal mechanism ensures transparency and accountability, supported by clear ethical guidelines and frameworks for fraud and corruption oversight.

45. The MOHMM has a structured procurement system led by the Secretary of Health as the Chief Accounting Officer (CAO), supported by a dedicated Procurement Division comprising around 30 personnel, including five Staff Grade Officers, responsible for planning and implementation. Additional divisions—Biomedical Engineering Services (BMES), Engineering Services, and Logistics—handle procurement and contract management tasks, and the MOHMM utilizes the eGP platform PROMISe.lk, with plans for expanded use, supported technically by the Central Engineering Consultancy Bureau (CECB) for construction-related procurement. At the provincial level, procurement activities rely on staff from accounting, planning, and engineering divisions without dedicated procurement positions; these personnel possess experience with donor-funded projects and have been trained in government procurement guidelines and manuals, exemplified by the Central Province's seven procurement-involved staff and the Northern Province's eleven, with similar structures and training in other provinces.

46. The overall pre-mitigated risk is *substantial*. While procurement operations under the project are generally not expected to be in contradiction to any of ADB´s fundamental policies and rules such as the ADB Charter and ADB's Investigation and Enforcement Framework (2024), the procurement risk assessment did identify two potential high impact risks for the ADB financed procurements under the RBL: a) The ADB Charter requires that there should be no restrictions for participation of ADB member countries in ADB-financed procurement. It must thus be assured that there are no direct or indirect restrictions on the eligibility of ADB member countries to participate in ADB-financed procurements; and b) Firms and individuals which that have been debarred by ADB or are subject to cross-debarment cannot be awarded with ADB-financed procurements.[14] While the impact of eligibility related risks is high, the likelihood of their materialization is considered low. Procurements under the program will be implemented by national competitive bidding or shopping method. The small value of procurements implemented at this level makes it unlikely that international firms will be interested in participating. Additional

[14] ADB. 2017. *Procurement Regulations for ADB Borrowers*. Manila.

procurement risks were identified during the procurement assessment and mitigation measures and actions points are proposed in Table 23.

b. Procurement System-Related Program Actions Status

47. Based on the assessment, the following program action plan has been prepared for procurement:

Table 19: Procurement System-Related Program Actions

Actions	Responsible Agency	Time Frame for Implementation	Status of Implementation
Procurement			
Conduct trainings to enhance the capacity of government users and vendors on eGP platform, PGL 2024 and PM 2024	DOPF / MOHMM	Continuous from Q2 2025	
Enhance Accessibility of the eGP platform to increase the vendor participation by providing labels of the platform in three languages, adjust vendor registration fee and establish a help desk in each province	DOPF / MOHMM	Q4 2025	
Institutionalize monthly procurement review meetings to monitor progress and compliance. Prepare Contract Management Plan, conduct training programs, introduce digital application for contract management	Additional Secretary of Procurement and 80 Procurement Entities of MOHMM and Provinces	Continuous from Q2 2026	
To improve procurement governance, enforce confidentiality forms, share bid opening minutes, establish PAB/PAC, implement Standstill provisions, and publish contract awards with reasons for rejections.	80 Procurement Entities of MOHMM and Provinces and Chief Audit Officers	Continuous from Q2 2026	
Enhance and institutionalize SBDs/RFQs mandated by the GOSL to include PGL 2024 provisions, improve procurement quality and timelines for health sector items, and adopt best practice models with and without Framework Agreements	MOHMM/ SPC/ NPC	Q4 2025	

3. Anticorruption System

a. Summary of Anticorruption System and Actions

48. The corruption risk is assessed to be *substantial*. Sri Lanka ranked 121st of 180 countries on transparency international's Corruption Perception Index for the year 2024, which the score 32 out of 100, which is the lowest of its score in the last 10 years (It was ranked 83rd of 168 countries in year 2015 with a score of 37). The passage of the 20th amendment to the Constitution in 2020, abolishing the 19th amendment, granted unfettered Presidential control over appointment processes in "independent" bodies such as the Central Bank, the Judiciary, and the Anticorruption Commission while eliminating regulatory bodies in procurement and auditing. The quick passage

of the 21st amendment in September 2022, reimposing limits on the authority of the President, demonstrated the resolve to unwind the recent attacks on accountability and the rule of law. This amendment established nine independent commissions including the commission to investigate allegations of bribery or corruption (CIABOC), the national procurement commission, the public service commission and the audit service commission, which are directly related to anti-corruption.

49. The RBL program will be implemented in accordance with the government's anti-corruption framework. The Anti-corruption Act, No. 9 of 2023 which came into effect in September 2023, gives effect to provisions of the United Nations Convention against corruption and other internationally recognized norms, standards, and best practices. The act provided CIABOC to detect and investigate allegations of bribery, corruption, and offenses related to the declaration of assets and liabilities and associated offenses and institute prosecutions thereto. In addition, the Assistance to and Protection of Victims of Crime and Witnesses Act No. 10 of 2023 also is effective from September 2023. Another important act against corruption is the Offences against Public Property Act, No. 12 of 1982 under which offenses are non-bailable.

50. The anticorruption system and integrity risk controls of Sri Lanka are based on the regulatory framework of the country and implementation practices, which consist of specific provisions in the Constitution of Sri Lanka, laws enacted by the parliament, government financial regulations, guidelines and circulars. The anti-corruption laws of Sri Lanka including the Penal Code criminalize corruption and attempted corruption. The important institutions in addition to CIABOC supporting to the fight against corruption are the Financial Crimes Investigation Division of the Sri Lanka Police, the Attorney General's Department, and the Financial Intelligence Unit of Sri Lanka under the Central Bank of Sri Lanka. With respect to the provincial councils, the 13th amendment of the Constitution provided the integrity regulations.

51. Corruption in the health sector was highlighted in a court case against the then cabinet minister of health, the secretary to the MOHMM and several other officials based on the charges with involvement in the procurement of substandard pharmaceuticals, moving away from the standard procurement procedures. They have been charged under the Public Property Act, No. 12 of 1982 and are in remand custody up to the date of this assessment, since March 2024. While the proposed RBL program will not support the procurement of pharmaceuticals, there are gaps in the procurement process in civil works, equipment and services as disclosed by the audit findings. To manage the observed risk, the program must ensure that robust and transparent PFM systems are in place, which will reduce opportunities for corruption. Accordingly, mitigating actions require that (i) the program be included in the audit plan of the internal auditors, and (ii) significant and recurring audit observations be monitored and solved in a systematic manner.

52. The government will instruct all relevant agencies[15] to (i) comply with the requirements of ADB's RBL anticorruption guidelines, (ii) ensure that any person or entity debarred or suspended by ADB is not eligible to be awarded a contract under or otherwise allowed to participate in the RBL program during the period of such debarment or suspension, and (iii) include a provision related to item (ii) in the bidding documents. The bidding documents should also reference[16]

(i) the list of debarred and suspended firms and individuals available on ADB's website (footnote 10);

[15] This includes all procuring entities, procurement agents, and other agencies at all levels under the RBL program.
[16] ADB Debarment and Suspension Register https://sanctions.adb.org

(ii) ADB's Office of Anticorruption and Integrity's website [17] where reports of allegations of integrity violations can be made
  (a) by email to integrity@adb.org or anticorruption@adb.org;
  (b) through the complaint form;
  (c) by secure telephone access +63 2 8632 5004;
  (d) by fax +63 2 8636 2152; or
  (e) by mail to Office of Anticorruption and Integrity, Asian Development Bank, 6 ADB Avenue, Mandaluyong City, 1550 Metro Manila, Philippines; and

(iii) the reservation by the DMC's procurement administration offices at each level of the right to reject the proposed award to debarred or suspended entities.

53. The guidelines will be issued in the joint names of MOHMM, Finance Commission, and 9 provincial councils, which are responsible for the oversight of the RBL program and may be updated within the program period.

54. ADB's guidelines on fraud, corruption, and other prohibited activities for RBL programs are in the **Appendix** 6.[18]

b. Anticorruption System-Related Program Actions Status

55. Based on the assessment, the following program action plan has been prepared for anticorruption:

Table 20: Anticorruption System-Related Program Actions

Actions	Responsible Agency	Time Frame for Implementation
Anticorruption		
Program to be audited annually and audit observations addressed timely and in a systemic manner	MOHMM, PDHS	Annually
Familiarize with ADB's Investigation and Enforcement Framework (2024).	MOHMM, PDHS	During the program inception mission

ADB = Asian Development Bank, MOHMM = Ministry of Health and Mass Media, PDHS = provincial director of health services.
Source: Asian Development Bank.

C. Satisfying Procurement Member Country Eligibility Restrictions

56. According to ADB's Policy Paper on Enhancing Operational Efficiency of the Asian Development Bank (2015), universal procurement will be applied to this RBL program as an ADB administered grant cofinancing is included in its overall financing.[19]

[17] ADB. Anticorruption and Integrity.
[18] Relevant information on the anticorruption systems and how to deal with fraud and corruption cases during implementation can be found in ADB. 2019. *Mainstreaming the Results-Based Lending for Programs.* Manila; and the staff instruction on business processes for RBL for programs.
[19] ADB. 2015. *Enhancing Operational Efficiency of the Asian Development Bank*.

D. Safeguard Systems

1. Summary of Safeguard System and Actions

57. The program activities involve in constructions of new facilities, renovations, refurbishments, repairs, upgrading existing facilities, installing machineries and equipment, etc. These works will involve clearing and grubbing, demolition of sections of buildings, land formation, excavation and piling, building construction (sub structures and super structures), finishing, painting, mechanical/electrical/plumbing works, transportation, installation and commissioning of medical equipment, etc. During construction, impacts due to disposal of demolition and construction waste (likely including asbestos cement waste mainly from roofing sheets), disposal of accumulated clinical waste (likely), construction vibration and noise (mainly at CDC), dust generation, supply of construction material, machinery and equipment transportation, drainage issues, soil erosion, disturbances to existing amenities such as water, sewerage, electricity and telecommunication etc., occupational safety risks and temporary access issues can be anticipated. The entire program shall not involve acquisition of private land and displacement (physical or economic) of people.

58. The proposed program activities are reversible, and site specific and within the guidelines and are predictable and manageable with existing processes/procedures. Importantly, all proposed sites are not located within any environmentally sensitive area. Further, all planned activities will proceed within existing healthcare facilities and do not require acquisition of private land. The program was categorized as category *B* for environmental safeguards and category *C* for Involuntary Resettlement (IR) and Indigenous People (IP). The Mission confirms the environmental and indigenous people's categorization.

59. All proposed sub-activities at national and provincial levels shall be screen and categorized based on SPS requirements. The program Environmental and Social Management Framework (ESMF) shall provide templates and tools to screen and categorize each activity. The ESMF includes a generic Environmental and Social Management Plan (ESMP). Training sessions for Program staff of the MOHMM / PDHS / Provincial technical Committee with environmental management responsibilities shall be conducted. The ESMP shall form part of the contract document and the contractor shall implement the ESMP and monitored by MOHMM and PDHS and reported to ADB.

60. Considering the nature of the activities proposed, existing capacities of the executing agency is considered adequate given that the MOHMM and PDHS in implementing environmental and social safeguards requirements, programmatic, institutional, and contextual risks are not expected to be significant. Safeguards actions shall be implemented immediately after the finalizing each annual plan (assuming the 5- year planning cycle).

61. A grievance redress mechanism (GRM) will be established, at least 2 months before the commencement of program, to receive and manage any public E&S issues that may arise due to the program implementation. For provincial works the GRM will follow three-tier arrangement: at the site, l RDHS levels, and at PDHS level. OH levels. For national level works a two-tier GRM will be established as one at the site and the other at MOHMM level. The MOHMM/PDHS will ensure that potentially affected persons/community groups are informed about the GRM at an early stage of the program implementation. GRM should continue throughout the program implementation.

62. The program safeguards system assessment is in Annex 3(vii) of RRP.[20]

2. Safeguard System-Related Program Actions Status

63. Based on the assessment, the following program action plan has been prepared for safeguards.

Table 21: Safeguards System-Related Program Actions

Actions	Responsible Agency	Time Frame for Implementation
Safeguard		
Screening and categorization.		
• MOHMM (for line ministry activities) and PDHS (for provincial level activities) to submit screening and categorization checklists to ADB for all activities	MOHMM, PDHS	Annually upon submission of annual costed RBL Program action plan
• Submit the duly filled BIQ to the relevant District office of CEA	MOHMM, PDHS	Annually upon submission of annual costed RBL Program action plan
• Submit EIA/IEE reports according to the TOR issued by the CEA	MOHMM, PDHS	Continuous from Q3 2025
Capacity building.		
• Nominate focal points within the MOHMM and PDHS on E&S safeguards	MOHMM, PDHS	Continuous from Q2 2025
• Training of program staff of the MOHMM, PDHS and Provincial Technical Committee with E&S responsibilities and HCW management	PCO, ADB	Continuous from Q3 2025
E&S Safeguards implementation.		
• The ESMP shall form part of the civil/E&M works contract documents.	MOHMM, PDHS	Continuous from Q3 2025
• Establish a safeguard monitoring system, Prepare semi-annual E&S monitoring report, and disclosure	MOHMM, PDHS, ADB	Continuous from Q3 2025
• Establish a robust, public-friendly, accessible and functional GRM.	MOHMM, PDHS, ADB	Continuous from Q2 2025

ADB = Asian Development Bank, BIQ = Basic Information Questionnaire, CEA = Central Environmental Authority, EIA = Environmental Impact Assessment, E&M = electrical and mechanical, E&S = environmental and social, ESMP = environmental and social management plan, GRM = grievance redress mechanisms, HCW = health care waste, IEE = initial environmental examinations, MOHMM = Ministry of Health and Mass Media, PCO = program coordiantion office, PDHS = provincial director of health services, Q = quarter.

[20] The program safeguards system assessment is in Annex 3(vii) to Strengthening Integrated Health Care and Governance for Universal Health Coverage Program (RRP SRI 58017-001)

E. Social Dimensions

64. The program aims to benefit the entire population of Sri Lanka, with a particular focus on the poor and other vulnerable groups, including individuals with non-communicable diseases, older adults, persons with disabilities, and women and children. The program addresses income and non-income dimensions of poverty and social exclusion. It is structured to i) enhance secondary health quality and service delivery on a broad scale; (ii) mitigate the risks related to out of pocket expenses for diagnostic assessments and medication by increasing secondary hospital diagnostic capacity and availability of pharmaceuticals; (iii) introduce identified services related to children, youth, gender, older persons, and persons with disabilities, including appropriate design features to enhance the accessibility and convenience of health care facilities; and (v) improve referrals with public and CSO run legal and social services for additional support through the Patient Information Centers, and inclusion of referrals to community-based services in the development of care pathways for high incidence diseases. Patient Information Centers will also provide mechanism for feedback from patients. The increase in facilities providing non communicable disease testing and management, functional physiotherapy/ rehabilitation units, day surgeries including the DLI on the reduction in waiting time for cataract surgeries, will increase functional ability and independence for persons with disabilities and the older population. The main challenge will be availability of trained staff to deliver services. The program will strengthen the Human Resource for Health unit under MOHMM, enhance staff quarters at secondary hospitals and providing training and continuous professional development training on new care pathways.

F. Gender Equality

65. The RBL program is categorized *effective gender mainstreaming (EGM).* The implementation of gender-equitable initiatives at base hospitals (BHs A & B) aims to enhance healthcare quality by reducing waiting times for elective surgeries by 30% and hospital-acquired infections by 40%. Special attention will be given to vulnerable groups, including pregnant women, the elderly, and gender-diverse individuals. Progress will be monitored through gender-disaggregated data on surgical wait times (DLI 1) and infection reductions (DLI 2), ensuring improved access and safety for all patients.

66. Gender mainstreaming will be incorporated into the five-year costed action plan (2025–2029) for first referral hospital development. Provinces will create gender-responsive annual plans, utilizing at least 80% of allocated resources and reporting with gender-disaggregated data. Health technology assessments will include gender-sensitive criteria, ensuring equitable access to medical advancements for all genders (DLI 3).

67. Operational measures, including optimized surgical scheduling, extended operating hours, and addressing staffing shortages, will improve patient care and ensure gender-balanced workforce participation. Gender-sensitive mental health services will support GBV survivors, while elder-friendly guidelines will enhance accessibility for elderly individuals, particularly elderly women. Infrastructure improvements, such as Mithuru Piyasa (GBV care centers) and Yowun Piyasa (adolescent healthcare centers), will ensure privacy and dignity for women, girls, and gender-diverse individuals. Establishing gender-inclusive Patient Information Centres will enhance accessibility by providing guidance on gender-specific healthcare concerns, maternal health, GBV support services. These centers will connect patients to social, legal, and disability support services while ensuring privacy through a transparent complaint's mechanism. Gender-sensitive disaster risk reduction strategies in annual action plans will ensure continuity of care during emergencies (DLI 4).

68. To promote gender equality in healthcare leadership, training will focus on gender-sensitive service delivery. Policies will target the retention of healthcare professionals, especially women, in response to high migration rates. Enhanced digital health solutions and referral systems will streamline patient navigation, benefiting rural women, older individuals, and marginalized groups. Specialized care pathways for emergency, maternal, cardiovascular, and mental health services will further improve access for all genders (DLI 5).

69. National guidelines will promote gender-equitable healthcare access, including elder-friendly services, private spaces for GBV survivors, and accessible sanitation and seating. Special access options will be available for pregnant women, disabled persons, older persons, and marginalized groups. Strengthening disease surveillance and quality assurance in public health laboratories will enhance monitoring with a gender-sensitive approach (DLI 6). These comprehensive actions will ensure that gender equality and women's empowerment remain central to improving healthcare access and outcomes for all individuals.

70. However, potential challenges in implementing gender actions include difficulties in consistently tracking gender-disaggregated data, particularly for elective surgeries and hospital-acquired infections, which may hinder accurate program evaluation. Staff shortages, especially among female healthcare professionals, may be worsened by high migration rates, limiting gender balance in healthcare roles. Additionally, infrastructure constraints could delay the development of elder-friendly spaces and private areas for GBV survivors, while logistical challenges may arise in integrating gender-sensitive strategies and action plans into existing frameworks for effectiveness.

71. To address these challenges, remedial actions will focus on enhancing digital data systems for better gender-specific tracking, staff training on data collection, and strengthened recruitment and retention strategies with incentives for female healthcare workers, particularly in underserved areas. Expedited infrastructure upgrades and integration of gender-sensitive annual plans into national frameworks will further support program objectives. By mainstreaming gender-responsive policies into hospital services, healthcare systems will become more inclusive, efficient, and equitable, ensuring improved health outcomes for all, especially marginalized populations.

1. Gender-Related Program Actions Status

72. Based on the assessment, the following program action plan has been prepared for safeguards.

Table 22: Gender-Related Program Actions

Actions	Responsible Agency	Time Frame for Implementation
Gender		
Annual provincial health bulletin incorporates sex disaggregated data where applicable to inform provincial health sector planning and priority setting.	All 9 Provincial Councils	Continuous from Q2 2025
Conduct assessment and facilitate policy dialogues on enhancing workplace safety of female healthcare workforce	MOHMM (through the support of TA)	By Q2 of 2026
Annual costed provincial plan should align with relevant government gender mainstreaming principles and incorporate gender awareness raising activities on secondary care services for healthcare workforce and general public	MOHMM and All 9 Provincial Councils	Continuous from Q2 2025

MOHMM = Ministry of Health and Mass Media, TA = technical assistance, Q = quarter.
Source: Asian Development Bank.

G. Communication and Information Disclosure Arrangements

73. Information on program matters will be communicated and disclosed through MOHMM, Finance Commission, 9 provincial councils, MOF and related government agencies' websites. Information disclosure requirements will follow the relevant government rules and regulations and the agreement made between ADB and the Government of Sri Lanka. Community awareness raising and outreach services supported by the program will ensure participation of beneficiaries, especially women, children, youth, elders, disabled, poor, and vulnerable populations, in local decision-making process. This will be monitored through the grievance redress mechanism of the program.

H. Development Coordination

74. The RBL program is designed in close coordination with the World Bank and Japan International Cooperation Agency (JICA) under MOHMM and the MOF's leadership, which complements their efforts to support the institutionalization of integrated healthcare services and coronary care strengthening. While the World Bank's ensuing loan, an investment project financing with performance-based conditions, will focus on supporting integrated health care at primary healthcare level, the RBL will complement it by focusing on first referral hospital and support the integration between curative, preventive, rehabilitative care, and non-healthcare government services. While JICA, with the rescoping its $35 million loan, is finalizing their support to constructing and equipping catheterization laboratories in 5 provinces which would seamlessly complement with the RBL's support for referral care. The RBL also supports addressing the capacity gaps on the prevention, detection and response of public health threats identified by WHO-led Joint External Evaluation as pandemic preparedness and response and closely collaborates with the 4 implementing partners of WHO, UNICEF, FAO and World Bank. ADB also works in collaboration with UNICEF on capacity development of pharmaceutical supply chain health workforce and in strengthening the supply chain system highlighted as gaps in an ADB-funded, assessment carried out in 2023/2024. The ADB works closely with UNFPA in strengthening elderly care services of the RBL program.

75. On the Pandemic Prevention, Preparedness and Response Trust Fund grant-financed output 2 of the RBL program, the development coordination will be done with the World Health Organization, the United Nations Children's Fund, the Food and Agriculture Organization of the United Nations, and the World Bank through monthly Pandemic Fund coordination committee and regular Pandemic Fund steering committee to be hosted by MOHMM. PCO of the RBL program will also support ensuring the synergy and coordination between Pandemic Prevention, Preparedness and Response Trust Fund grant-financed RBL program activities and the Pandemic Fund activities to be implemented by other development partners from time to time during the RBL Program Implementation.

76. For RBL Program activities under Output 1 and 3, required development coordination will be facilitated through the PCO and ADB from time to time during the RBL program implementation. Development partners will also be invited to attend the annual Central–Provincial Technical Dialogue to discuss the synergy between the RBL program and relevant initiatives and interventions of development partners.

V. INTEGRATED RISKS ASSESSMENT AND MITIGATING MEASURES

A. Key Risks and Mitigating Measures

77. The program assessment and program systems assessments carried out as a part of the program due diligence have identified the following key risks. The risks and their mitigation measures will be monitored during the program implementation and any changes in the risk profile or impact will be updated to inform any corrective actions. ADB and the program stakeholders, led by MOHMM, 9 Provincial Councils, Finance Commission, and Ministry of Finance, Planning, and Economic Development will discuss key risks during the review missions (Table 23), to be updated as necessary.

Table 23: Status of Integrated Risk Assessments and Mitigating Measures
(as of 4 April 2025)

Risks	Risk Description	Risk Rating without Mitigation Measures	Key Mitigating Measures	Timeline and Responsible Agent	Implementing Status
Results					
	The ongoing piloting of the OpenMRS system may not get scaled up in a timely manner	Moderate	Ensure regular review of the progress of the rollout of OpenMRS, identify the sequence of OpenMRS rollout among clusters, and conduct timely trouble shooting on relevant technical issues.	Continous from loan effectiveness, Director HIU and 9 PDHS	
	The MOHMM may not complete the construction of CDC, MRI during the 3-year Pandemic Prevention, Preparedness and Response Trust Fund grant implementation period	Moderate	Conduct regular review of the progress of CDC construction and MRI renovation through the overall Pandemic Prevention, Preparedness and Response Trust Fund grant monitoring mechanism.	Continous from loan effectiveness, DGHS Director MRI, and Chief Epidemiologist	
Overall risk		**Moderate**			
Monitoring and Evaluation					
	While planning units are available and functioning at hospital, RDHS, PDHS, and MOHMM levels, there is no designated staff for M&E activities.	Moderate	Assign focal person for the monitoring and evaluation of the RBL Program results at PDHS, RDHS, DDG MS2, PCO, and other concerned MOHMM offices	Upon loan effectiveness, PDHS, RDHS, DDG MS2, PCO, and other concerned MOHMM offices	
	There may not be a functional QMUs in each of the Base Hospital A&B and therefore the data reporting may be late.	Moderate	Ensure all Base Hospitals A&B have either a functional QMU or an dedicated focal for serving the same role and responsibility.	By end of 2026, all Base Hospitals A&B	
	Majority of patient data in the health sector are paper-based and managed in silos	Moderate	Introduce digital information systems to improve the timeliness and accuracy of hospital data, collection and reporting	Continuous from loan effectiveness, Director HIU and 9 PDHS	
	Low capacity of hospital staff to use digital information systems for patient data reporting	Moderate	Provide training on the use of digital information systems to base hospital staff	Annually from 2026 onwards, Director HIU and 9 PDHS	
Overall risk		**Moderate**			
Financial management					
A. Inherent risk					
1. Country-specific risks	Overall the government has adequate PFM system in place. However the slow roll out of ITMIS and its integration	Moderate	ADB to monitor implementation of the ongoing PFM reforms including implementation of new PFM Act and of	ADB, from time to time.	

Risks	Risk Description	Risk Rating without Mitigation Measures	Key Mitigating Measures	Timeline and Responsible Agent	Implementing Status
	with CIGAS may hamper program budgeting and execution.		ITMIS across MOHMM and 9 Provincial Councils under the RBL program		
2. Program-specific risks	Involvement of multilayer agencies (central and 9 provinces) poses challenges regarding unclear systems of accountability between implementing agencies.	Substantial	Monitor (i) the timely and adequate budget release, (ii) the actual utilization of funds against approved requests, (iii) the findings and status of implementation of internal and external audit recommendations and report them to ADB in the semi-annual program performance reports.	PSC, PCO. By 28 February and 31 August every year.	
B. Control risk					
1. Funds flow	Government's fiscal constraints risk, inadequate or delay in timely budget allocation for the program which may hamper achievement of program results.	Substantial	The PCO will monitor the program budget requests, allocations, timeliness and adequacy of budgets. PCO and concerned financial and accounts staff of MOHMM, Finance Commission, and 9 Provincial councils to be trained on ADB's disbursement procedures and financial management requirements by completing e-learning and attending trainings.	PSC, PCO. Annually	
2. Staffing	The program-related financial information as required by ADB may be delayed due to non-availability of qualified financial management staff.	Moderate	Qualified accountants to be mobilized at MOHMM and each Province within one quarter of loan effectiveness.	CFO of MOHMM and DCSF of 9 Provincial Councils and PCO. Within one quarter of loan effectiveness	
3. Accounting and financial reporting	Use of multiple accounting systems may not produce complete and accurate bookkeeping and timely PFS.	Moderate	Submit annual PFS to NAO with copies to ADB. PCO to monitor and track the compliance.	CFO of MOHMM and DCSF of 9 Provincial Councils and PCO. By 30 June every year	
4. Internal audit	The program may not be included in the internal audit plan. Also, timely action on audit recommendations may not be taken. Program funds are not used for intended purposes considering economy and efficiency.	Substantial	The RBL program to be included in the audit plan of the internal and external auditors within first quarter of loan effectiveness.	PCO in coordination with MOHMM and 9 Provincial Councils. With in one quarter of loan effectiveness	
5. Independent audit	The program may not be included in the audit plan and Lack of timely action to address the audit findings and	Substantial	Coordinate with NAO to finalize the statement of audit needs and audit opinion letters, management letters and	CFO of MOHMM and DCSF of 9 Provincial Councils With in one	

Risks	Risk Description	Risk Rating without Mitigation Measures	Key Mitigating Measures	Timeline and Responsible Agent	Implementing Status
	recommendations may lead qualified program financial statements.		to ensure the RBL program is included in the audit plan of NAO. The audit report are prepared and APFS to be submitted in a timely manner.	quarter of loan effectiveness CFO of MOHMM and DCSF of 9 Provincial Councils. By 30 September every year	
Overall control risk		**Substantial**			
Overall risk		**Substantial**			
Procurement					
	Lack of capacity in using PROMISe.lk PGL 24 and PM 24 by government users and vendors	Substantial	Provide training for all stakeholders, conduct peer-to-peer knowledge exchanges, build capacity in PGL 24 and PM 24, ensure labels of the eGP platform are available in all three languages, adjust vendor registration fees, and establish a help desk in each province.	Continuous from Q2 2025 DOPF	
	Inadequate procurement performance monitoring and contract management	Substantial	Institutionalize monthly procurement review meetings to monitor progress and compliance. Prepare Contract Management Plan, conduct training programs, introduce digital application for contract management	MOHMM, Provincial Councils/PDHS	
	Lack of anticorruption, conflict of interest, and sustainable procurement principles in existing SBDs/RFQs	Moderate	Implement new PGL 2024 with stringent provisions, modify current RFQs and SBDs, conduct capacity building.	Q2 2026 NPC, CIDA, DGPF, MOHMM	
	Procurement of Pharmaceutical and medical devices using ad hoc documents	Substantial	Develop and institutionalize pharmaceutical-specific and medical devices-specific SBDs.	Q2 2026 MOHMM, NPC	
	Declaration of Impartiality not always followed	Moderate	Include Declaration of Impartiality in training, ensure appointment letters indicate the requirement, use PROMISE.LK.	CAO of Provincial Council, MOHMM/PDHS	
Safeguards	Risk of use of Program funds for activities with complex E&S impacts.	Moderate	Each activity shall be screened and categorized by MOHMM and PDHS for E&S impacts when preparing annual costed RBL program action plan. Category A activities for environment and	MOHMM/PDHS immediately after the scope of activities are finalized	

Risks	Risk Description	Risk Rating without Mitigation Measures	Key Mitigating Measures	Timeline and Responsible Agent	Implementing Status
	Gaps in awareness and capacity of the MOHMM/ PDHS/ Provincial Technical Committee in implementation of safeguards requirements.	Moderate	Category A and B for IR/IP shall be excluded from the program. Conduct training sessions on E&S safeguards in the 'two-day residential Central–Provincial Technical Dialogue' each year	PCO Annually	
	Risk of Civil work contractors not complying with E&S requirements during civil works.	High	The ESMP shall form part of the contract documents and the contractors shall implement the ESMP and monitored by MOHMM and PDHS and reported to ADB.	MOHMM / PDHS Throughout the program cycle	
	Gaps in capacity on increased requirement of HCW management with the expanded healthcare facilities	Moderate	Conduct training sessions for operational staff at national and provincial level new and renovated / upgraded healthcare facilities on HCW management.	MOHMM/PDHS/ Directorate of Environmental Health, Occupational Health and Food Safety From the second year of implementation of the program.	
Integrity	EA and IAs' unfamiliarity with ADB's Investigation and Enforcement Framework (2024)	Substantial	Familiarize with ADB's Investigation and Enforcement Framework. Conduct regular awareness/training sessions on (i) ADB's Anticorruption Policy and (ii) adequate due diligence during bid evaluation to identify any irregularities, inconsistencies, and/or potential misrepresentations on the bids.	MOHMM, Provincial Councils/PDHS	
Overall RBL program risk		**Moderate**			

ADB = Asian Development Bank, APFS = audited program financial statement, CAO = chief administrative officer, CFO = chief financial officer, CIDA = Construction Industry Development Authority, CIGAS = Computerized Integrated Government Accounting System, DGPF = Director General of Public Finance, DOPF = Department of Public Finance, DSCF = deputy chief secretary finance, ESMP = Environmental and Social Management Plan, E&S= environmental and social, GOSL = Government of Sri Lanka, HCW = health care waste, IR/IP = involuntary resettlement/ indigenous peoples, ITMIS = Integrated Treasury Management Information System, M&E = monitoring and evaluation, MOHMM = Ministry of Health and Mass Media, NAO= national audit office, NPC = National Procurement Committee, PCO = program coordination office, PDHS = Provincial Directorate of Health Services, PFM = Public Financial Management, PFS = program financial statements, PGL = procurement guidelines, PPCC = provincial program coordination committee, SBD = standard bidding documents, RBL = results-based lending, RFQ = request for quotations, SBD = standard bidding documents.
Sources: ADB.

VI. PROGRAM ACTION PLAN

A. Status of Program Action Plan

78. Table 24 consolidates the program actions discussed in other relevant sections of the PID.

Table 24: Status of Program Action Plan
(as of 4 April 2025)

Actions	Responsible Agency	Time Frame for Implementation	Status of Implementation
Area 1: Technical			
Conduct annual Central–Provincial Technical Dialogue to share best practices of efficiency and quality enhancement measures, update provinces on relevant new and/or revised policies, plans, guidelines related to RBL program, discuss governance strengthening measures, and review RBL program implementation program	PCO, MOHMM, 9 Provincial Councils, ADB	Continuous from Q3 2025	
Area 2: Monitoring and Evaluation			
Assign focal person for the monitoring and evaluation of the RBL program results	PDHS, RDHS, DDG MS2, and other concerned MOHMM offices assigned	Before loan and grant effectiveness	
Engage technical firm to support Independent Verification Agency	DPMM	By Q1 2026	
Area 3: Gender			
Annual provincial health bulletin incorporates sex disaggregated data where applicable to inform provincial health sector planning and priority setting.	All 9 Provincial Councils	Continuous from Q2 2025	
Conduct assessment and facilitate policy dialogues on enhancing workplace safety of female healthcare workforce	MOHMM (through the support of TA)	By Q2 of 2026	
Annual costed provincial plan should align with relevant government gender mainstreaming principles and incorporate gender awareness raising activities on secondary care services for healthcare workforce and general public	MOHMM and All 9 Provincial Councils	Continuous from Q2 2025	
Area 4: Financial Management			
Monitor the program budget requests, allocations and progress of activities.	PCO	Continuous from Q3 2025	
Monitor the timeliness and adequacy of budget release as	ADB	Continuous from Q3 2025	

Actions	Responsible Agency	Time Frame for Implementation	Status of Implementation
part of semi-annual financial reporting.			
Financial management-related staff of PCO, PPCC and ERD be trained through e-learning or physical trainings on ADB's disbursement procedures and financial management requirements	ERD, PCO, PPCC	Continuous from Q3 2025	
The PCO and PPCC to be staffed with a qualified accountant to ensure ADB's financial management requirements are met.	PCO, PPCC	Before loan effectiveness	
Ensure timely preparation and submission of annual PFS to Auditor General with copies shared with ADB and	PCO, PPCC	Annual	
Compile periodic financial information and report to ADB	PCO, PPCC	Semi-annual	
Include the RBL program into the audit plan of the internal auditors	PCO, PPCC	Within the first quarter of loan and grant effectiveness.	
The internal audit will report its findings to the PSC. Findings and status of implementation of the recommendations will be included in the semi-annual progress report and shared with ADB.	PCO, PPCC	Semi annual	
Coordinate with NAO to finalize the statement of audit needs and audit opinion letters as well as management letters and to ensure the RBL program is included in the audit plan of NAO and the audit report is prepared in a timely manner.	PCO, PPCC	Within the first quarter of loan and grant effectiveness.	
Monitor and resolve program audit observations in a timely manner and report the progress in semiannual progress report to ADB.	PCO, PPCC	Semi annual	
Area 5: Procurement			
Conduct trainings to enhance the capacity of government users and vendors on eGP platform, PGL 2024 and PM 2024	DOPF / MOHMM	Continuous from Q2 2025	
Enhance Accessibility of the eGP platform to increase the vendor participation by providing labels of the platform in three languages, adjust vendor registration fee and establish a help desk in each province	DOPF / MOHMM	Q4 2025	

Actions	Responsible Agency	Time Frame for Implementation	Status of Implementation
Institutionalize monthly procurement review meetings to monitor progress and compliance. Prepare Contract Management Plan, conduct training programs, introduce digital application for contract management	80 PEs	Continuous from Q2 2026	
To improve procurement governance, enforce confidentiality forms, share bid opening minutes, establish PAB/PAC, implement Standstill provisions, and publish contract awards with reasons for rejections.	PEs/CAOs	Continuous from Q2 2026	
Enhance and institutionalize SBDs/RFQs mandated by the government to include PGL 2024 provisions, improve procurement quality and timelines for health sector items, and adopt best practice models with and without Framework Agreements	MOHMM/SPC/NPC	Q4 2025	
Area 6: Anti-corruption			
Program to be audited annually and audit observations addressed timely and in a systemic manner	MOHMM, PDHS	Annually	
Familiarize with ADB's Investigation and Enforcement Framework (2024).	MOHMM, PDHS	During the program inception mission	

ADB = Asian Development Bank, CAO = Chief Accounting Officers, DDG = deputy director general, DOPF = Department of Public Finance, DPMM = Department of Project Management and Monitoring, ERD = Department of External Resources, MOHMM = Ministry of Health and Mass Media, NAO = National Audit Office, NPC = National Procurement Committee, PCO = program coordination office, PDHS = provincial director of health services, PE = procurement entity, PGL = procurement guideline, PPCC = provincial program coordination committee, Q = quarter, RBL = result-based loan, RDHS = regional department of health services, RFQ = request for quotation, SBD = standard bidding documents, SPC = State Pharmaceutical Cooperation.
Source: ADB.

VII. TECHNICAL ASSISTANCE

A. Summary

79. A TA with an indicative amount of $2 million will be attached to the proposed RBL program. The TA is expected to be financed on a grant basis by the Japan Fund for Prosperous and Resilient Asia and the Pacific, subject to the final approval of respective donor agency.[21] The TA will provide support to upstream analytical work and policy dialogues of key health sector reforms with relevance to the RBL. It will also provide capacity building support to the government in addressing key governance and systems issues, making delivery of secondary care services

[21] The $0.48 million was originally the fee that ADB charged to administrate the Pandemic Prevention, Preparedness and Response Fund grant for the Government of Sri Lanka. ADB program processing team is now seeking a special waiver to be approved by its management to donate this fee to the proposed attached Technical Assistance.

more relevant and efficient considering the healthcare challenges. It will also allow the government to benefit from international and national expertise that could significantly improve health sector planning, standardize healthcare delivery, build lasting systems for continuing professional development, and introduce pressing health governance reforms. The TA will also support setting up a program coordination office to support MOHMM and 9 provincial councils in implementation, monitoring and evaluation, and progress reporting of the RBL program. The TA will be administrated directly by ADB.

B. Implementation Status

80. The status will be updated during implementation.

C. Issues and Changes

D. Consulting Service Requirement

81. About 301 person-months (14.5 international, 286.5 national) of individual consulting services as well as about 38.9 person-months (20.2 international, 18.7 national) of firm consulting services are required to (i) support secondary care hospital development , (ii) provide capacity building support to treat and manage high burden diseases, (iii) provide technical support to health governance reforms, and (vi) provide support to RBL program implementation, monitoring, and reporting. ADB will engage consultants following ADB Procurement Policy (2017, as amended from time to time) and related Procurement Staff Instructions.

82. Consultants may be selected either through competitive selection of firms, individual consultant selections, or as resource persons, whichever is applicable. The TA may engage United Nations Population Fund and United Nations Children's Fund through direct contracting or establishing administrative arrangements for fund transferring to carry out the nationwide hospital and community survey of the health utilization status of elderly and the readiness of elderly-friendly services at hospitals and develop comprehensive training modules for pharmaceutical supply chain residential pre-assignment training and CPD online refresher courses on selected thematic areas, respectively.

83. The TA’s monitoring and reporting requirements will follow ADB’s applicable project administration and staff instructions with compliance of the JFPR implementation guidelines. All changes in the TA scope and objectives will be discussed with the JFPR team. The TA completion report will be shared with the Government of Japan.

84. The status of consulting service engagement will be updated during implementation.

VIII. MONITORING OF KEY PROGRAM COVENANTS

85. The status of key program covenants and any major issues during implementation will be updated here.

IX. SUMMARY OF KEY OUTSTANDING ISSUES

86. The key outstanding issues and the status in addressing them, including the expected time frame will be summarized here during implementation.

Table 25: Key Outstanding Issues and Actions
(as of {date})

Number[a]	Key Issues	Status in Addressing the Issues	Next Steps	Responsible Agencies and People	Time Frame for Implementation

Either define abbreviations within the table or list them alphabetically and define them below the table. Use a consistent approach and do not define some in the table and others below the table.
[a] Add or delete rows as needed. To ensure that the program is results-focused and actions can be achieved, the number of actions should be limited and the actions should be carefully selected.
Source(s): List table source(s).

X. ACCOUNTABILITY MECHANISM

87. The Accountability Mechanism provides an independent forum and process whereby people adversely affected by ADB-assisted operations can voice and seek a resolution of their problems, as well as report alleged violations of ADB's operational policies and procedures.[22] People who are, or may in the future be, adversely affected by a program supported by RBL may submit complaints to ADB's Accountability Mechanism.

88. Before submitting a complaint to the Accountability Mechanism, affected people should make a good faith effort to resolve their problems and/or issues by working with the concerned ADB operations department. Only after doing that, and if they are still dissatisfied, should they approach the Accountability Mechanism.

XI. CHANGES IN PROGRAM SCOPE AND IMPLEMENTATION ARRANGEMENTS

89. Major and minor changes in scope and implementation arrangements during implementation will be recorded to provide a chronological history of these changes.

Table 26: Changes in Scope and Implementation Arrangements
(as of {date})

Number[a]	Changes and Key Reasons[b]	Date	Names of Documents[c]
1			

Either define abbreviations within the table or list them alphabetically and define them below the table. Use a consistent approach and do not define some in the table and others below the table.
[a] Add or delete rows as needed.
[b] Summarize the changes and reasons. Be brief.
[c] List the names of the document authorizing the changes, e.g., Memo approved by Director xxx dated xxxx.
Source(s): List table source(s).

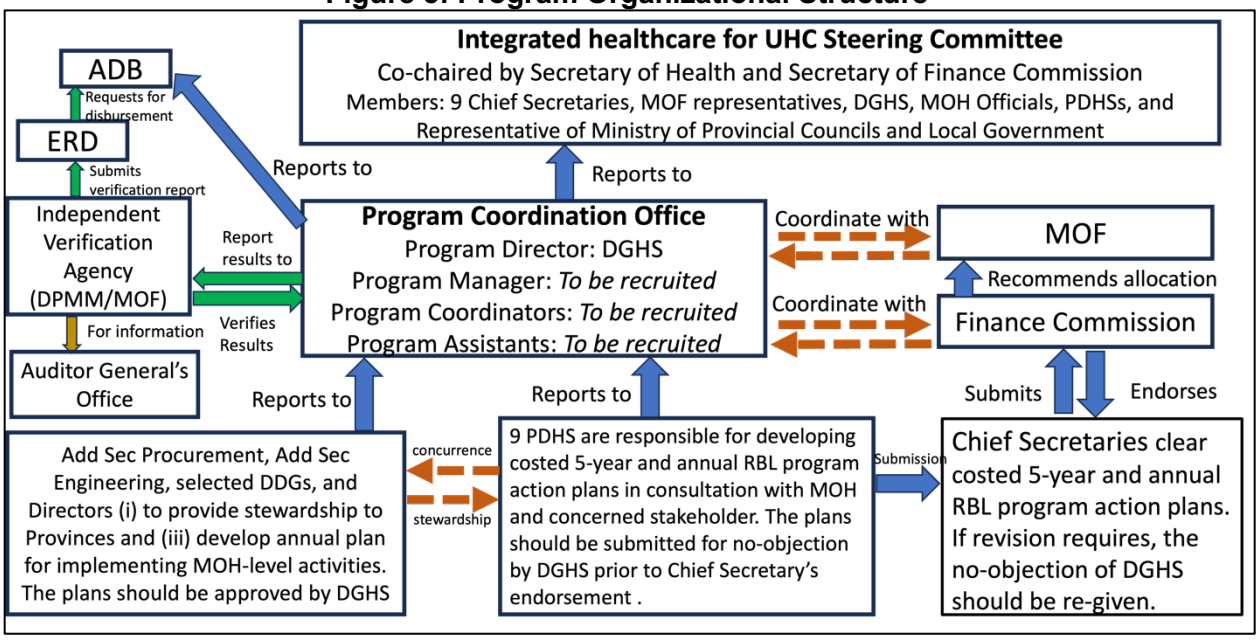
XII. PROGRAM ORGANIZATIONAL STRUCTURE AND FOCAL STAFF

A. Organizational Structure

90. Figure 5 below shows the main institutions involved in the project.

[22] ADB. 2012. *Accountability Mechanism Policy 2012*.

Figure 5: Program Organizational Structure



ADB = Asian Development Bank, Add Sec = Additional Secretary, DDG = deputy director general, DGHS = Director General of Health Services, DPMM = Department of Project Management and Monitoring, DST = Deputy Secretary Treasury, ERD = External Resource Department, MOF = Ministry of Finance, Planning, and Economic Development, MOHMM = Ministry of Health and Mass Media, PDHS = Provincial Department of Health Services, UHC = universal health coverage.
Source: ADB.

B. Program Officers and Focal Persons

1. Initial Arrangements

Table 27: Program Officers and Focal Persons
(as of 4 April 2025)

Number	Key Government Staff and Positions	Key ADB Staff and Positions
1	Dr. Anil Jasinghe Secretary of Health	Ms. Gi Soon Song Director, Human and Social Development Sector Group, Sector Department 3
2	Mr. A.T.M.U.D.B. Tennakoon Secretary of Finance Commission	Mr. Dai-Ling Chen Program Team Leader, Health Specialist, Human and Social Development Sector Group, Sector Department 3
3	Mr. J.M. Jayasinghe Chief Secretary of the North Central Province	Mr. Herathbanda Jayasundara Co-program Team Leader, Senior Social Development Officer, Human and Social Development Sector Group, Sector Department 3
4	Mr. T.A.C.N. Thalangama Chief Secretary of the Eastern Province	
5	Ms. S.L. Dhammika K. Wijayasinghe Chief Secretary of the Western Province	
6	Mr. M.L. Gammampila Chief Secretary of the Uva Province	
7	Mr. G.H.M.A. Premasinghe Chief Secretary of the Central Province	
8	Mr. Sumith Alahakoon Chief Secretary of the Southern Province	

Number	Key Government Staff and Positions	Key ADB Staff and Positions
9	Mr. L. Ilaangovan Chief Secretary of the Nothern Province	
10	Ms. E.K.A. Suneetha Chief Secretary of the Sabaragamuwa Province	
11	Mr. I.M.I. Ilangakoon Chief Secretary of the North Western Province	
12	Dr. Asela Gunawardena Director General of Health Services	

ADB = Asian Development Bank.
Sources: ADB and Government of Sri Lanka.

2. Changes during Implementation

91. Changes during implementation in the ADB mission leader and key executing agency staff indicating the new names, titles, dates of the changes, and the reasons for the changes will be monitored and recorded here.

Table 28: Changes in Key Executing Agency Staff and ADB Mission Leader
(as of {date})

Number[a]	Changes	Date	Reasons for the Change[b]
1			
2			

Either define abbreviations within the table or list them alphabetically and define them below the table. Use a consistent approach and do not define some in the table and others below the table.
[a] Add or delete rows as needed.
[b] Summarize the reasons. Be brief.
Source(s): List table source(s).

LIST OF TYPE A AND TYPE B BASE HOSPITALS

	Province	District	HIN	Base Hospital
1	**Western**	**Colombo**	PCB0004002	BA Homagama
2			LCB0000125	BB Mulleriyawa
3		**Kalutara**	LKT0000885	BB Beruwala
4			PKT0010280	BA Panadura
5				Kethumathi Women's Hospital
6			PKT0010298	BB Pimbura
7		**Gampaha**	PGP0005660	BB Kiribathgoda
8			PGP0005686	BB Minuwangoda
9			PGP0005652	BA Watupitiwela
10			PGP0005678	BB Meerigama
11	**Central**	**Kandy**	LKY0000984	BB Gampola
12			PKY0011551	BB Digana Rehabilitation Hospital
13			PKY0010751	BB Teldeniya
14		**Matale**	PMT0013409	BA Dambulla
15		**NuwaraEliya**	PNE0013938	BB Rikillagaskada
16			PNE0013920	BA Dickoya
17	**Uva**	**Badulla**	PBD0003160	BB Welimada
18			PBD0003145	BA Diyatalawa
19			PBD0003152	BA Mahiyanganaya
20		**Moneragala**	PMG0011882	BB Wellawaya
21			PMG0011874	BB Siyambalanduwa
22			PMG0011866	BB Bibile
23	**North Central**	**Anuradhapura**	PAN0001354	BB Kahatagasdigiliya
24			PAN0001388	BB Medawachchiya
25			PAN0001370	BB Kekirawa
26			PAN0001362	BB Kebitigollewa
27			PAN0001396	BB Padaviya
28			PAN0001347	BA Thambuttegama
29		**Polonnaruwa**	PPN0014548	BA Medirigiriya
30			PPN0014555	BB Hingurakgoda
31			PPN0014563	BB Welikanda
32	**Eastern**	**Trincomalee**	PTM0016519	BB Kinniya
33			PTM0016527	BB Mutur
34			PTM0016535	BB Pulmodai
35			LTM0001172	BA Kantalai

	Province	District	HIN	Base Hospital
36		**Batticaloa**	PBC0002600	BB Kattankudy
37			PBC0002592	BB Eravur
38			PBC0002584	BA Valachchanai
39			PBC0002576	BA Kaluwanchikudy
40		**Ampara**	PAP0002253	BB Mahaoya
41			PAP0002246	BB Dehiattakandiya
42		**Kalmunai**	LKL0000844	BA Akkaraipattu (Elawatuwan)
43			LKL0000851	BA Kalmunai North
44			LKL0000869	BA Kalmunai South (Ashroff Memorial Hospital)
45			PKL0009662	BB Nintavur
46			PKL0009621	BB Potuvil
47			PKL0009639	BB Sammanthurai
48			PKL0009688	BB Thirukovil
49	**Northern**	**Kilinochchi**	PKN0010082	BB Mulankavil
50		**Jaffna**	PJF0007062	BB Chavakachcheri
51			PJF0007047	BA Point Pedro
52			PJF0007054	BA Tellipallai
53			PJF0007070	BB Kayts
54		**Mullativu**	PML0012278	BA Mallavi
55			PML0012286	BB Mankulam
56			PML0012302	BB Puthukkudyiruppu
57		**Mannar**	PMN0012567	BB Murunkan
58		**Vavuniya**	PVN0017004	BB Cheddikulam
59	**North Western**	**Puttlam**	PPT0014951	BA Puttalam
60			PPT0014969	BB Anamaduwa
61			PPT0014977	BB Marawila
62		**Kurunegala**	PPT0014993	BB Kalpitiya
63			PKG0008250	BB Polpitigama
64			PKG0008227	BB Dambadeniya
65			PKG0008235	BB Galgamuwa
66			PKG0008243	BB Nikaweratiya
67	**Southern**	**Galle**	PGL0004853	BA Elpitiya
68			PGL0004861	BB Udugama
69			PGL0004846	BA Balapitiya
70		**Matara**	PMR0012856	BB Deniyaya
71			PMR0012849	BA Kamburupitiya

	Province	District	HIN	Base Hospital
72		**Hambantota**	PHT0006528	BB Tissamaharama
73			PHT0006510	BA Tangalle
74			PHT0006536	BB Walasmulla
75	**Sabaragamuwa**	**Ratnapura**	PRP0015610	BB Kahawatta
76			PRP0015602	BB Balangoda
77			PRP0015628	BB Kalawana
78			PRP0015644	BA Eheliyagoda
79			PRP0015685	BB Kolonna
80		**Kegalle**	PKE0007666	BB Warakapola
81			PKE0007641	BB Karawanella
82			PKE0007658	BB Mawanella

SAMPLE WITHDRAWAL APPLICATION FORM

WITHDRAWAL APPLICATION

Asian Development Bank ADB

To: Asian Development Bank (ADB)
6 ADB Avenue, Mandaluyong City
1550 Metro Manila, Philippines
Attention: Loan Administration Division, Controller's Department (CTLA)

ADB Loan/Grant No. ____ - ____
Application No. ____

1. Type of Disbursement (indicate an 'x' in the appropriate box)

☐ Reimbursement ☐ Direct Payment ☐ Policy-based Lending ☐ Results-based Lending
☐ Initial/Additional Advance ☐ Liquidation and Replenishment ☐ Liquidation Only

2. In connection with the Loan or Grant Agreement (Agreement) of the said ADB Loan or Grant number, please pay from the Loan or Grant Account (Account):

Application Currency	Application Amount (in figures)	Application Amount (in words)

3. Payment Instructions (Not required in the case of liquidation only):

A. Payee's Name and Address

Payee's Name & Address

B. Name and Address of Payee's Bank and Account No.

Bank Name
Bank Address
Payee's Account No. SWIFT Code

C. Correspondent Bank [*If payee's bank is not located in the country whose currency is claimed, enter the name and address of their bank's correspondent in the country whose currency is to be paid*]

Bank 1 Name
Bank 1 Address
Account No. of Payee's Bank SWIFT Code
Bank 2 Name
Bank 2 Address
Account No. of Bank 1 SWIFT Code

D. Special Payment Instructions and Other References

4. This application consists of [*indicate an 'x' in the appropriate box(es)*];

☐ Summary/Statement of Expenditures (SOE) sheets ☐ Advance Account Reconciliation Statement
☐ Estimate of Expenditures sheets ☐ Certificates for Force Account for Works (FAW)
☐ Copies of supporting documents (e.g., invoices, receipts, etc.) ☐ Summary Sheet for Results-based Lending
☐ Others (please specify or attach list as necessary): _____

5. The undersigned certifies and agrees as follows:

a. The expenditures were or will be made for the purposes specified in the Agreement and in accordance with its terms and conditions, and the undersigned has not previously withdrawn from the Account or obtained or will obtain any other loan, credit, or grant for the purpose of fully or partially meeting these expenditures.
b. The works, goods, or services claimed for reimbursement, liquidation of advance, or direct payment have been procured in accordance with the Agreement and the cost and terms of the purchase thereof are reasonable and in accordance with the relevant contract(s).
c. The works, goods, or services were or will be produced in and supplied by a member country of ADB, unless specifically permitted otherwise by the ADB Board of Directors.
d. This application is claimed in accordance with ADB's *Loan Disbursement Handbook*, and all documents related to the expenditures covered by this application are available for examination by auditors and by ADB upon request.
e. Unless otherwise restricted in the Agreement, if the disbursement pursuant to this application results in the agreed allocation of the corresponding expenditure categories of the Account being exceeded, ADB may process the disbursement and subsequently reallocate to such categories from other categories to the extent required to meet the shortfall.
f. The payee is able to receive payments through the international banking system.
g. For direct payment, the payee is not on ADB's complete Sanctions List, based on checks done by the borrower, the executing agency, or the implementing agency pursuant to the Project Administration Manual, other project documents and applicable ADB regulations, and in connection with the underlying contracts related to this withdrawal application. A guide on ADB's complete Sanctions List and how to get access to it is available at www.adb.org/publications/faqs-adb-sanctions.
h. For direct payment, the payee is not subject to sanctions by decisions of the United Nations Security Council taken under Chapter VII of the Charter of the United Nations.

By (Name of Borrower or Recipient)		Date Signed	
Signature of Authorized Representative(s)			
Printed Name/Title of Authorized Representative(s)			

ADB Form No. ADB-WA

Instructions for preparing the Withdrawal Application Form (ADB Form No. ADB-WA)

General Instructions

- Submit original withdrawal application (WA) form to the Asian Development Bank (ADB) (or to its resident/regional Mission, if instructed).[1]
- Number WA consecutively, using five digits or characters.
- The value of a WA should be at least US$200,000 equivalent, or 1% of the loan or grant amount, whichever is lower, unless otherwise stipulated in the Project Administration Manual (PAM).[2] Individual payments below this amount should be paid (i) by the Borrower or Recipient and subsequently claimed to ADB through reimbursement, or (ii) through the advance fund procedure (if such procedure is stipulated in the PAM), unless otherwise accepted by ADB.
- When the WA is completed, verify completeness of supporting documentation and accuracy of details before passing to the authorized representative(s) for signature. Mistakes and omissions result in delayed disbursement.

Withdrawal References

ADB Loan or Grant No.: Indicate the number assigned by ADB to the Loan or Grant Agreement (i.e., Loan or Grant + [4 digits serial numbers]-[3 characters of country code]).
Application No.: Number WA consecutively using 5 digits or characters. If the project has more than one executing agency (EA) or implementing agency, the project coordinator should assign an alpha identification for each EA, e.g., A0001 to A9999 for EA no. 1 and B0001 to B9999 for EA no. 2.

1. Type of Disbursement: Check the appropriate box of the disbursement type, whether for (i) reimbursement, (ii) direct payment, (iii) policy-based lending (PBL), (iv) results-based lending (RBL), (v) initial/additional advance, (vi) liquidation and replenishment, or (vii) liquidation only.

2. Application Amount

Application Currency: Indicate the name of the currency requested for disbursement and/or liquidation. Prepare a separate WA for each application currency and each payee. The application currency for direct payment or reimbursement procedure is the currency of the contract or the currency in which the cost of goods and services has been paid or is payable. The application currency for the advance fund procedure is the currency of the advance account. For PBL and RBL, the application currency is the currency of the denomination of the PBL and RBL as specified in the legal agreement (e.g., the Special Drawing Rights [SDR]).
Application Amount: Indicate the amount to be disbursed and/or liquidated in figures and words. The amount must be the sum of the summary/statement of expenditures (SOE) sheet(s) (except PBL and RBL). For RBL, the application amount should equal the amount indicated in the summary sheet for results-based lending.

3. Payment Instructions

A. Payee's Name and Address: Indicate full name and address of the payee for identification of payment.
B. Name and Address of Payee's Bank and Account No.: Indicate full name and address of the payee's bank, which may include a banker and/or branch designation. Account number is important. Provide SWIFT code if the payee's bank is a member of SWIFT.
C. Correspondent Bank: When payment is to be made to a payee's bank not located in the country of the disbursement currency, indicate full name and address of its correspondent bank located in the country of the disbursement currency. Provide SWIFT code if the bank is a member of SWIFT. (If the payee's bank does not have a correspondent account in a bank located in the country of the disbursement currency, indicate an intermediary bank in Bank 1, and indicate its correspondent bank located in the country of disbursement currency in Bank 2. The head office of the payee's bank can also act as an intermediary bank, as applicable, provided that the bank is a member of SWIFT.)
D. Special Payment Instructions: Indicate any particulars, special instructions, or references to facilitate payment or identification of payment. When the disbursement currency is different from the application currency for the PBL and RBL (e.g., Concessional Loans from Ordinary Capital Resources), indicate "pay the application amount in [the currency name to be disbursed] equivalent."

4. Documentation

Summary/SOE Sheets: Submit a separate form for each category or subcategory. List items of payment to the same supplier together, one below another. This form is not applicable for PBL and RBL.
Summary Sheet for Results-based lending: Submit the Summary Sheet for Results-based lending (RBL) to CTL for clearance together with a draft version of the WA.
Certificates for Force Account for Works (FAW): Submit two certificates (Parts I and II) for FAW. These certificates are applicable if such procedure is stipulated in the PAM.
Estimate of Expenditures Sheet: Submit this form for initial or additional advance to the advance account, or if the requested level of advance is larger than the appropriate level of advance. The estimate should be endorsed by the ADB's project officer or specialist in charge of administration of the project. Estimated expenditures for the forthcoming 6 months should normally be based on the amount of contracts awarded and to be awarded. For expenditures related to operational costs, the amount should be linked to the project's annual budget provision.
Advance Account Reconciliation Statement: Submit this form for liquidation and/or replenishment of the advance account. A copy of the ending balance per the corresponding bank statement should be attached.
Copies of Supporting Documents: Submit supporting documents in accordance with the *Loan Disbursement Handbook* (Section 7.6, 8.30, 9.5, or 10.6) to substantiate eligibility of the expenditure claimed (except PBL and RBL), unless SOE or FAW procedure is applicable to the payments.

5. Certifications and Signature

Certifications: Modifications to any certification are not valid or binding, unless otherwise agreed by ADB.
By (Name of Borrower or Recipient): Fill in the name as it appears in the Loan or Grant Agreement.
Date Signed: Enter the date WA is signed by authorized representative(s), not the date it was prepared.
Authorized Representative(s): Pass this application to authorized representative(s), who is (are) designated in the Evidence of Authorized Persons to Sign Withdrawal Applications form submitted to ADB. Verify that the list of authorized representative(s) has not been changed.

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[1] Online submission of WA using the ADB's Client Portal for Disbursements (CPD) (https://cpd.adb.org) is encouraged.
[2] A PAM is prepared for project loans, Activity Administration Manual (AAM) for Small Expenditure Financing Facility (SEFF), Facility Administration Manual (FAM) for multitranche financing facility (MFF), and a Program Implementation Document (PID) for results-based lending (RBL). The term "PAM" also refers to these (and similar) documents unless the context requires otherwise.

Planning Guideline for 5-Year and Annual RBL Program Implementation Plan Development

Planning Guideline

to be adopted when developing the 5 year and annual plans supported under the RBL Program 2025 to 2030

Section 1: Introduction:

The ADB is providing a Results based loan (RBL) for USD 100 million and with a Pandemic Prevention, Preparedness and Response Trust Fund (Pandemic Fund) grant of USD 6.9 million expected to be effective from mid 2025 to close in mid 2030. The scope of the RBL program (USD 106.9 million) is within the component of **integrated secondary health care of the** National Strategic Framework for Development of Health Services (2016 to 2030). The proposed loan will support results achieved at both the central and provisional levels and strengthen the government-owned program to improve coordination and integration within health sector (primary, secondary and tertiary care levels) and with non-health stakeholders for providing elderly care including palliative and rehabilitation care, disease surveillance and prevention of diseases and includes measures to strengthen governance in the sector. A comprehensive secondary health care service package will benefit the total population living across the country as these secondary care hospitals function as first referral hospitals located in 82 cities across the 26 districts in the 9 provinces.

The RBL program's impact will be based on both the Government of Sri Lanka resources and the support provided via the ADB RBL loan to have a healthier population with UHC that contributes to the economic, social, mental, and spiritual development of Sri Lanka. The outcome will be to improve efficiency and quality of ***secondary health services*** as first referral care.

The program outcome will be measured by 2 outcome level indicators

1. DLI 1: percentage reduction in the waiting time of patients requiring selected elective surgical procedures (cataract surgeries, hernia repairs, and hysterectomies).
2. DLI 2: percentage reduction of hospital acquired infections (surgical site infections) reported at secondary hospitals.

The RBL will have 3 outputs.

Output 1: First referral care services enhanced. This output will address the gaps in services at secondary hospitals that provide first referral services across the country. There are three DLIs under this output to measure implementation progress.

1. DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened through concurrence of costed provincial secondary care improvement action plans, institutionalization of health technology assessments for new medical equipment and pharmaceuticals, approval of national guidelines for provision of core secondary health services, and improvement of healthcare workforce management;
2. DLI 4: Patient-centered secondary care services with quality, safety, climate resilience measures enhanced through improving the availability of day surgery, rehabilitation, and NCD diagnostic services, improving the provision of children, youth, gender, elderly, and disability-friendly care services, and introducing quality, safety, biomedical waste management, and climate resilience measures in secondary hospitals; and
3. DLI 5: Care pathways linking first referral hospitals for selected NCD high burden diseases formalized by institutionalizing the shared care cluster service delivery

approach linking secondary and primary health care facilities using a digital information system with a functional patient referral and back referral care pathways.

Output 2: Pandemic prevention, preparedness, and response enhanced. This output will address identified gaps in pandemic prevention, preparedness and response related activities. There is one DLI under this output to measure implementation progress.

1. DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved with the establishing of the Sri Lanka Centre for Disease Control, renovation of the Medical Research Institute, enabling early warning of notifiable diseases, and improving quality assurance of pathology, biochemistry, haematology and microbiology laboratories.

Output 3: Health sector technical capacity and pharmaceutical supply chain management improved. This output will address measures related to improving transparency and governance in the sector. There are two DLIs under this output to measure implementation progress:

1. DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced through improving the storage condition of pharmaceuticals with climate resilient measures and expanding capacity of quality assurance laboratories of National Medicines Regulatory Authority and its network.
2. DLI 8: Procurement management capacity enhanced by expediting the digitization of government procurement and introducing good procurement practices in the health sector and by reducing the time taken to initiate services for repairs and renovations of buildings and equipment.

This planning guideline is expected to be referred to when developing the 5-year costed plan by each of the provinces and when developing the annual plans each year by both the Provinces and the MOHMM units.

Section 2: General Guidelines:

- Funds should be used, as much as possible to DIRECTLY benefit the population across all interventions. Establishing, or further strengthening efforts to provide patients (with special emphasis on vulnerable populations) and staff friendly services is essential.

- Investments should be prioritized for reaching results targets and where possible beyond targets for each of the DLIs which are described above and detailed in the Program Results Framework.

- Activities and investments required to implement the Program Action Plan given in the Project Information Document should also be addressed in the annual and 5-year implementation plans by both the Ministry of Health and Mass Media and by the Provincial Health Ministries.

- Prioritization should be carried out objectively with measurable criteria defined by each Province and by the MOHMM for each year. This will ensure that development will be equitable and that the limited resources will be best used to provide higher quality services in a more efficient manner to the people who seek care in the Base Hospitals in Sri Lanka.

- Hospital development must be guided by policies, strategy documents, circulars, guidelines of the Ministry of Health and Mass Media and of the Provinces and therefore upgraded levels of development beyond the guidance given in the circulars will be strictly not authorized. (e.g. If a BH A is authorized to have a A&E services Level 3 facility based on the MOHMM guidelines, then utilizing funds to develop a higher-level facility is not authorized).

- Health service provision via clusters with BHs A & B as Apex institutions is prioritized by the Government and is fully supported by the UHC policy 2018 of the MOHMM. Therefore, defining clusters and planning within clusters for better service provision and improved access to patients need to be included in the 5 year and the annual plans.

- Funds are provided to strengthen secondary health care hospitals (Base Hospitals A & B) functioning as the first referral hospitals and support to other hospitals in the province (Tertiary level District General Hospitals or some Teaching hospitals that also function as a up-referral point) and Primary health care hospitals that function as feeder hospitals in clusters with BH A or a BH B as the apex and MOHMM offices can receive funds if essential to develop the referral and care pathways to be functional for all selected care pathway areas[ii]. All such broad areas and activities will need to be defined in the provincial or in the Line Ministry annual plans submitted and prior approved by the DGHS and the respective Chief Secretary and the Finance Commission (for provincial plans).

- Planning teams must ensure that the same activity is not supported via other fund sources like the World Bank or the GOSL but activities need to be planned as complimentary with other funding sources.

- As strengthening governance measures within the health system is considered essential and is prioritized under the RBL Program, initiatives to improve transparency related to disclosing prices, names of suppliers of awarded contracts, adopting digital technology for procurement, finance, supervision, monitoring is encouraged.

- Similarly, planning and monitoring results is considered as one of the most important measures under the RBL Program. Efforts to develop and monitor DLIs, Cluster specific results frameworks, hospital specific results frameworks will ensure better timely results.

- When planning for results each year, as there are many results that require more than one calendar year of implementation, it is best to plan for all results by creating required allocations and monitoring each of the results annually.

- Standalone new constructions / buildings identified in the Master Plans or otherwise cannot be included in the ADB RBL plans but extensions, completion of buildings, renovations, repairs, restorations, and sewerage systems and other waste management related systems can be included. All relevant social and environmental safeguard documents (Section 4 below) need to be identified in the 5-year plan and submitted as an annex to the annual plan.

- Climate adaptation and mitigation measures (as identified in DLI 4i) need to be considered, adopted and implemented under the ADB RBL program.

- International and local level training can be carried out using an upper limit of 3% of the provincial allocation or the line ministry total allocation each year to attend international health conferences and local health conferences /workshops including the Central /

provincial conference defined in the Project Information Document that will be held annually in August each year from 2025 to 2029. Charges for resource persons (local and international) to carry out country-based training is included. The areas of training courses will need to be within or closely related to each DLI area or to program action areas (M&E, procurement; finance; gender; climate change; safeguards social and environmental). Whenever possible, training should be provided for all categories of staff as required and at least 25% of the training funds should be made available for finance, procurement, Engineering, safeguards, monitoring and evaluation, planning, pharmaceutical capacity building, budgeting etc. related courses for both medical and non-medical staff working in the 9 provincial councils, and the line Ministry. The same individual can obtain resources for international training from these funds only once during the year. Officials due to retire within 6 months of the training program are not encouraged to participate in international training programs.

- Monitoring capacity in the provinces and the line ministry are expected to improve by first establishing a monitoring cell in each of the planning units at the provincial and RDHSs levels and at the MOHMM levels. It is encouraged to establish a mechanism for monitoring results and program actions within the BHs.

- BHs currently do not have standard designs or designs tailor made for patient and staff convenience as structures built over the years are not located to provide a smooth patient and service flow. It is encouraged to devise where possible arrangements /renovations etc. to provide the best possible functioning units.

- Planning templates (is the same as the Finance Commission PSDG format) are in **Annex 1** of this Planning Guideline.

- The responsible units / directorates to lead the achievement of the agreed results under the ADB RBL Program is provided in **Annex 2** of this Planning Guideline.

Section 3: Ineligible Expenditures:

The ADB RBL resources cannot be used for the following purposes:

- activities under other donor-funded projects, ayurveda expenses, and specialized projects;
- procurement of pharmaceuticals and related consumables;
- expenses related to salaries and wages, overtime and holiday payments and other allowances to staff.

Section 4: Detailed guidance for prioritizing actions under each DLI indicator

- **DLI 1 – The average waiting time of patients for selected elective surgeries at BHs (Target: reduced by 30% by March 2030).**

What should be done to achieve this? Preferably achieved before 2029 and maintained at this level or beyond.

  - Organize **day surgeries** at OPD level or linked to the ETU/ Accident and Emergency units.
  - May need a **minor operating theatre**. – need to define the type plan and find space and develop.
  - **Canvas** to fulfil the surgical cadres (all staff categories)

- **Estimate** upwards to have adequate stocks of surgical consumables, laboratory reagents and medicines.
- Procurement gaps in relevant medical equipment and accessories
- Daily inspection of OTs to be in constant readiness
- Regularly **review** the waiting time of patients for selected surgeries

- **DLI 02 – Hospital Acquired Infections in the BHs (Target: reduced by 40% from Baseline (by March 2030)**
  - Recording all infection incidences from ICUs, PBUs, wards, and overall hospitals – Keep Data and review numbers and introduce measures to identify HAIs,
  - Initiate measures to address under reporting
  - Sterility, pre, post, surgical checklists and antibiotic prescription charts use reviewed and reintroduced in the ICUs and PBUs, wards, theatres, procedure rooms etc.
  - Review hand hygiene practices and address gaps in facilities, training etc.
  - Review access to water and sanitation facilities and address gaps in facilities.
  - Review knowledge and practice of universal precautions of staff across all levels and introduce / update staff on Infection Prevention Control (IPC) measures in hospital
  - Review regularly the sterilization processes and adherence to protocols

- **DLI 03 – Planning, monitoring, budgeting and human resource management capacity of health sector strengthened (Target: 5-year plan in Aug 2025 and Annual plan each year by January 15 from 2026).**

  - When preparing the Development Master Plan at BH level:
    - Form a committee to identify the development needs of the hospital and the cluster of hospitals – Consultants, MOs, Matron, Ward Sisters, AO, Chief Pharmacist, Chief MLT, Overseer etc.
    - Consider the present layout and the other existing infrastructure, and plan to develop, to provide the Essential Service Package (ESP) relevant to the hospital category – Base Hospital A or B.
    - Inspect, observe the whole premises and identify even the minutest feature which needs attention and upgrading. They can be
      - **New structures** (extremely essential like theatre complexes, on-call rooms, quarters, waste disposal and sewerage systems),
      - **Expansions** to have more adaptable spaces for improved service provision, comfort for the patients (waiting areas), and most needed staff duty & rest rooms,
      - **Repairs** to electrical lines and wiring, water lines, storage tanks, drainage systems, all buildings, toilets and washrooms etc.
      - **Refurbishments** of wards, clinics, theatres, OPD, waiting areas etc.
      - **Land scaping** for beautification of the hospital premises, including **security measures** (fences, gates, CCTV, etc.).
    - Identify the medical equipment need after considering the lack of certain equipment, for immediate and future, and the need for replacements of old or outdated equipment (over the next 5 years).
    - Identify the IT equipment, general equipment and base hospital furniture needs. (spacing it out over the next 5 years 2025 – 2029)
    - At the province level and above and RDHS levels:
      - Identify the cadre requirement according to the norms of the relevant category of the hospital. It will be very useful and important if a total work

study is done to identify the optimum workforce. (best to carry out these at province level or at RDHS levels). Filling the existing cadre and enhancing the cadre should be prioritized and spread over the next 5 years.

- Need to properly identify the transport needs; Ambulances (new or replacements), Lorries, Utility vehicles (these assessments should be carried out at the Province and RDHS levels for better management whenever possible)
- Need of IT equipment / office and general equipment, repairs etc.to be identified and spaced across the 5 years for providing better planning, monitoring services, procurement and financial management service and safeguards services.

- Whenever possible, it is recommended to plan as a cluster with the Apex as the BH A or the BH B. Financing under the ADB RBL is mainly to the Cluster Apex, but interventions that require interconnected tasks can be supported by these resources ensuring that the World Bank or any other donor funds are used complimentarily.
- The Physical development (Infrastructure,), the Human Resource plan and the Essential Service provision plan must coincide and be parallel to each other. The development plan should coordinate all the above areas. It is not cost-effective and inefficient if ESP cannot be provided even after Infrastructure is fulfilled without the health staff; or the vice versa, to have the full cadre and without the necessary facilities.

- DLI 3c: Health Technology Assessment process for new medical equipment and new pharmaceuticals institutionalized with the introduction of 7 of the 8 initiatives. (MOHMM indicator but should be used, adopted by provinces too). **(Target: Met at least 2 initiatives in 2027, 4 initiatives in 2029 and 7 initiatives in 2030)**

  At MOHMM Level:

  - Engage with the Budget department to create required budget lines
  - Develop the organogram, establish technical expert panel, and seek clearances
  - Establish a mechanism to review with expert teams prior to introduction of a new equipment or pharmaceutical.
  - Establish mechanisms to review and revise the Essential Medicines List (EML)
  - Develop steps required to have technical specifications of medical equipment uploaded in MOHMM website.
  - Develop the steps to use the Web-based Need Assessment and Prioritization Model (NAPM) for new medical equipment.
  - Develop the processes when requesting a new pharmaceutical or a medical equipment.
  - Develop a cost accounting system for use by the Hospitals

92. At province levels:
    - Develop a mechanism to use the NAPM (in footnote 1) to ensure that medical equipment is not procured outside of the system.
    - Ensure that technical specifications for a replacement or a new equipment is within the approved level of the facility and the specifications is a general specification recommended by the MOHMM. (e.g.5 or 7 part biochemistry analyzers, introduction of hormone assay machines

advanced anesthetic machines, US scanners, X ray machines, Laparoscopes etc.)

- DLI 3d: Approved 8 national guidelines for the provision of services at BHs A&B. **(Target: Guidelines approved by March 2027)**

  - At the MOHMM level:
    - Carryout stakeholder consultations throughout the process from planning to final drafts of the guidelines are completed for the 8 areas:
      - Elderly-friendly services,
      - Hospital Laboratory quality enhancement
      - Provision of Day Surgical services
      - Mithuru Piyasa
      - Yowun Piyasa
      - Guidelines on establishing Green, Healthy and Safe Hospitals
      - services as a cluster of hospitals linking with preventive services and population
      - Guideline on establishing norms for standardizing facilities at Base Hospitals
      - Patient Information Centre

  - At the Province level:

    - Based on the national guidelines, develop province specific guidelines as necessary especially for patient Information Centre, Day Surgical services, Elderly friendly services.
    - Issue /Develop province specific guidelines on quality and safety measures, climate mitigation and adaptation measures, elder friendly and other service provision processes and procedure improvements, Managing digital systems etc.
    - Encourage BHs A&B and Clusters to adopt and implement recommendations of the guidelines.

- DLI 3e: Health human resource (i) databases adopting the National ID number operational at MOHMM and Provinces, (ii) HRH unit functional at MOHMM **(Target: HRH databases functional by March 2028)**
  - Review existing data bases at the MOHMM and at each of the province levels and define the scope of the work to develop an interoperable HRH system that uses the ID card or any other unique identification number.
  - Include required capacity building and other IT

- **DLI 4 –Patient centred secondary care services with quality, safety, climate resilience measures enhanced.**
  - **DLI 4a.** % of BHs A&B implement quality and safety measures **(Target: By March 2027, 50% of BHs have introduced 3 initiatives and by March 2029, 50% of BHs have introduced 5 initiatives)**
  - Based on the guideline of the MOHMM available via the links below and any other associated guidelines should be used to plan for these results.
    - pharmaceutical labelling (based on the guidelines given in - Implementing the circular on Proper labelling of medications during dispensing (HQSC/06/2024 of August 7, 2024 from

https://quality.health.gov.lk/images/pdf/resources/circulars/Labelling_circular_with_sample_labels.pdf

- Good Storage Practices for pharmaceutical (based on the guidelines dated October 15, 2019 of National Medicine Regulatory Authority available at https://cdn.prod.website-files.com/666d0695ca3ba7fa496a5068/66bc5e97ae159fcc637dc308_Guideline-on-Good-storage-practices%20(1).pdf
- Adverse events reporting Circular on Adverse Events and Incident Reporting HQSE/05/2021 dated January 31, 2023 from https://drive.google.com/file/d/1GGT0zU2DtMCv2aT3GzX_Q3b8xHgfkGzm/view.
- Early warning Score (Patient Observation Chart) from Implementing the Patient Observation Chart Early warning Score Circular (HQSH/01/2022 of Nov 13, 2023 from https://quality.health.gov.lk/images/pdf/resources/circulars/Patient_Observation_Chart_Circular.pdf
- Circular on antibiotic prescription chart dated July 29, 2024 from https://www.health.gov.lk/wp-content/uploads/2023/11/02-116-2024.pdf.

➢ DLI 4b: % BHs A&B provide identified services related to women, children, youth, elderly, and persons with disabilities. **(Target: By March 2028, 25% of the BHs and by March 2030, 50% of the BHs should have introduced all these 7 initiatives)**

➢ The BHs should paln to address all 7 of these interventions wherever possible.

- Make arrangements to provide access to male, female and disability access toilets in OPD and in Clinic waiting areas. (Disability access guidelines based on the Government Notification on September 20,2006 of the Act Protection of the Rights of Persons With Disabilities Act, No. 28 of 1996 from https://arts.cmb.ac.lk/sociology/cdrep/disabled-persons-accessibility-regulations-no-1-of-2006/)
- Plan to provide holding bars in walking areas in OPD area, Clinic area and corridors leading to wards, labs (Based on Government notification of the Act above),
- Access to drinking water in OPD and clinic waiting areas.
- Make available adequate seating available at clinics and OPD, (approximately 25 seats in each area).
- Special arrangements for providing easy access options for elders who require assistance, disabled persons, key populations, women with small children, infectious diseases patients) at OPD registration, pharmacy and laboratory. This Includes pathways and process improvements to provide Special easy access options for people with special needs at registration, pharmacy, laboratory.
- Provision of gender-based violence care services (Mithuru Piyasa) with adequate privacy, (Based on Circulars issued by the FHB, MOHMM and the Guideline accessible from https://srilanka.unfpa.org/sites/default/files/pub-pdf/National%20Guidelines%20Booklet.pdf.
- Provision of adolescent health care services (Yowun Piyasa) with adequate privacy. (Based on Circulars issued by the FHB, MOHMM and information from http://www.yowunpiyasa.lk/index.php?option=com_content&view=article&id=12&Itemid=121&lang=en#ampara-district)

➢ DLI4c: % BHs A&B with facilities available for Lipid Profile, HBA1c and Troponin I tests. (***Target: By March 2028, at least 50% of BHs have introduced all 3 tests)***

- Ensure that all 3 tests are available throughout the year for patients who require these tests. This includes decisions on what approach will be taken to provide the tests - should point of care tests be purchased, should a PPP be arranged with a accredited provider or should the equipment and reagents be invested by the GOSL funds.
- Plan to provide the tests at the BHs based on the option selected.

➢ DLI 4d. % of BHs A and B with functional physiotherapy / rehabilitation unit ***(Target: by March 2029, at least 40% of BHs A&B)***

- Physiotherapy rehabilitation services include all three areas of physiotherapy, occupational therapy and speech therapy. In BHAs with all these actual availabilities of the 3 supplementary areas should be prioritized to develop the units comprehensively in the following 3 areas.
    - access to the standard set of equipment,
    - physical facilities, disability access and
    - linkages with the Social Service Officers and other service providers in Government and where appropriate non-governmental.

- In BHs where the cadres are available but with vacancies in these 3 units, development should be carried out selectively as much as possible prioritizing BHs A&B availability of the required staff to run the physiotherapy, occupational therapy and speech therapy.

- If positions are vacant, explore to create arrangements / Links with other providers in DGHs or in another BH A&B or in the Private sector to provide the services comprehensively.

➢ DLI 4e. % of BHs A&B that have obtained Environment Protection Licence (EPL) and Scheduled Waste Management Licence (SWML) from the Central Environmental Authority. ***(Target: By March 2029, at least 50% of BHs A&B should have both EPL and SWL)***

- The respective provinces need to review the current situation and objectively prioritize the BHs A&B that require to obtain the licences and should therefore plan to provide the required resources in their 5-year plans and annual plans accordingly.

➢ DLI 4f. % of identified BHs A & B have renovated /expanded/ repaired staff quarters ***(Target: 20% by March 2029 and 40% by March 2030)***

- The respective provinces need to review the current situation and objectively prioritize the BHs A&B that require to repair, renovate, expand the staff quarters to provide facilities as given below. The provinces will need to therefore plan to provide the required resources in their 5-year plans and annual plans accordingly.
- The staff quarters renovated /expanded/ repaired needs to be guided by the currently available staff facilities by staff category and should ensure that staff accommodation is available for minimum of
    - 4 specialist consultants,

- for Intern medical officers (in relevant BHAs),
- for House officers,
- Nurses,
- Supplementary staff and
- support staff as guided by MOHMM /Province circulars.

- Please note that new constructions for staff quarters will NOT be approved, and only existing staff quarters can be renovated /expanded/ repaired.
- If necessary, a case-by-case discussion should be carried out with the FC and the ADB)

➢ DLI 4g. % of secondary hospitals (BHs A&B) that provide day surgical services (**Target:** ***20% by March 2029 and 40% by March 2030)***

- A day surgical unit should have the following features:
  - availability of staffing arrangements,
  - reporting arrangements with a new register in place, and
  - facilities for day surgeries with patient admissions, pre-op, post-op and discharge occurring within the day for a surgical procedure (e.g. eye surgery/ lump removal / wound toilet/ etc.) and
  - day surgical service theatre accessible for day procedures under Eye, ENT, General Surgery, Gynae and Obstetrics, and dental,
  - should have a waiting area, recovery area, with access to the Central Sterile Supplies Department (CSSD), pre-op room, and changing rooms / staff resting rooms by gender

- Day surgical services should be prioritized within the province and within each BH A&B to reduce the waiting time of patients for surgeries.

- Based on a circular issued by the MOHMM the Provinces should provide guidance and support to the BHs to implement the circler.

- To be operational, Day surgical unit should have the following features to carryout day surgery procedures in the following areas should be made available (foot note below). This includes (i) a data reporting register, (ii) facilities to carry out day surgeries in all the required specialist areas which includes Eye, ENT, General Surgery, Gynae and Obstetrics, and dental, (iii) a core team of day surgery staff. Opportunities should be created for staff rotation in day surgery units.

➢ DLI 4h. No of BHs A&B that have met the criteria of the National Laboratory Quality Standard of MOHMM (***Target: By March 2029, 5 labs and by Mar 2030, 9 labs meet the quality standard as one per province)***

- Based on the guideline issued by the MOHMM on laboratory quality standard, guided by the new circular which will be based on

the ISO 15189 standard managed via the Sri Lanka Accreditation Board https://www.slab.lk, and the WHO Laboratory Quality Standard of 2011 https://www.who.int/publications/i/item/9789290223979, the province will identify the BH A (or a BH B) laboratory that will be upgraded and developed to meet the laboratory quality standard. This will include physical infrastructure, equipment, digital systems and training etc.

- DLI 4i. % of BHs A&B that have introduced at least 8 of the 9 climate resilient measures ***(Target: By March 2029, 20% of BHs and by March 2030, 30% with at least of BHs have introduced 8 of the 9 initiatives***

  - Under this activity, 9 activities are provided for and BHs A & B need to define the appropriate mechanisms to reach the target. The possible interventions under each of the 9 areas are given below.
  - Reducing greenhouse gas emissions:
    - Establishing Green tree gardens, increasing the green spaces in the hospital premises and surroundings
    - Initiating energy efficient ambulance transport systems in hospitals using efficient use of vehicles with GIS monitoring of ambulances in the province to optimize routes etc.
    - Anesthetic gas management by adopting use of low-flow techniques, switching to lower-emission alternatives, and optimizing equipment.
    - Other initiatives identified by teams
  - Improving water management:
    - Introduce /adopt water saving techniques (repair leaking water lines and taps, introduce low-flow taps, toilets, and showers, as well as water-efficient laundry machines
    - Introduce grey water recycling systems: (Grey water is (water from sinks, showers, and laundry) in the hospital,
    - Introduce grey water treatment strategies like filtration and other treatment methods.
    - Introduce efficient storage and distribution of treated greywater to various points of use within the hospital.
    - Have close monitoring and maintain regular maintenance and repair.
    - Carry out staff and patient training and tips on water management and efficient use.
  - Sourcing food locally and reducing food waste
    - Giving local contracts for food supply
    - Improved food need forecasting and planning
    - Use food waste for composting or anaerobic digestion and food donation programs
    - Freezing food for storage to reduce food waste.
  - Improving water, sanitation and hygiene (WASH) measures
    - focus on ensuring access to safe water,
    - functioning handwashing facilities, and proper sanitation,
    - promoting hygiene practices among staff and patients to prevent infections.
  - Improving energy efficiency by

        - purchasing energy efficient appliances and lighting systems,
        - utilizing renewable energy sources like solar power,
        - conducting energy audits to identify inefficiencies, and
        - investing in building renovations
    - Building stronger infrastructure to withstand extreme weather
        - Backup power generators of adequate capacity to manage high risk areas (ICUs, Theatres, SBCUs, etc.)
        - Ensuring that buildings are safe during extreme weather
    - Relocating infrastructure from vulnerable areas are considered
        - Regular supervision of infrastructure for climate resilience
    - Availability of a Disaster Response Plan for activating during a climate related disaster situation affecting the hospital
        - Regular review of a Disaster Response plan
        - Simulation of the Disaster response plan
        - Creating mechanisms for providing required resources for carrying out a disaster response plan
    - Promoting behavioral changes among staff by training on
        - Climate Change Basics**:** Educate staff about the impacts of climate change on health and the role of healthcare in mitigating it.
        - Hospital's Carbon Footprint: Communicate the hospital's current carbon footprint and how different behaviors contribute to it.
        - Sustainable Practices**:** Promote sustainable practices in daily routines, such as energy conservation, waste reduction, and responsible purchasing.

- **DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized.**
    - DLI 5a. % of BHs A&B that have defined clusters, including for sharing of laboratory services, for empaneled populations based on cluster circular ***(Target: By March 2027, at least 75% of the BHs should have a cluster defined)***
        - An establish of a cluster system with the Apex, a BH A or B, and the PMCIs as feeder institutions with links to community via MOHMM etc.
        - The cluster is expected to be functional with links for Referral, Back-referral, Lab networking, Ambulance services networking, Telemedicine facilities established and functional and out-reach clinics by consultants in the BHs with PMCIs and MOHMMs.
        - The BHs A and B are considered as a cluster apex. The maximum number of clusters would be the number of BHs A &B. (Detailed information will be in the MOHMM Circular on Clusters to be issued in 2025)
        - The empaneled populations are currently defined for each PMCI and for each of the BHs from the circular of February 3, 2022 (can be accessed from https://hsep.lk/images/Downloads/Circulars/CIR01012022.pdf)
        - This information is now available on a GIS map on https://slhealthmap.health.gov.lk.
        - The clusters for each BH A& B will also be available with the release of the Cluster guideline by the MOHMM.

- Each of the BHs need to review/ refine and finalize the empaneled populations by verifying with the names of the GN divisions from where the patients currently come for treatment.
- Each cluster can map should include the Laboratory sharing cluster and any other pathway for provision of referral services.

- DLI 5b. % of clusters (with BH A or Bs as Apex) with a functioning digital information system ***(Target: By March 2027, at least 10% of clusters and by March 2028, 20% of clusters have a functioning digital system)***.
    - The OPENMRS based digital information system is currently partly operational in the Thambuthegama cluster. It is expected to scaleup this cluster information system at the minimum to 2 clusters in each province by March 2028.
    - A functional digital information system will have the following features:
    - All hospitals in the cluster should adopt this system
        - for patient registration,
        - to report notifiable disease to relevant medical officer of health area,
        - for authorized health professionals to retrieve patient information, laboratory testing information and radiology related information
        - use the OPD module and
        - use the Clinic modules.
    - The province team needs to identify the Clusters to which the digital system will be introduced.
    - Carryout training /awareness on the system.
    - If necessary, travel to Thambuthegama cluster for observation.
    - Identify the equipment needed, computers and accessories etc. from the HIU and include it in the 5-year plan and in the detailed relevant annual plans.
    - Install the system, review implementation progress and address bottlenecks etc.

- DLI 5c. % of BHs A&B that have a functional Patient Information Centre. ***(Target: By March 2028, at least 50% of hospitals should have a Patient Information Centre with a minimum of 3 criteria).***
    - The PDHS and the RDHSs should agree with the BHs that will establish a Patient Information Centre. (to reach the planned targets).

- The physical space for a PIC has to be identified along with responsible persons identified by the BH A&B hospitals and a hotline phone number.
- The centre has to be established to provide the following services:
- Appointment services for patients referred up from
    - Patient referred from PMCIs, other hospitals,
    - Well Women clinics,
    - Healthy Lifestyle Centers (HLCs),
    - Family planning services,
    - School medical and dental inspections,
    - STI clinics,
    - Medico legal units.
- Links with other sectors a. For social services, b. legal services for women's medico legal issues, c. NGOs for key population service, d. Disability support for special needs patients. The center must have information of the following aspects and a mechanism to update this information regularly.
    - an assistive device available outlet,
    - list of legal support options,
    - list of paid care giver centers/ persons,
    - elders homes list (paid and free homes) with contact information,
    - Link with the Police Department, Social service, Grama Niladhari, MOHMM, with contact information etc.
- The Centre will have a complaints /suggestions box or another mechanism to receive, review (via a review committee) and act on complaints and suggestions.

➢ DLI 5d. % of BHs A&B that have improved facilities (infrastructure, equipment, training, linkages) for at least 5 care pathways out of the identified 15 areas. **(Target: March 2029, at least 60% of BHs have improved facilities for 5 care pathway areas)**

- The BHs need to identify the gaps in infrastructure, air conditioning, equipment, staff training and where relevant linkages to other sectors (this includes the need for renovation, repairs, painting, etc. training, meetings, procurement of equipment, monitoring, supervision, etc.) of wards, theatres, labs, Xray departments, Physio /rehab units/Blood banks/ QMUs/ Planning and administrative units/ Clinic and OPD areas, common areas, toilets (male/female/ disability access) required to serve the 15 care pathways identified below.
    - Accident and Emergency care service package;
    - Comprehensive emergency obstetric care facilities EMOC, Special Baby Care units, adolescent reproductive services,
    - Medical care package for managing heart diseases and CVAs;
    - Medical care package for managing lung diseases,
    - Medical, rehabilitative and palliative care package;
    - Medical care package for managing diabetes mellitus;
    - Medical care package for managing selected cancers;
    - Comprehensive package of Surgical services;
    - Comprehensive package for Nephrology services;

- Care Package for dental services;
- Care package for Eye and ENT services;
- Care package for Mental Health and Supporting services
- Comprehensive package for laboratory and imaging services;
- Antibiotic Stewardship Programme;
- Comprehensive Medico legal services;

- As resources are limited, the BHs need to prioritize the infrastructure renovations, equipment, training and the linkages etc. and review from the perspective of providing a comprehensive care package/pathway to the people to know if the facilities, services available to provide that care pathway is available.
- Gaps in these for selected 5 care pathways (at the minimum) should be addressed in the plan.

➢ DLI 5e. The number of care pathways that have at least 1 circular/guideline defining the standard package of care that includes gender-sensitive care provision, 1 referral and back referral guideline, and 1 training programme developed and uploaded to the Continuous Professional Development (CPD) system. **(Target: By March 2030, 10 care pathways defined)**

- This is a MOHMM led result and will be managed by the Quality and Safety Unit of the MOHMM. The QMU will carry out these tasks in close collaboration with all relevant Professional Colleges and where necessary with the PDHS, RDHSs and the BHs.
- Workshops will be carried out to define the number of separate care pathways required for each of the main 15 care pathway areas identified above.
- The 15 care pathway areas will be drafted and thereafter piloted in the clusters where the IT system will be introduced to.
- Care pathway implementation training will be carried out using a module developed for each of the care pathways. (Development of module will be facilitated via Technical Assistances grant funds)
- One care pathway will be developed from at least10 care pathway areas as a Continuous Professional Development package and uploaded to the CPD system for health staff training.

DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved (Pandemic Fund Grant)

➢ DLI 6a. Sri Lanka Centre for Disease Control functional ***(Target: CDC Functional by March 2028)***

- Will be led by the Chief Epidemiologist
- The cost estimates to be within the available allocations will be finalized
- construction will need to be initiated and regular monitoring carried out to ensure completion on target.

➢ DLI 6b. Medical Research Institute (MRI) building renovations completed ***(Target: Completed by March 2028)***

- Will be led by the Director MRI

- Cost estimate completed after necessary apporvals and required TA
- construction of renovations will need to be initiated, and regular monitoring carried out to ensure completion on target.

- DLI 6c. % of hospitals updating / reporting notifiable diseases via the GIS based early warning system (***Target: By March 2027, at least 30% of BHs and by March 2028, at least 60% of BHs report notifiable diseases via the IT system /application)***
  - Will be led by the Chief Epidemiologist
  - The Epidemiology unit of Sri Lanka monitors 28 notifiable diseases. Currently notification from hospital to the respective Medical Officer of Health area is via the postal system for Group B diseases.
  - Will review and adopt the TA supported ADB facilitated Web based GIS application linking to the OPEN MRs system will be explored to improve disease surveillance from hospitals to the community level.

- DLI 6d. % of BHs A&B that use the External Quality Assurance system of the MRI at all 4 labs of the Pathology, Biochemistry, Haematology and Microbiology.
  - Will be led by the Director MRI
  - Relevant detailed plans for scaling up the external quality assurance system will be completed for BH As.

- **DLI 7** – **Logistics capacity and quality assurance of the pharmaceuticals enhanced.**

  - DLI 7a.% of identified stores of MSD and FHB that have renovated pharmaceutical storage facilities ***(Target: By March 2030, at least 50% of drug stores developed)***
    - Will be led by DDG MSD
    - Appropriate plans developed to address the development.
    - Mechanisms to regular monitoring will be introduced.

    93.
  - DLI 7b. The National Quality Assurance Laboratory of NMRA has obtained ISO/IEC 17025. **(Target: By March 2030, NMRA lab would have got the ISO certification)**
    - Will be led by CEO, NMRA
    - Detailed plans for this activity will be developed.

  - DLI 7c. The % change of number of tests that can be performed by the NMRA (NMQAL) directly or via laboratories under MOUs/Agreements in line with the established risk-based sampling and testing approach. **(Target: By March 2029, 90% increase from Baseline)**
    - Will be led by CEO, NMRA
    - Detailed plans for this activity will be developed.

- **DLI 8** – Procurement, Finance, Contract Management and HR management capacity enhanced – responsibility of RDHS, PDHS and the Provincial authorities.

- DLI 8a. % of procurement entities of the MOHMM and 9 PDHS offices that complete all *3 of these steps*: (i) has the master procurement plan updated in the eGP system PROMISe.lk (ii) has the annual procurement plan in the eGP system PROMISe.lk (ii) utilizes PROMISe.lk for all RFQ contracts identified in the annual Procurement Plan. **(Target: By March 2027, at least 50% of MOHMM PEs (71) will utilize eGP for above 3 processes and by March 2028, at least 50% of Province PEs (35) will utilize eGP for above 3 processes)**

    - Will be led by Additional Secretary Procurement in the MOHMM
    - At the province, 9 Deputy Chief Secretaries Finance and Engineering.

- DLI 8b. No of Framework Agreements signed for pharmaceuticals and medical supplies (excluding buy back). **(Target: By March 2028, at least 10 FAs signed by SPC)**
    - Will be led by Add Secretary Procurement of the MOHMM
    - Plans to reach this target will be developed by Add Sec procurement and DDG MSD in close collaboration with the State Pharmaceutical Corporation (SPC).

- DLI 8c. Standard Bidding Documents (SBDs) for Pharmaceuticals and Medical equipment (i) developed (ii) 50% of pharmaceutical and medical equipment contracts have used the pharmaceutical and medical equipment SBDs (excluding buy back). (**(Target: By March 2027, the new SBDs developed, and by March 2030, at least 50% for pharmaceutical and medical equipment contracts have used the bid documents.**

    - Will be led by Additional Secretary Procurement of the MOHMM
    - Plans to reach this target will be developed by Add Sec procurement and DDG MSD in close collaboration with the State Pharmaceutical Corporation (SPC).

- DLI 8d. % change in the average time taken from request to initiation of repairs/service etc. of a building or a medical equipment at centrally managed hospitals **(Target: By March 2027, 10% reduction of time taken and by March 2029, 20% reduction of time taken from baseline)**
    - Will be led by Additional Secretary Engineering and DDG BMES of the MOHMM
    - Plans to reach this target will be developed by Add Sec Engineering and DDG BMES.

Section 4: Summary of Program Safeguards Actions

Introduction

Activities are eligible under RBL program, unless they are assessed to be likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people. ADB Safeguard Policy Statement will continue to apply to RBL. The program is designed to achieve the policy objectives and adhere to the policy principles of the Safeguard Policy Statement.

A Program Safeguards System Assessment (PSSA) has been conducted aiming to examine the safeguard systems of the Ministry of Health and Mass Media and Provincial Councils and its related implementation practices and capacities and to suggest Safeguard Program Action Plan to bridge the identified gaps and weaknesses.

With respect to the proposed Strengthening Integrated Health Care for Universal Health Coverage Program (RBL), **ADB's environmental safeguards are triggered only for activities involving civil and electrical and mechanical (E&M) works**. All new construction, renovation, and repair works are confined to the premises of existing healthcare facilities. Acquisition of private land is not envisaged for these activities. The RBL program is classified as category B for environmental safeguards, and category C for involuntary resettlement and indigenous peoples.

Based on the PSSA and the Program Action Plan, a program Environmental and Social Management Framework (ESMF) has been formulated. The ESMF provides broad guidelines outlining measures, processes, institutional arrangements, procedures, tools, and instruments that need to be adopted by the project executing agency during the implementation of program activities to avoid, minimizing or mitigate any adverse environmental or social impacts.

The following guidance note provides a summary on safeguards screening and categorization, preparation of Initial Environmental Examination (IEE), preparation of Environmental and Social Management Plan (ESMP), capacity building, monitoring and reporting and grievance redress mechanism (GRM). Detailed descriptions are provided in the ESMF.

1. Screening and categorization (ADB standards)

This requirement applies **only to interventions/activities involving civil or E&M works**. One screening and categorization checklist needs to be completed for each healthcare facility, irrespective of the number of sub activities carried out in that healthcare facility (Screening and categorization checklists are provided in **Annex 3** of this Planning Guideline) and submitted to the ADB for approval. Following submission, ADB will confirm the environmental categorization of the activity. Any healthcare facility which is categorized as category A will be excluded. If categorized as category B, an IEE must be prepared (as outlined in Section 3 below). For activities classified as category C, an ESMP must be prepared (as detailed in Section 4 below). This process is to be undertaken with the annual planning cycle and will continue from Q3 of 2025. However, if a provincial council has a 5-year plan, the screening and categorization can be completed based on the approved plan.

2. Confirmation for the Requirement of project approval under National Environmental Act (NEA)

This requirement applies **only to interventions/activities involving civil or E&M works**. For each province (for interventions proposed in all the healthcare facilities), one Basic Information Questionnaire (BIQ), as provided in **Annex 4** of this Planning Guideline, must be completed and submitted to the Central Environmental Authority (CEA). The CEA will evaluate the BIQ and determine the environmental approval requirement. If the proposed interventions qualify as a prescribed activity, the CEA will issue Terms of Reference (TOR) for the preparation of an environmental assessment report, as elaborated in section 3 below. If the interventions do not fall within the prescribed category, environmental recommendations will be issued. This process is aligned with the annual planning cycle and will be undertaken continuously from the Q3 of 2025. However, if a provincial council has a 5-year plan, this process can be completed based on the approved plan.

3. Preparation of IEE

This requirement applies **only to interventions/activities involving civil or E&M works**. When an intervention is categorized as category B / a prescribed activity under NEA process, an IEE report must be prepared following the ADB guideline detailed in **Annex 5** of this Planning Guideline / TOR issued by the CEA. The completed IEE report should be submitted

to the ADB / CEA for review and approval. This process ensures compliance with ADB environmental safeguard requirements / NEA requirements and must be carried out in accordance with the annual planning cycle. However, if a provincial council has a 5-year plan, this process can be completed based on the approved plan.

4. Preparation of ESMP and Incorporating in Civil / E&M Works Contract Documents

This requirement applies **only to interventions/activities involving civil or E&M works**. A general ESMP is provided in **Annex 6** of this Planning Guideline. This ESMP should be modified to suit with specific interventions for each healthcare facility. **The ESMP must then be included in all civil and E&M works contract documents.** This ensures that environmental and social implementation responsibilities are clearly defined and assigned to the respective contractors. Preparation and inclusion of the ESMP must commence at the beginning of the procurement process for each contract and continue from the Q3 of 2025. However, if a provincial council has a 5-year plan, this process can be completed based on the approved plan, providing the name of healthcare facilities in the blank column for each corresponding impact and mitigation measure in the general ESMP (**Annex 6** of this Planning Guideline).

6. Capacity Building on Safeguards Requirements of the Program

For each intervention under MOHMM and Provincial Director of Health Services (PDHS) must designate focal points responsible for overseeing environmental and social (E&S) safeguards. Capacity building training sessions will be conducted by Program Coordination Office (PCO) focusing on tasks such as screening and categorization, preparation of IEE and ESMP documents, monitoring and reporting, grievance redress mechanism (GRM) implementation, and healthcare waste (HCW) management etc. These efforts aim to raise awareness and strengthen the capacity of the PDHS in relation to program safeguard requirements. This activity will be implemented annually through a two-day Central-Provincial Technical Dialogue starting in the Q2 of 2025 and continuing every Q3 thereafter. Capacity building will be continuously supported by ADB.

7. Monitoring and Reporting

A safeguard monitoring system to oversee environmental and social compliance throughout the program will be implemented. This includes the preparation and disclosure of semi-annual E&S monitoring reports, as outlined in **Annex 7** of this Planning Guideline. All safeguard documents, including the PSSA, ESMF, IEEs, and monitoring reports must be publicly disclosed via the ADB website as well as the MOHMM and relevant Provincial Council websites. These activities ensure adherence to the program's safeguard-related monitoring and reporting obligations and are to be carried out continuously from the Q3 of 2025 through the duration of the program.

8. Grievance Redress Mechanism (GRM)

A robust, public-friendly, accessible and functional two-tier Grievance Redress Mechanism (GRM) must be established. The two levels will be (i) at site/healthcare facility, (ii) at national / provincial level. A grievance register should be maintained at site/healthcare facility level, and public notices displaying the GRM procedures and contact numbers for lodging complaints must be prominently displayed at construction sites. Implementation is expected to begin in the Q2 of 2025 and continue throughout the program duration.

ANNEX 1 of the Planning Guideline: Planning and Reporting Templates

For the ADB Project: Health Sector – Planning Form1

(Finance Commission Form 3)

Table 1: Health Sector Planning Format (Form1)

No	Component and Budget (LKR)	SDG Target No and Indicator No	Sub component and Budget (LKR)	Outcomes				Broad Activity Area	Output	Budget (LKR)
				KPIs	Baseline	Target				
					2024	Year ….	2030			

For the ADB Project: Health Sector – Planning Form 2 (Table 2: Detailed List of activities) to be separately filled for each of the 3 components (Improvement of Curative services, Improvement of preventive services, Organizational and management Services).

(Finance Commission Form 3a)

Table 2: Detailed List of activities by components

Subcomponent and Budget (LKR Mn)	Broad Activity Area and Budget (LKR Mn)	List of Activity	Total Estimated Cost (TEC) (LKR Mn)	Budget (LKR Mn)		
				District 1	District 2	District 3 etc.

For ADB Program related: Continuation of works and Bills in Hand from previous year/s.

Table 3: Continuation of works and Bills in Hand

Project / Activity	Year commenced	Total estimated Cost	Cumulative expenditure as of Dec 31. ….	Amounts for Year …..		
				Bills in Hand upto Dec 31, of previous year	Continuation Works	Total

ANNEX 2 of Planning Guideline: Responsible Units / Directorates to lead the achievement of the agreed results under the ADB RBL Program

DLI / Result area	Description	Responsible and Associated Units for Implementation and Results Reporting	
		Province	**Line Ministry**
DLI 1:	Average waiting time for selected surgeries	***All PDHSs,*** RDHSs, MSs from BHs	***DDG MS2*** College of Surgeons
DLI 2:	Hospital Acquired Infections	***All PDHSs***, RDHSs, MSs from BHs	***DDG Lab*** College of Microbiologists and other Colleges
DLI3:	5 Year Plans of BHs	***All PDHSs,*** RDHSs, MSs from BHs	***DDG MS2*** DDG Planning
	Annual Plans of BHs	***All PDHSs,*** RDHSs, MSs from BHs	***DDG Planning*** DDG MS2
	HTA	-	DDG MS1 **Director MTS**
	Guidelines: Elderly Friendly services	-	DDG PHS 2 ***Director YED***
	Guidelines: Hospital Lab quality and options for making selected tests available at BHs	-	***DDG Lab*** Director Lab Services
	Guidelines: Day Surgical Services	-	***DDG MS2*** DDG MS1
	Guidelines: Mithuru Piyasa, Yowun Piyasa	-	DDG PHS 1 ***Director FHB***
	Guidelines: Green,Healthy, Safe, Hospital	-	***DDG Env and Occ Health*** Director Env and Occ Health
	Guidelines: Clustering of Hospitals with BH as Apex	-	***DDG MS 2 and*** **Director Organization and Development** Director Health Information Unit Director Lab Director PHC
	Guidelines: Establishing norms for standardizing facilities	-	***DDG MS 2*** **Director Organization and Development** Director Medical Services
	Guidelines: Establishing Patient Information Centres at BHs	-	***DDG MS 2 and*** **Director Organization and Development** Director Medical Services
	HRH Database and Unit		***Add Sec Medical Services*** DDG MS1 DDG MS2, DDG Admin 1 DDG Admin 2.
DLI 4	BH development	***All PDHSs***, RDHSs, MSs from BHs	**DDG MS 2**
DLI 5:	Integrated services	***All PDHSs***, RDHSs, MSs from BHs	**DDG MS 2**
	Care Pathways, CPD	-	DDG ETR DDG NCD DDG Lab DDG MS 1&2 ***Director Quality Secretariat*** All Relevant Professional Col*leges*
	Continuous Professional Development		***DDG ETR***

DLI 6:	Pandemic Fund: CDC	-	DDG PHS 1 ***Chief Epidemiologist***
	Pandemic Fund: Disease notification	***All PDHSs***, RDHSs, MSs from BHs	DDG PHS 1 ***Chief Epidemiologist***
	Pandemic Fund: MRI Building	-	Add Sec Engineering DDG Logistics DDG ETR ***Director MRI***
	Pandemic Fund: MRI EQA		DDG Lab ***Dirrector MRI*** Laboraotry Consultants at MRI
DLI 7:	Pharmaceutical logistics capacity	-	***DDG MSD*** Director MSD
	Pharmaceutical Quality Assurance		CEO NMRA ***Director NMQAL, NMRA***
DLI 8:	Procurement management capacity eGP system	***All PDHS***	***Add Sec Procurement*** DDG MSD Managing Director SPC
	Procurement management capacity Standard Bidding Documents, Framework Agreement	-	***Add Sec Procurement*** DDG MSD Managing Director SPC
	Procurement management capacity Engineering efficiency		***Add Sec Engineering*** DDG Logistics
	Procurement management capacity BME efficiency		***DDG BMES***

(***Bold,*** *italics unit* is the responsible unit for each of the DLIs)

ANNEX 3 of Planning Guidelne: Environmental, Involuntary Resettlement, and Indigenous Peoples Screening Checklists and Categorization Forms

Note: All three checklists need to be completed for all activities and submitted to ADB for approval before commencement of bidding process for the respective activity.

Rapid Environmental Assessment (REA) checklist
Activity name:
Province/ district:

Screening Questions	Yes	No	Remarks
A. Project Siting Is the Project area adjacent to or within any of the following environmentally sensitive areas?			
▪ Cultural heritage site			
▪ Legally protected Area (core zone or buffer zone)			
▪ Wetland			
▪ Mangrove			
▪ Estuarine			
▪ Special area for protecting biodiversity			
B. Potential Environmental Impacts Will the Project cause…			
▪ impairment of historical/cultural areas; disfiguration of landscape or potential loss/damage to physical cultural resources?			
▪ disturbance to precious ecology (e.g. sensitive or protected areas)?			
▪ Alteration of surface water hydrology of waterways resulting in increased sediment in streams affected by increased soil erosion at construction site?			
▪ Deterioration of surface water quality due to silt runoff and sanitary wastes from worker-based camps and chemicals used in construction?			
▪ increased air pollution due to project construction and operation?			
▪ noise and vibration due to project construction or operation?			
▪ involuntary resettlement of people? (physical displacement and/or economic displacement)			
▪ disproportionate impacts on the poor, women and children, Indigenous Peoples or other vulnerable groups?			
▪ poor sanitation and solid waste disposal in construction camps and work sites, and possible transmission of communicable diseases (such as STI's and HIV/AIDS) from workers to local populations?			
▪ creation of temporary breeding habitats for diseases such as those transmitted by mosquitoes and rodents?			
▪ social conflicts if workers from other regions or countries are hired?			

Screening Questions	Yes	No	Remarks
▪ large population influx during project construction and operation that causes increased burden on social infrastructure and services (such as water supply and sanitation systems)?			
▪ risks and vulnerabilities related to occupational health and safety due to physical, chemical, biological, and radiological hazards during project construction and operation?			
▪ risks to community health and safety due to the transport, storage, and use and/or disposal of materials such as explosives, fuel and other chemicals during construction and operation?			
▪ community safety risks due to both accidental and natural causes, especially where the structural elements or components of the project are accessible to members of the affected community or where their failure could result in injury to the community throughout project construction, operation and decommissioning?			
▪ generation of solid waste and/or hazardous waste?			
▪ use of chemicals?			
▪ generation of wastewater during construction or operation?			

Environment Category

☐ Category A ☐ Category B ☐ Category C

Required Assessment:

☐ IEE ☐ ESMP

Prepared by:	**Approved by**:
Date:	Date:

Involuntary Resettlement Screening Checklist

Activity name:

Province/ district:

Probable Involuntary Resettlement Effects	**Yes**	**No**	**Not Known**	**Remarks**
1. Will there be land acquisition?				
2. Is the site for land acquisition known?				
3. Is the ownership status and current usage of land to be acquired known?				
4. Will easement be utilized within an existing Right of Way (ROW)?				
5. Will there be loss of shelter and residential land due to land acquisition?				
6. Will there be loss of agricultural and other productive assets due to land acquisition?				
7. Will there be losses of crops, trees, and fixed assets due to land acquisition?				
8. Will there be loss of businesses or enterprises due to land acquisition?				
9. Will there be loss of income sources and means of livelihoods due to land acquisition?				
Involuntary restrictions on land use or on access to legally designated parks and protected areas				
10. Will people lose access to natural resources, communal facilities and services?				
11. If land use is changed, will it have an adverse impact on social and economic activities?				
12. Will access to land and resources owned communally or by the state be restricted?				
Information on Displaced Persons:				
Any estimate of the likely number of persons that will be displaced by the Project? [ ] No [ ] Yes If yes, approximately how many?				
Are any of them poor, female-heads of households, or vulnerable to poverty risks? [ ] No [ ] Yes				
Are any displaced persons from indigenous or ethnic minority groups? [ ] No [ ] Yes				
IR categorization of activity	Cat. A	Cat . B	Cat. C	
Remarks/ recommendations:				
Prepared/ endorsed by (date):				

Indigenous Peoples Impact Screening Checklist
Activity name:
Province/ district:

KEY CONCERNS (Please provide elaborations on the Remarks column)	**YES**	**NO**	**NOT KNOWN**	**Remarks**
A. Indigenous Peoples Identification				
1. Are there socio-cultural groups present in or use the project area who may be considered as "tribes" (hill tribes, schedules tribes, tribal peoples), "minorities" (ethnic or national minorities), or "indigenous communities" in the project area?				
2. Are there national or local laws or policies as well as anthropological researches/studies that consider these groups present in or using the project area as belonging to "ethnic minorities", scheduled tribes, tribal peoples				
3. Do such groups self-identify as being part of a distinct social and cultural group?				
4. Do such groups maintain collective attachments to distinct habitats or ancestral territories and/or to the natural resources in these habitats and territories?				
5. Do such groups maintain cultural, economic, social, and political institutions distinct from the dominant society and culture?				
6. Do such groups speak a distinct language or dialect?				
7. Has such groups been historically, socially and economically marginalized, disempowered, excluded, and/or discriminated against?				
8. Are such groups represented as "Indigenous Peoples" or as "ethnic minorities" or "scheduled tribes" or "tribal populations" in any formal decision-making bodies at the national or local levels?				
B. Identification of Potential Impacts				
9. Will the project directly or indirectly benefit or target Indigenous Peoples?				
10. Will the project directly or indirectly affect Indigenous Peoples' traditional socio-cultural and belief practices? (e.g. child-rearing, health, education, arts, and governance)				
11. Will the project affect the livelihood systems of Indigenous Peoples? (e.g., food production system, natural resource management, crafts and trade, employment status)				
12. Will the project be in an area (land or territory) occupied, owned, or used by Indigenous Peoples, and/or claimed as ancestral domain?				
C. Identification of Special Requirements *Will the project activities include:*				
13. Commercial development of the cultural resources and knowledge of Indigenous Peoples?				
14. Physical displacement from traditional or customary lands?				
15. Commercial development of natural resources (such as minerals, hydrocarbons,				

forests, water, hunting or fishing grounds) within customary lands under use that would impact the livelihoods or the cultural, ceremonial, spiritual uses that define the identity and community of Indigenous Peoples?				
16. Establishing legal recognition of rights to lands and territories that are traditionally owned or customarily used, occupied or claimed by indigenous peoples?				
17. Acquisition of lands that are traditionally owned or customarily used, occupied or claimed by indigenous peoples?				

D. Anticipated project impacts on Indigenous Peoples

Project component/ activity/ output	**Anticipated positive effect**	**Anticipated negative effect**
1. LIST ALL PROJECT COMPONENT / ACTIVITY / OUTPUTS HERE	**---- INDICATE EFFECTS TO IPS OR PUT N/A AS NECESSARY**	
2.		
3.		

IR categorization of activity	Cat. A	Cat . B	Cat. C	
Remarks/ recommendations:				
Prepared/ endorsed by (date):				

Note: The project team may attach additional information on the project, as necessary.

Annex 4 of Planning Guideline: BASIC INFORMATION QUESTIONNAIRE (BIQ)
(ALSO AVAILABLE AT: HTTPS://WWW.CEA.LK/WEB/IMAGES/PDF/REVISEDBIQ-ENGLISH1STEDITION27.11.2014-1.PDF)

Application No.	

Central Environmental Authority

BASIC INFORMATION QUESTIONNAIRE

Essential information to determine the environmental approval requirement of projects

(Note: Use separate sheets as and when required)

1. **BACKGROUND INFORMATION**

1.1 Project Title:

1.2 Name of the Project Proponent:
(Company/Firm/Individual)

1.3 Details of the Project Proponent:

Postal Address:

Phone No:

Fax No:

E-mail Address:

1.4 Details of the Contact Person:

Name:

Designation:

Phone No:

Fax No:

E-mail Address:

2. PROJECT LOCATION DETAILS

2.1. Location of the project:

Province/s:

District/s:

Divisional Secretariat Division/s:

Local Authority/s:

(***Provide location in 1:50,000 scale Toposheet***)

2.2. Physical scale or the extent of the project site (in ha):
(*Provide Survey plan*)

2.3. Does the project wholly or partly fall within any area specified below?

Area	Yes	No	Remarks
100m from the boundaries of or within any area declared under the National Heritage Wilderness Act No. 4 of 1988			
100m from the boundaries of or within any area declared under the Forest Ordinance (Chapter 451)			
Coastal Zone as defined in the Coast Conservation Act. No. 57 of 1981			
Any erodable area declared under the Soil Conservation Act (Chapter 450)			
Any flood area declared under the Flood Protection Ordinance (Chapter 449)			
Any flood protection area declared under the Sri Lanka Land Reclamation and Development Corporation Act No. 15 of 1968 as amended by Act No. 52 0f 1982			
60 meters from the bank of a public stream as defined in the Crown Lands Ordinance (Chapter 454) and having width of more than 25 meters at any point of its course.			
Any reservation beyond the full supply level of a reservoir.			
Any archaeological reserve, ancient or protected monuments as defined or declared under the Antiques Ordinance (Chapter 188)			
Any area declared under the Botanic Gardens Ordinance (Chapter 446)			
Within 100 meters from the boundaries of or within, any area declared as a Sanctuary under the Fauna and Flora Protection Ordinance (Chapter 469)			
Within 100 meters from the high flood level contour of or within a public lake as defined in the Crowns Lands Ordinance (Chapter 454) including those declared under section 71 of the said Ordinance			
Within a distance of one mile of the boundary of a National Reserve declared under the Fauna and Flora Protection Ordinance			

2.4. Present ownership of the project site:

State	Private	Other (Specify)

(If state owned, please submit a letter of consent of the release of land from the state agency)

2.5 Present land use type of the project site (approximate % of the total project site):

Land use type	%	**Land use type**	%
Marsh/mangrove		Bare land	
Water bodies		Paddy	
Dense forest		Tea	
Sparse forest		Rubber	
Scrub forest		Coconut	
Grassland		Built-up area	
Home gardens		Any other (Specify)	

3. **PROJECT DETAILS**

3.1. Objective/s of the project:

3.2. Present stage of the project in the project cycle:

(i)	Pre-feasibility	
(ii)	Feasibility	
(iii)	Design	
(iv)	Other (specify)	

3.3. Type of the project (Please tick the relevant cage/s):

Land development/clearing		Hotels / Recreational Facilities	
Timber extraction/tree felling		Housing and building	
Reclamation of Land/ wetland		Resettlement	
Conversion of forests into non-forest uses		Laying of gas and liquid (excluding water) transferring pipelines	
Urban development		Mining	
Port and Harbour Development		Tunneling	
Transportation system		Fisheries and aquaculture	
River basin development/Irrigation		Disposal of solid/liquid/hazardous wastes	
Power generation and transmission		Salterns	
Surface/groundwater extraction		Any other (Specify)	
Industry/Industrial Estates and Parks			

3.4. Physical scale or the magnitude of the project:

3.5. Major components of the project:

3.6 Project layout plan (Conceptual)

3.7 Project process/s in terms of:

- Inputs including resources such as raw materials, water, energy used in construction/operational phases of the project and source of such resources
- Outputs (including products and by-products)
- Major types of equipment/technology to be used

3.8. Does the project involve any of the following activities other than the major project activities?

	Activity	**Yes**	**No**	**If yes please quantify**
(i)	Reclamation of land/wetland			
(ii)	Conversion of forests into non-forest uses			
(iii)	Clearing of lands			
(iv)	Extraction of timber			
(v)	Mining and mineral extraction			
(vi)	Lying of pipe lines			
(vii)	Tunneling			
(viii)	Power generation & transmission			
(ix)	Resettlement			
(x)	Extraction of surface/ground water			
(xi)	Disposal of wastes (solid/liquid/hazardous)			

3.9. Amount of capital investment:

Foreign:	
Local:	

3.10. Proposed timing and schedule including phased development:

3.11. Details of availability of following services/infrastructure facilities:

(i) Roads/access (Specify):
(ii) Water (Specify):
(iii) Power (Specify):
(iv) Telecommunication (Specify):
(v) Common waste water treatment facilities (Specify):
(vi) Common solid waste management facilities (Specify):
(vii) Any other (Specify):

3.12. Will the development result in displacement of people or property : (Quantify)?

3.13. Will the development result in change of way of life of local people? :

3.14. Will the project has plans for future expansion with/without land/space demands? :

3.15. Information on likely impacts of the project (Please tick the relevant cage/s):

Impact/s	Yes	No	Short term	Medium term	Long term
• Impacts on people & human health					
• Impacts on fauna/flora/sensitive habitats					
• Impacts on soils and land use					
• Impacts on water quality (surface and ground)					
• Impacts on drainage /hydrology					
• Impacts on air quality					
• Generation of excessive noise and vibration					
• Impacts on landscape/visual environment					
• Impacts on historical and cultural resources					
• Presence and aggravation of hazards					
• Any other (Specify)					

3.16. Information and measures being considered to mitigate likely impacts of the project cited under 3.15 :

3.17. Relationship with other existing /planned developments :

3.18. Details of any other permits required for the project :

4. **OTHER**

Provide any other information that may be relevant

I …….. certify that the information provided above is true and correct to the best of my knowledge. I am aware that this information will be utilized in decision making.

Name: .....

Designation: .....

Signature: ..... Date:: .....

For Office Only

1. Date of receipt of the application:

2. Payment of EIA administration fee:

   Date of payment:
   Amount:
   Receipt No:
   Code No:

3. Site inspection information:

   Date of inspection:
   Name/s of the officers:
   Special comments regarding significant environmental concerns (based on the site inspection:

4. Required approval under Part IV C of NEA:

Yes	No

5. If need to go through the EIA process appropriate PAA:

6. Other remarks:

Annex 5 of Planning Guideline: OUTLINE OF AN IEE

A. Executive Summary

This section describes concisely the critical facts, significant findings, and recommended actions.

B. Policy, Legal, and Administrative Framework

This section discusses the national and local legal and institutional framework within which the environmental assessment is carried out. It also identifies project-relevant international environmental agreements to which the country is a party.

C. Description of the Project

This section describes the proposed project; its major components; and its geographic, ecological, social, and temporal context, including any associated facility required by and for the project (for example, access roads, power plants, water supply, quarries and borrow pits, and spoil disposal). It normally includes drawings and maps showing the project's layout and components, the project site, and the project's area of influence.

D. Description of the Environment (Baseline Data)

This section describes relevant physical, biological, and socioeconomic conditions within the study area. It also looks at current and proposed development activities within the project's area of influence, including those not directly connected to the project. It indicates the accuracy, reliability, and sources of the data.

E. Anticipated Environmental Impacts and Mitigation Measures

This section predicts and assesses the project's likely positive and negative direct and indirect impacts to physical, biological, socioeconomic (including occupational health and safety, community health and safety, vulnerable groups and gender issues, and impacts on livelihoods through environmental media [Appendix 2, para. 6]), and physical cultural resources in the project's area of influence, in quantitative terms to the extent possible; identifies mitigation measures and any residual negative impacts that cannot be mitigated; explores opportunities for enhancement; identifies and estimates the extent and quality of available data, key data gaps, and uncertainties associated with predictions and specifies topics that do not require further attention; and examines global, transboundary, and cumulative impacts as appropriate.

F. Analysis of Alternatives

This section examines alternatives to the proposed project site, technology, design, and operation-including the no project alternative-in terms of their potential environmental impacts; the feasibility of mitigating these impacts; their capital and recurrent costs; their suitability under local conditions; and their institutional, training, and monitoring requirements. It also states the basis for selecting the particular project design proposed and, justifies recommended emission levels and approaches to pollution prevention and abatement.

G. Information Disclosure, Consultation, and Participation

This section:

(i) describes the process undertaken during project design and preparation for engaging stakeholders, including information disclosure and consultation with affected people and other stakeholders;

(ii) summarizes comments and concerns received from affected people and other stakeholders and how these comments have been addressed in project design and mitigation measures, with special attention paid to the needs and concerns of vulnerable groups, including women, the poor, and Indigenous Peoples; and

(iii) describes the planned information disclosure measures (including the type of information to be disseminated and the method of dissemination) and the process for carrying out

consultation with affected people and facilitating their participation during project implementation.

H. Grievance Redress Mechanism

This section describes the grievance redress framework (both informal and formal channels), setting out the time frame and mechanisms for resolving complaints about environmental performance.

I. Environmental Management Plan

This section deals with the set of mitigation and management measures to be taken during project implementation to avoid, reduce, mitigate, or compensate for adverse environmental impacts (in that order of priority). It may include multiple management plans and actions. It includes the following key components (with the level of detail commensurate with the project's impacts and risks):

(i) Mitigation:

(a) identifies and summarizes anticipated significant adverse environmental impacts and risks;
(b) describes each mitigation measure with technical details, including the type of impact to which it relates and the conditions under which it is required (for instance, continuously or in the event of contingencies), together with designs, equipment descriptions, and operating procedures, as appropriate; and
(c) provides links to any other mitigation plans (for example, for involuntary resettlement, Indigenous Peoples, or emergency response) required for the project.

(ii) Monitoring:

(a) describes monitoring measures with technical details, including parameters to be measured, methods to be used, sampling locations, frequency of measurements, detection limits and definition of thresholds that will signal the need for corrective actions; and
(b) describes monitoring and reporting procedures to ensure early detection of conditions that necessitate particular mitigation measures and document the progress and results of mitigation.

(iii) Implementation arrangements:

(a) specifies the implementation schedule showing phasing and coordination with overall project implementation;
(b) describes institutional or organizational arrangements, namely, who is responsible for carrying out the mitigation and monitoring measures, which may include one or more of the following additional topics to strengthen environmental management capability: technical assistance programs, training programs, procurement of equipment and supplies related to environmental management and monitoring, and organizational changes; and
(c) estimates capital and recurrent costs and describes sources of funds for implementing the environmental management plan.

(iv) Performance indicators: describes the desired outcomes as measurable events to the extent possible, such as performance indicators, targets, or acceptance criteria that can be tracked over defined time periods.

J. Conclusion and Recommendation

This section provides the conclusions drawn from the assessment and provides recommendations.

Annex 6 of Planning Guideline: GENERAL ESMP

Abbreviations: MOHMM-Ministry of Health and Mass Media; PDHS-Provincial Director of Health Services; PED-Provincial Engineering Department; PCO-Program Coordination Office; Imp- Implementation responsibility; Mon- Monitoring responsibility; LA-Local Authority; DS-Divisional Secretariat

This column should be filled (as Yes/ No) by MOHMM/PDHS based on the activity proposed

Subject for concern	Environmental & Social impact	Mitigation measures	Relevance to the activity#	Monitoring method	Responsibility Implement / Monitor	Cost / Source of funds	Time frame
Pre-construction							
Removal of trees	Loss of trees and vegetation may lead to: ▪ Increase in disaster related issues (i.e. soil erosion, landslides); ▪ Lack of ventilation and shading; ▪ Reduction in aesthetic value and greening of area	▪ Explore alternative options to minimize the loss of trees and vegetation. ▪ Implement compensatory planting of trees and vegetation of the same or similar species for any trees removed. ▪ Minimize the use of wood for construction. ▪ Utilize locally sourced materials as much as possible. ▪ Incorporate innovative solutions into the design.		Trees planted; Progress reports	Imp: MOHMM, PDHS, Hospital through licensed contractors Mon: MOHMM, PDHS, HCU, Hospital	Internalized to the project cost	Before constructions
Shifting of utilities: water supply & sanitation services, electricity, drainage structures etc.	▪ Temporary disruption to water supply and sewer pipes, drainage structures, and electric poles and wires; ▪ Flooding, waterlogged conditions and may lead to increased erosion due to modification/alteration of drainage paths, canals and structures	▪ Plan the shifting of utilities and drainage structures well in advance of site clearing. ▪ Provide alternative or temporary supplies to minimize the impact on users. ▪ Ensure that the wastewater treatment plant, if located at the lowest elevation within the hospital site, is properly diverted to account for stormwater flow.		Site inspections and reporting	Imp: MOHMM, PDHS, Hospital through licensed contractors Mon: MOHMM, PDHS, HCU, Hospital	Internalized to the project cost	Before constructions
Access interruptions to the patients, hospital staff and visitors	▪ Movements of visitors to the hospital, including patients, vehicular flow (especially emergency vehicles) and parking facilities, may be affected during construction. ▪ Impacts are notable if routes for delivery and storage of construction materials and temporary blockages are not planned and coordinated properly.	▪ Coordinate and plan all activities thoroughly before commencing construction works. ▪ Ensure that no facility or service is discontinued due to construction or renovation works, and issue prior notices to hospital staff and users. ▪ Install temporary wayfinding boards to guide patients, hospital staff, and visitors.		Site inspections and reporting	Imp: MOHMM, PDHS, Hospital Mon: MOHMM, PDHS, HCU, Hospital	Internalized to the project cost	Before constructions
Construction							
Demolition of existing buildings: Waste management	Spoil material generated due to any demolition work, cutting, and grinding work (e.g. for electrical work) would obscure the landscape and may be a	▪ Dispose of solid waste and sewage in accordance with relevant guidelines and with the assistance of the local authority. ▪ Dispose of healthcare waste (HCW) following established guidelines and with		Site inspections and reporting .	Imp: Contractor, LA, through licensed HCWM service provider	Internalized to the project cost	Daily during demolition works

	health risk to the surrounding community and workers.	the support of an authorized HCW service provider. ▪ Identify disposal locations before commencing demolition activities. ▪ Demarcate a designated area within the construction premises for waste collection until disposal. ▪ Implement waste minimization practices, including reuse as filling material and recycling. ▪ Prohibit open burning of any demolished material, both on-site and off-site.			Mon: MOHMM, PDHS, Hospital, PED		
Demolition of existing buildings: Handling of asbestos waste	Health and safety hazards with loose asbestos fibers for the workers and hospital.	▪ Follow the rules and guidelines outlined by the CEA under the NEA; ▪ Provide covers properly and temporarily store at the premises until taken away for the disposal		Site inspections and reporting .	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Daily during demolition works
Demolition of existing buildings: Health and Safety concerns for the workers and community	▪ Unless precautions are taken during demolition it may lead to accidents of workers and in-house and nearby community. ▪ Unless safety measures are adoption it may lead to compromised health.	▪ Restrict the demolition area with barriers and install clear signage to prevent unauthorized access. ▪ Carry out demolition activities at a convenient time with minimal disturbance, in consultation with hospital management. ▪ Ensure that any electrical systems in the demolition area are switched off before commencing work. ▪ Require workers to adopt safety measures and wear appropriate protective gear. ▪ Erect dust screens if necessary, depending on the scale of the demolition.		Site inspections and reporting	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Regularly during demolition works
Site preparation activities: clearing and land preparation, cutting and levelling	Waste generation, emission of dust, and noise are direct impacts that can be expected due to site clearing. Such impacts may cause a nuisance to hospital staff, patients, visitors and the neighborhood	▪ Implement erosion control measures during land preparation, cutting, and filling within the site. ▪ Avoid land clearing during rainy periods where possible. Divert surface runoff away from the site or construction area and channel drainage through silt traps if needed. Compact any loose soil as soon as possible. ▪ Cover all spoil, topsoil, demolition waste, and cut vegetation with secure tarpaulins when stored on-site or transported off-site to prevent wind dispersal.		Site inspections and reporting	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Regularly during site preparation

Slope instability due to exposed slopes, cutting and filling operations, altered landscape, removal of trees, roots, and trunks, drainage modifications, and modified flow patterns etc.	▪ Slope instability may lead to loss of ground, causing damage to public and private land and built property in the neighborhoods. ▪ Soil erosion and sedimentation may occur during construction due to land clearing, earthworks (cutting/filling, trenching, excavating, reclaiming, and landfilling), diversion of existing drainage paths, transport and stockpiling of construction material, residue, spoil, and dredged material.	For Slope Instability: ▪ Obtain recommendations from the National Building Research Organization (NBRO) for constructions in landslide-prone or potential slope stability areas to minimize risk. ▪ Consider medium- to long-term slope stability when selecting sites for treatment plants and project interventions, particularly in sloping terrain. ▪ Avoid land clearing at sites with vertical relief to prevent slope instability, especially during rainy seasons. ▪ Implement slope reinforcement techniques, such as retaining walls or terracing, to enhance stability. ▪ Design proper drainage systems to manage surface water and prevent water-induced slope failure. For Soil Erosion and Sedimentation: ▪ Install silt fences and sediment traps to prevent sediment from reaching water bodies. ▪ Divert surface runoff away from disturbed areas to minimize erosion. ▪ Revegetate disturbed areas promptly to stabilize the soil and reduce erosion. ▪ Cover stockpiled materials to prevent them from being dispersed by wind or water.		Site inspections and reporting	Imp: Contractor, NBRO Mon: MOHMM, PDHS, Hospital, PED, NBRO	Internalized to the project cost	Regularly during site preparation
Drainage issues	▪ Impacts can occur from drainage obstruction during activities such as constructing access roads, land reclamation, diversion of drainage paths, trenching, filling, disposal of spoil, and material transport. These may lead to reduced water flow, surface water contamination, and potential flooding if not properly managed.	▪ Ensure that drainage systems are designed and implemented separately for construction activities, preventing wastewater and runoff from affecting existing hospital drainage. ▪ Maintain clear segregation of construction-related drainage and hospital drainage systems to protect the hospital's water quality and prevent cross-contamination. ▪ Regularly inspect drainage systems to ensure they are functioning properly and do not allow construction waste to enter hospital drainage or water sources.		Site inspections and reporting	Imp: Contractor, Mon: MOHMM, PDHS, Hospital, PED,	Internalized to the project cost	Regularly during site preparation
Water quality impacts	▪ Untreated or partially treated wastewater, improper disposal of waste (both liquid and solid waste), silt	▪ Minimize contamination of nearby surface water by preventing untreated or partially treated wastewater, improper disposal of liquid and solid waste, silt materials, runoff		Site inspections and reporting	Imp: Contractor	Internalized to the project cost	Weekly during site construction

	materials, runoff from stockpiled materials, and chemical contamination from fuels and lubricants during construction works can contaminate nearby surface water quality.	from stockpiled materials, and chemical contamination from fuels and lubricants during construction works. ▪ Ensure that drainage systems are properly designed to prevent contamination of water sources from construction activities. ▪ Monitor surface runoff and implement hydrological modifications to control water quality impacts.			Mon: MOHMM, PDHS, Hospital, PED		
Impacts on Air quality	Emissions during site preparation, vehicles, equipment, and machinery used for excavation and construction may resulting in dust and air-borne pollutants.	▪ Erect effective dust barriers to prevent dust from being blown towards other parts of the hospital. These barriers should also serve as noise/dust containment and fencing for safety. Louvres/pergolas of nearby buildings must be temporarily covered with polythene sheets until construction work is completed. ▪ Clean the site daily, particularly surfaces affected by soil and dust. Carry out regular watering at least twice a day (mid-morning and mid-evening) for dust suppression on the construction site. ▪ Cover excavated soil temporarily stored on-site with tarpaulins or other suitable materials to prevent dust particles from becoming airborne. ▪ Store construction stockpiles and debris piles away from the functional areas of the hospital, where possible. ▪ Ensure that any equipment and machinery using diesel are properly maintained to control emissions. The contractor must ensure that vehicles entering the site have obtained Vehicle Emission Certificates.		Site inspections and reporting; Checking the relevant certificates	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Weekly during site construction
Noise and vibration	▪ Increased noise levels and vibrations may occur due to excavation, earth-moving, blasting (if any), and the transport of equipment, materials, and people. ▪ Installation of electro-mechanical components may emit high levels of noise. ▪ Operation of heavy equipment and machinery at night can cause a nuisance	▪ Ensure that construction work, vehicles, and equipment used in construction meet CEA standards for noise and vibration in Sri Lanka. ▪ Schedule high noise-generating activities after informing and obtaining consent from the hospital authorities. ▪ Erect noise barriers if needed to reduce high noise levels; alternatively, the contractor can use a delineated barrier that serves dual purposes of dust/noise containment and safety.		Site inspections and reporting	Imp: Contractor, Authorized party for crack survey Mon: MOHMM, PDHS, Hospital, PED, NBRO	Internalized to the project cost	Weekly during site construction

	to the surrounding hospital environment and people. ▪ Damages to existing nearby structures, both inside and outside, due to vibration-causing activities such as piling, excavation etc.	▪ Restrict the use of noisy machines and, where possible, implement noise-reducing measures for construction machinery. ▪ Conduct construction activity between 8:00 am and 6:00 pm daily to avoid discomfort caused by noise and vibration to in-patients and the surrounding neighborhood. ▪ If nighttime construction activities are unavoidable, ensure they are carried out using noise-reducing means or low-noise technologies. ▪ Schedule noisy construction machines/activities to coincide with non-clinic and non-OPD days/times or during periods of minimum patient visitation. ▪ Liaise with hospital authorities regarding work schedules and provide prior notices of noise-generating activities to avoid confusion. ▪ Conduct a condition survey (crack survey) of existing nearby structures, both inside and outside, to assess their condition prior to vibration-causing activities such as piling, excavation etc. ▪ Comply with the Interim Standard on Vibration Pollution Control for Sri Lanka. ▪ Ensure that if vibration causes structural damage to nearby structures, the contractor is responsible for rectifying such damage					
Waste generation: construction debris and waste generated from labor camps, officer's accommodations	Construction debris, spoil, and waste generated from labor camps, officer's accommodations may impose several negative environmental and social impacts to the activity affected area including impact on ecology, public health and scenic beauty.	▪ Consult the Local Authority at the onset of the activity regarding waste collection and disposal. ▪ Seek approval from the DS for the storage and disposal of spoil material and other gravel. ▪ Ensure that the disposal site selected by the contractor is not located near public or environmentally sensitive areas. ▪ Reuse all debris and residual spoil materials generated from construction activities wherever possible. ▪ Provide proper solid waste disposal, sanitation, and sewerage facilities (drinking		Site inspections and reporting	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Weekly during construction

		water, urinals, toilets, and washrooms) at the construction site and labour camps. ▪ Obtain approval from the Building Department Engineer for the location of labour camps, ensuring compliance with guidelines and recommendations issued by the CEA and LAs. ▪ Provide garbage bins at all worker-based camps and construction sites, and ensure regular disposal in a hygienic manner under the supervision of the Public Health Inspector (PHI).					
Sourcing and supply of construction materials	Transportation of construction materials may block the access roads and may lead to accessibility problems	▪ Purchase construction materials only from approved suppliers with the necessary approvals. ▪ Ensure that construction materials and machinery are placed in a manner that does not block roads, paths, or local access points. ▪ Unload construction materials in a way and at times that do not block roads, paths, or access. ▪ Prohibit the placement of waste on the road.		Construction material sources inspections; Checking for required approvals; Site inspections and reporting	Imp: Contractor, Construction material suppliers Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Once prior to selection of supplier; Regularly during supply of material
Occupational health and safety	Occupational hazards can arise during construction (e.g., trenching, falling objects, high levels of noise and vibration, accidents, etc.)	▪ Ensure a safe construction site by: (i) Maintaining fully functional and well-kept equipment. (ii) Providing emergency equipment and safety warnings. (iii) Equipping workers with personal protective equipment (PPE) and enforcing strict safety practices with proper supervision, monitoring, and feedback. ▪ Provide workers with first-aid and health facilities. Train supervisors in first aid. ▪ Conduct occupational health and safety training programs for workers. ▪ Keep machinery and equipment prone to electrocution in a secure area within the site, under the supervision of an experienced worker. Conduct regular safety checks for vehicles, equipment, and labour huts. ▪ Assign responsibilities to relevant personnel. Enforce a strict prohibition on alcohol and narcotic substances that could		Site inspections and reporting; Regular patrols to check unsafe areas; Checking accident reports	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Continuously throughout the construction

		impair workers' judgment during construction activities. ▪ Barricade excavated areas using barricading tapes and signboards. Ensure work at higher elevations is carried out and supervised by experienced workers					
Community health and safety	▪ Disturbances caused to accessing property and facilities (especially vehicular access) to hospital facilities and services can cause inconvenience to patients, hospital staff and visitors during construction, trenching, and other construction activities. ▪ Community hazards can arise during construction (e.g., open trenches, air quality, noise, falling objects, etc.). Trenching within hospital premises on pavements or any other paved road and areas using pneumatic drills will cause noise and air pollution.	▪ Demarcate the construction site from the rest of the hospital using barricading tape or other suitable materials to create a physical separation. ▪ Provide a safe pedestrian pathway to hospital buildings if regular access via the nearby gate and hospital access road is blocked. ▪ Place signboards and directional signs for detours and facility shifts in both local languages at prominent locations, using large-sized lettering. Ensure the safety of peripheral areas and access paths at all times by maintaining non-slippery surfaces, clearing obstructions, and keeping the site clean and well-managed. ▪ Install safety signs at appropriate locations to inform the public of potential dangers from construction activities. ▪ Ensure emergency access remains unobstructed at all times. Provide alternative access for ambulances and other vehicles when necessary. ▪ Implement strict entry controls to prevent unauthorized access to the site. ▪ Notify hospital staff and users about the construction schedule, highlighting particular hazards, noise, and dust episodes. ▪ Prohibit parking of concrete mixer trucks and other construction vehicles outside the hospital premises, especially on narrow or busy access roads. ▪ Display advance public notices to inform hospital users of any planned tree cutting. ▪ Strengthen all slopes with appropriate engineering interventions. Rehabilitate access roads and paths to their original conditions upon completion of construction.		Site inspections and reporting; Regular patrols to check unsafe areas; Checking accident reports	Imp: Contractor Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Continuously throughout the construction

Physical Cultural Resources	There are structures in some hospitals which are more than 100 years old. Excavations and trenching can uncover and/or damage archaeological and historical resources.	▪ Obtain prior approval from Department of Archaeology in case of renovation/repair works are involved in hospital building which are more than 100 years old. ▪ All the staff and laborers of the contractor should be informed about the possible items of historical or archaeological value, which include old stone foundations, tools, clayware, etc. If something of this nature is uncovered, the Department of Archaeology shall be contacted, and work shall be stopped immediately. The chance finds procedure of archaeological and cultural artefacts should be established.		Site inspections and reporting; Inspection of relevant reports / approvals	Imp: Contractor, Department of Archaeology Mon: MOHMM, PDHS, Hospital, PED	Internalized to the project cost	Regularly during the construction
		Operation					
Healthcare waste (HCW)	▪ The risks associated with operations and maintenance-related injuries must be effectively managed to ensure the safety of workers and the general public, while exposure to hazardous materials during the operation of healthcare waste and wastewater treatment plants, as well as sanitation facilities, should be minimized ▪ Inadequate waste management practices and unhygienic conditions within facilities can lead to public health concerns, particularly the spread of diseases. ▪ Leachate from healthcare waste transfer stations and storage chambers can contribute to environmental pollution and create a nuisance for nearby communities. ▪ Stagnant water resulting from inadequate stormwater drainage systems and poor waste management practices poses a significant health risk by providing breeding	▪ Ensure the safe handling of healthcare waste (HCW) during collection, storage, transportation, treatment, and disposal according to the "Guidelines for the Management of Scheduled Waste in Sri Lanka" published by the CEA, according to the regulations published in the Gazette Extraordinary No. 1534/18 dated 01.02.2008 through licensed service provider/s for HCW disposal. Plan and design HCW management measures at an early stage. ▪ Provide proper training for workers involved in the handling, storage, transportation, treatment, and disposal of HCW to ensure they follow safety protocols. ▪ Equip workers with personal protective equipment (PPE) such as gloves, masks, and protective clothing to minimize exposure to hazardous materials. ▪ Implement colour-coded waste segregation systems to clearly differentiate between hazardous and non-hazardous waste, reducing the risk of contamination. ▪ Ensure secure storage of HCW in designated, well-ventilated, and safe containers to prevent accidental exposure or leakage.		Site inspections and reporting; Checking records on generation and disposal of HCW	Imp: MOHMM, PDHS, HCU, Hospital, Licensed service provider/s for HCW disposal Mon: MOHMM, PDHS, HCU, Hospital, Directorate of Environmental & Occupational Health	Internalized into Hospital expenditure	Regularly during the operation

	grounds for disease vectors such as mosquitoes, flies, and rats.	▪ Regularly monitor healthcare waste disposal sites to ensure compliance with environmental and health safety standards. ▪ Develop emergency response plans for accidents involving hazardous waste, including spill containment and decontamination procedures where applicable. ▪ Ensure proper transportation of HCW using dedicated, leak-proof vehicles that comply with regulatory safety standards. ▪ Minimize HCW generation by promoting waste reduction strategies, such as the use of reusable materials in healthcare facilities. ▪ Use environmentally sound treatment technologies such as autoclaving or incineration to reduce the environmental impact of HCW disposal. ▪ Conduct regular audits and inspections to ensure adherence to safe waste management practices and to identify areas for improvement.					
Solid waste management	▪ Lack of management of domestic waste water may cause health risks and obscure the landscape ▪ Since solid waste collection will not be on a daily basis, there is risk of solid waste piling up within the premises ▪ These can lead to an increase in vector population and health risks	▪ Dispose solid waste through the designated Local Authority in accordance with a pre-agreed collection and disposal schedule ▪ Adhere to CEA guidelines of solid waste collection and disposal ▪ Ensure demarcated solid waste storage area with source separation for organic waste and other domestic non-organic waste.		Site inspections and reporting; Checking records on disposal	Imp: MOHMM, PDHS, Hospital through LA or licensed service provider Mon: MOHMM, PDHS, Hospital	Internalized into Hospital expenditure	Regularly during the operation
Sewage management	▪ Leaking sewers and septic tanks can damage human health and contaminate soil and groundwater. ▪ Lack of disposal of the domestic waste water will result in health issues to the worker	▪ Ensure that the domestic wastewater is directed to suitable collection / treatment facility such as soakage pits in conformance to local authority guidelines. ▪ Dispose of sewage in accordance with relevant guidelines and with the assistance of the local authority.		Site inspections and reporting; Checking records on disposal	Imp: MOHMM, PDHS, HCU, Hospital through LA or licensed service provider Mon: MOHMM, PDHS, Hospital	Internalized into Hospital expenditure	Regularly during the operation

For category B projects, the contractor shall prepare a site specific ESMP including the following details

A. Identification of impacts and description of mitigation measures

Firstly, Impacts arising out of the project activities need to be clearly identified. Secondly, feasible and cost-effective measures to minimize impacts to acceptable levels should be specified with reference to each impact identified. Further, it should provide details on the conditions under which the mitigatory measure should be implemented (e.g., routine or in the event of contingencies). The EMP also should distinguish between the type of solution proposed (structural & non-structural) and the phase in which it should become operable (design, construction and/or operational).

B. Monitoring program

To ensure that the proposed mitigatory measures have the intended results and comply with national standards and donor requirements, and environmental performance monitoring program should be included in the ESMP. The monitoring program should give details of the following;

- Meaningful Monitoring indicators to be established and periodically measured for evaluating the performance of each mitigatory measure (for example, national standards, engineering structures, the extent of area replanted, etc.).
- Monitoring mechanisms and methodologies
- Monitoring frequency
- Monitoring locations

C. Institutional arrangements

Institutions/parties responsible for implementing mitigatory measures and for monitoring their performance should be clearly identified. Where necessary, mechanisms for institutional coordination should be identified as often monitoring tends to involve more than one institution.

D. Implementing schedules

Timing, frequency and duration of mitigation measures with links to the overall implementation schedule of the project should be specified.

E. Reporting procedures

Feedback mechanisms to inform the relevant parties on the progress and effectiveness of the mitigatory measures and monitoring itself should be specified. Guidelines on the type of information wanted, and the presentation of feedback information should also be highlighted.

F. Cost estimates and sources of funds

Implementation of mitigatory measures mentioned in the EMP will involve an initial investment cost as well as recurrent costs. The EMP should include costs estimates for each measure and identify sources of funding.

Annex 7 of Planning Guideline: OUTLINE FOR A SEMI-ANNUAL ENVIRONMENTAL AND SOCIAL MONITORING REPORT

1. Introduction
    a. Overall project description and objectives
    b. Details of site personnel and/or consultants for environmental monitoring
    c. Description of activities and status of implementation
    d. Approach and methodology for environmental monitoring of the project
2. Compliance status with national/state/local statutory environmental requirements
3. Compliance status with environmental and social loan covenants
4. Compliance status with the environmental and social management plan
5. Implementation of grievance redress mechanism and public complaints
6. Overall compliance with ESMP and EMOP
7. Monitoring of environmental impacts on project surroundings
8. Conclusions and recommendations

INDICATIVE STATEMENT OF AUDIT NEEDS FOR GOVERNMENT

PROPOSED RBL PROGRAM FOR STRENGTHENING INTEGRATED HEALTH CARE AND GOVERNANCE FOR UNIVERSAL HEALTH COVERAGE PROGRAM (LOAN NO: XXXX)

1. **Background.** Achieving universal health coverage (UHC) is the highest-level objective of the health sector of Sri Lanka since its independence in 1948, and Sri Lanka has steadily progressed towards UHC to 67 in 2021. Sri Lanka provides healthcare services free of cost at point of delivery to all citizens at the preventive, primary, secondary and tertiary care levels. Health services are a devolved subject as per the Constitution and primary and secondary care is delivered at the local level by nine (9) provincial councils and tertiary care at the central level. Training of nurses, supplementary medical professionals and procurement of all pharmaceuticals and medical supplies required by all levels of hospitals are centrally managed. Each province has a Provincial Directorate of Health Services led by a Provincial Director of Health Services (PDHS), and there is a total of 26 Regional Directorates of Health Services led by a Regional Director of Health Services (RDHS). The Ministry of Health and Mass Media (MOHMM) is responsible for planning and stewardship, pharmaceutical supply chain management for the entire country, management of all training institutes under the health sector, and the service provision of tertiary health care services via management of approximately 41 tertiary care hospitals across the country with a bed capacity of 42,897 in 2023 while the Provincial Councils manage the 1034 primary care institutes, 75 secondary care hospitals with specialist care beds 18,800 and primary care beds 21,425.

2. Asian Development Bank (ADB) will support the government's National Strategic Framework for the Development of Health Services (NSFDHS) in addressing long-lasting gaps in the health sector to enable the timely achievement of universal health coverage and strengthen MOHMM's and Provincial institutional capacity by providing financing as part of results-based lending (RBL) instrument. The key outputs of the ADB RBL program include: (i) Integrated curative care services via first referral hospitals enhanced, (ii) Pandemic prevention, preparedness, and response enhanced; and (iii) Health sector technical capacity and pharmaceutical supply chain management improved

3. **Results based lending.** Under the RBL modality, the ADB financing is an integral part of government's NSFDHS program financing, which includes financing from the country's own resources. As a result, the disbursement of the ADB RBL proceeds will not depend on evidence of expenditures or transactions. Instead, the ADB loan disbursements will be directly linked to the achievements of program results as measured by disbursement-linked indicators (DLIs) and is conditioned upon verification that the DLIs have been achieved. Each DLI will be accompanied by a clear verification protocol that will define how achievements will be measured and verified.

4. **Disbursement Linked Indicators.** The disbursement-linked indicators (DLIs) are outlined below [to be updated based on the final agreed DLIs after loan negotiations]:

Outcome: Efficiency and quality of first referral hospital care services enhanced

- DLI 1: The average waiting time of patients for 3 elective surgeries (cataract, hernia) (by sex) and hysterectomy) at first referral hospitals (BHs A&B) reduced by 30% from baseline
- DLI 2: The % of IV cannula and surgical site Hospital Acquired Infections (disaggregated by sex) at first referral hospitals (BHs A&B) reduced by 40% from baseline

Output 1: Integrated curative care services via First referral hospitals enhanced

- DLI 3: Planning, monitoring, budgeting and human resource management capacity of health sector strengthened
- DLI 4: Patient centred secondary care services with quality, safety, climate resilience measures enhanced
- DLI 5: Care pathways linking first referral hospitals for selected high burden diseases formalized
- DLI 6: Notifiable disease surveillance and quality assurance of public health laboratories improved

Output 3: Health sector technical capacity and pharmaceutical supply chain management improved

- DLI 7: Logistics capacity and quality assurance of the pharmaceuticals enhanced
- DLI 8: Procurement management capacity enhanced

5. **Verification protocol.** The disbursement will subject to the achievement and verification of the agreed DLIs. The verification will be done by Independent Verification Agent in accordance with the verification protocol agreed between the government and ADB and provided in the program Implementation document. Evidence of verifying the achievement of the DLIs will be attached to the withdrawal application submitted to ADB. Any amounts not disbursed for unmet DLIs will be disbursed once they have been achieved. Selected DLIs allow partial disbursement following mechanisms described in the verification protocol.

6. **Program expenditure framework.** The government has estimated that approximately $11.7 billion is required to implement the NSFDHS 2025–2030. ADB will support the NSFDHS by focusing on secondary care development and governance improvement measures and the RBL program expenditure framework was prepared based on the NSFDHS budget estimates for the period of 2025–2030. The RBL program expenditures form part of the government budget for UHC activities. The total RBL program cost, including ADB loan and grant proceeds and the government counterpart financing, amount to $660 million. The RBL program expenditure is clearly prepared using the budget codes relevant for secondary care development and governance improvement measures and are based on broader government program and RBL program period. To achieve RBL outputs, at MOHMM level, the RBL program will support the program code operational activities[23] and development activities. At Provincial Council level, as majority of the secondary hospitals are managed by the provincial councils, the related RBL outputs are intended to be achieved through the program codes ‘general health services’, ‘hospital service’, ‘public health services’, ‘health training’, and ‘provincial / general administrative services’. The expenditure not covered under the RBL program are: (i) expenditure under other donor-funded projects, ayurveda expenses, tertiary health institutions and specialized projects; (ii) procurement of pharmaceuticals and related consumables; and (iii) expenses related to salaries and wages, overtime and holiday payments and other allowances to staff. Table 1 summarizes the size of eligible expenditure of the RBL program.

Table 1: Summary of Program Expenditure Framework, 2025–2030

($ million)[1]

Items	Broader Program		Expenditure Program[2]	
	Amount	Share of Total (%)	Amount	Share of Total (%)
Ministry of Health and Mass Media				
Recurrent expenditure	8,323.2	71.0%	49.5	0.4%
Capital expenditure	1,428.8	12.2%	55.8	0.5%

[23] Calculated using the number of beds for secondary care hospitals over the total number of beds across all hospitals operated by MOHMM.

Items	Broader Program		Expenditure Program[2]	
	Amount	Share of Total (%)	Amount	Share of Total (%)
Central Province				
Recurrent expenditure	190.1	1.6%	29.2	0.2%
Capital expenditure	6.1	0.1%	6.1	0.1%
Eastern Province				
Recurrent expenditure	168.1	1.4%	31.4	0.3%
Capital expenditure	14.6	0.1%	14.6	0.1%
Northern Province				
Recurrent expenditure	177.6	1.5%	38.3	0.3%
Capital expenditure	15.8	0.1%	15.8	0.1%
North-Central Province				
Recurrent expenditure	135.0	1.2%	27.4	0.2%
Capital expenditure	15.9	0.1%	15.9	0.1%
North-Western Province				
Recurrent expenditure	196.6	1.7%	36.9	0.3%
Capital expenditure	0.3	0.0%	0.3	0.0%
Sabaragamuwa Province				
Recurrent expenditure	229.4	2.0%	50.1	0.4%
Capital expenditure	14.2	0.1%	14.2	0.1%
Southern Province				
Recurrent expenditure	258.7	2.2%	45.7	0.4%
Capital expenditure	1.1	0.0%	1.1	0.0%
Uva Province				
Recurrent expenditure	158.5	1.4%	29.1	0.2%
Capital expenditure	14.3	0.1%	14.3	0.1%
Western Province				
Recurrent expenditure	357.0	3.0%	57.7	0.5%
Capital expenditure	19.8	0.2%	19.8	0.2%
Total	**11,725.0**	**100.0%**	**553.1**	**4.7%**
ADB Loan Proceeds for the RBL Program			100.0	
Pandemic Prevention, Preparedness and Response Trust Fund Grant			6.9	
TOTAL RBL PROGRAM FINANCING			**660.0**	

Note: Numbers may not sum precisely because of rounding.

[1] US$ 1 = LKR 295

[2] The eligible budget codes for RBL program are (i) MOHMM: 111-01-05, 111-02-13, 111-02-17, 111-02-20, 111-02-25, and 111-02-26 (the expenditure is further categorised under object codes 11–17 and 20–25 for each of above identified project codes/ subproject codes); and (ii) for Provincial Councils (PMOHMM and PDHS) : Western : 105-03-01, 105-71-01, 113-70-01, 113-71-01, 113-72-01; Sabaragamuwa: 810-71-03, 810-72-01, 811-70-01, 811-71-01, 811-72-01; Southern: 304-03-01, 304-03-01, 305-70-02, 305-70-03, 305-71-02, 305-72-02, 305-72-03; Northen: 450-03-08, 450-09-03, 450-70-04, 450-72-05, 450-72-06; Eastern: 950-03-02, 951-03-02, 951-70-01, 951-70-01, 951-71-01, 951-72-01; Uva: 710-03-02, 710-03-03, 710-03-04, 710-71-03, 710-72-04, North-Central: 630-72-05, 630-70-06, 630-71-07, 811-72-01, 811-72-01, 811-72-01, Central: 561-02-04, 561-74-01, 561-71-01, 811-74-01, 811-72-06; and North-Western: 811-70-01, 811-71-01, 811-72-01. (include capital and recurrent expenditure incurred under object codes and 11–17 and 20–25 for each of above identified project code/subproject code)

7. The RBL program is estimated to cost $660.0 million, of which the government will finance $553.1 million (83.8%), Pandemic Fund (grant) is likely to support $6.9 million (1.0%) and ADB will finance $100 million (15.2%) through ordinary capital resources. The ADB financing in the form of RBL loan will be upon achieving the agreed disbursement linked

indicators and terms and conditions of the loan agreement. The financing plan for the program is summarised in Table 2.

Table 2: Proposed Financing Plan

Source	Amount ($ million)	Share of Total (%)
Asian Development Bank		
Ordinary capital resources (regular loan)	100.0	15.2
Pandemic Prevention, Preparedness and Response Trust Fund (grant)[1]	6.9	1.0
Government	553.1	83.8
Total	**660.0**	**100.0**

8. **Statement of intent.** PCO, MOHMM will agree with National Audit Office (NAO) that the government's program for NSFDHS supported by the ADB results-based lending will be audited in accordance with the following terms of reference. The audit will be conducted annually and cover the period [STATE THE PERIOD OF AUDIT].

9. **Audit scope.** The program financial statements will be audited by the NAO in accordance with Sri Lankan Auditing Standards, which are based on International Standards of Supreme Audit Institutions (ISSAI).

10. As part of the program audit, the NAO will audit the following: (i) the program financial statements of MOHMM and (ii) separately all nine Provinces level accounts (aggegated for Provincial Ministry of Health and PDHSs). The audit will cover hospitals and health institutions on sample basis as deemed necessary. The audit will include such test and controls as the auditor considers necessary under the circumstances. It is expected that the audit includes on a sample basis health institutions benefiting from the program in the audit, as deemed necessary.

11. When conducting the audit, special attention shall be paid to the following:

i. The financial statements of the RBL program as prepared by MOHMM and the nine Provinces reflect the program expenditure and financing;
ii. Program expenditure is in accordance with the ADB RBL program agreement and necessary supporting documentation, records and accounts have been kept in respect of the program expenditure and the is clear linkage between the books of account and the program financial statements;
iii. Program funds have been used in accordance with the program financing agreement and only for the purpose intended;
iv. The program financial statements have been prepared in accordance with Sri Lanka Public Sector Accounting Standards;
v. An adequate system of internal controls including internal audit over program expenditure was operational and effective over the program period; and major observation in internal audit reports that may affect the system; and
vi. Progress of implementation of the program action plan in respect of the activities relating to strengthening of financial management and procurement.

12. A sample template for the audit opinion on specific donor requirements has been given in **Appendix 4.1**.

13. Furthermore, it is expected that the NAO will discuss / review the audit observations (particularly the serious financial irregularities) through tripartite meetings with ADB to facilitate executive follow-up on audit observations and recommendations.

14. **Financial reporting.** MOHMM, and all the Provinces (PMOHMM and PDHS) will prepare their annual financial statements for the RBL program. The program financial

statement will reflect the expenditures incurred under the MOHMM and PMOHMM and PDHS budget Heads and codes (and as amended from time to time) relevant for secondary care development and governance improvement as follows :

(i) Central level institution:

MOHMM: the eligible recurrent and capital expenditure incurred under object codes 11–17 and 20–25 respectively, for each of identified project code/subproject code as below:

- MOHMM: Budget head 111: (i) Program code 01- Operational activities; Project Code 05- Hospital Operations; (ii) Program Code 02 – Development Activities; Project Code 13 - Hospital Development Projects, (iii) Program Code 02 – Development Activities; 17 - Medical Research, (iv) Program Code 02 – Development Activities; 20 - Human Resource Development, (v) Program Code 02 – Development Activities; 25 - Medical Supplies, (vi) Program Code 02 – Development Activities; 26 - Prevention and Control of Communicable & Non-Communicable Diseases.

(ii) Provincial level institutions:

Provincial Ministry of Health (PMOHMM) and PDHS Budget heads: The eligible recurrent and capital expenditure incurred under object codes 11–17 and 20–25 respectively, for each of identified project code/subproject code as below:

- Western Province:
  a. PMOHMM: Budget head 105 : (i) Program code 03 - Provincial Administration, Project code 01 - General Administration & Establishment Services - Minister's Office; (ii) Program code 71 - Hospital Services, Project code 01 - Patient care Services;
  b. PDHS: Budget Head: 113: (i) Program Code 70 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; (iii) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

- Sabaragamuwa Province:
  c) PMOHMM: Budget Head 810: (i) Program code 71 - Public Health Services, Project code 03 - Patient care Services; (ii) Program code 72 - Public Health Services, Project code 01 - Community Health Services.
  d) PDHS: Budget Head 811: (i) Program Code 70 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; (iii) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services.

- Southern Province:
  c) PMOHMM: Budget Head 304: (i) Program code 03 - Provincial Administration, Project code 01 - Health Development; (ii) Program code 03 - Provincial Administration, Project code 02 Primary health Development Project
  d) PDHS: Budget Head 305: (i) Program Code 70 - Provincial Services, Project Code 02 - General Administration & Establishment Services; (ii) Program Code 70 - Provincial Services, Project Code 03 - Bio Medical Engineering Service; (iii) Program Code 71 - Hospital Services, Project Code 02 - Patient care Services; (iv) Program Code 72 - Public Health Services, Project Code 02 -

Community Health Services (Preventive); (v) Program Code 72 - Public Health Services, Project Code 03 - Management of Information & Health Education

- Northen Province
  c) PMOHMM: Budget Head 413: Program code 03 - Provincial Administration, Project code 08 - General Administration & Finance;
  d) PDHS: Budget Head 450: (i) Program Code 03 - Provincial Administration, Project Code 08 - General Administration & Finance; (ii) Program Code 09 - Human Resources Management , Project Code 03 - Health and Training; (iii) Program Code 70 - Hospital Services, Project Code 04 - General Health Services; (iv) Program Code 72 - Public Health Services, Project Code 05 - Patient Care Services - Curative; (v) Program Code 72 - Public Health Services, Project Code 06 - Patient Care Services - Cancer Unit

- Eastern Province
  c) PMOHMM: Budget Head 950: Program code 03 - Provincial Administration, Project code 02 - General Administration & Finance
  d) PDHS: Budget Head 951: (i) Program Code 03 - Provincial Administration, Project Code 02 - General Administration & Finance; (ii) Program Code 70 - Hospital Services, Project Code 01 - General Health Service; (iii) Program Code 71 - Public Health Services, Project Code 01 - Patient Care Services (Curative); (iv) Program Code 72 -General Health Services, Project Code 01 - Community Health Services (Preventive)

- Uva Province
  c) PMOHMM: Budget Head 707 : Program code 72 - Public Health Services, Project code 07 24 - PSDG
  d) PDHS: Budget Head 710: (i) Program Code 03 - Provincial Council Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 71 - Public Health Services, Project Code PSDG; (iii) Program Code 71 - Public Health Services, Project Code 03 - Patient care Services; (iv) Program Code 72 - General Health Service, Project Code 01 - General Health Services

- North-Central Province
  c) PMOHMM: Budget Head 630: (i) Program code 03 -Provincial Council Administration, Project code 02 - General Administration & Establishment Services (Ministry Staff); (ii) Program code 72 - General Health Services, Project code 05 - Health Service; Budget Head 630: Program code 70 - Hospital Services, Project code 06 - Patient Care Services; (iii) Program code 71 - Public Health Services, Project code 07 - Public Health & Prevention of Diseases
  d) PDHS: Budget Head 811: (i) Program Code 72 - General Health Services, Project Code 01 - General Administration & Establishment Services; (ii) Program Code 72 - General Health Services, Project Code Health Service (Ministry Interventions); (iii) Program Code 70 - Hospital Services, Project Code 01 - Patient care Services; (iv) Program Code 72 - Public Health Services, Project Code Public Health & Prevention of Diseases; (v) Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

- Central Province
  c) PMOHMM: Budget Head 561: (i) Program code 02 - General Administration, Project code 04 - Ministry Secretariat Office; (ii) Program code 74 - Research & Development Activities, Project code 01 - Health Services

d) PDHS: Budget Head 561: (i) Program Code 01 - General Administration, Project Code 04 - General Administration & Establishment Services; (ii) Program Code 71 - Hospital Services, Project Code 01 - Patient care Services (Curative); (iii) Program Code 74 - Research & Development Activities, Project Code 01 - Health Services; (iv) Program Code 72 - Public Health Services, Project Code 06 - Community Health Services.

- North-Western Province
  c) PMOHMM: Budget Head 811: (i) Program code 70 - Provincial Administration, Project code 02 - General Administration - Ministry Administration; (ii) Program code 70 - Hospital Services, Project code 01 - Patient care Services; (iii) Program code 72 - Public Health Services, Project code 01 - Community Health Services.
  d) PDHS: Budget Head 811: Program Code 70 - Provincial Administration, Project Code 01 - General Budget Head 811: Program Code 71 - Hospital Services, Project Code 01 - Patient care Services; Budget Head 811: Program Code 72 - Public Health Services, Project Code 01 - Community Health Services

15. The program financial statements shall be supplemented by additional notes and disclosures to align them with Sri Lankan Public Sector accounting standards and satisfy ADB's requirements. In this regard, the notes of the Program financial statements for MOHMM will include a statement of expenditures per selected budget heads and program/project codes and prorated for secondary care hospitals using the applicable number of beds ratio for the year in question.

16. **Appendix 4.2** includes detailed guidance on the Budget Heads and Codes applicable to the RBL program for MOHMM, the estimated amounts and the applicable beds ratio to be used for Program code 01- Operational activities; Project Code 05- Hospital Operations. The **Annex 2-2** includes detailed guidance on the Budget Heads and Codes applicable to the RBL program for Provinces.

17. **Appendix 4.3** includes a sample report template to be included in the notes of the program financial statements to report the estimated expenditures incurred as part of RBL program

18. The program financial statements of MOHMM and agregated program financial statement of all PMOHMM and PDHS under each province shall include:

94. Statement of program expenditure by major budget heads and program and project codes for the fiscal year, previous year and cumulative;
i. Statement of budgeted vs. actual expenditures by major budget heads and program and project codes for the fiscal year with significant variance explained in the notes;
ii. Statement of disbursement (statement of amount claimed under the ADB loan and funds disbursed by ADB for the fiscal year, and cumulative)
iii. Statement of appropriation accounts/ budgeted vs. actual expenditures by major budget heads and program and project codes for each central and provincial level entity; and
iv. Notes to the financial statements including significant accounting policies and breakdowns of the amount of expenditures incurred under the Program code 01- Operational activities; Project Code 05- Hospital Operations prorated for secondary care hospitals using the applicable number of beds ratio for the year in question;

19. **Audit report.** The objective of the audit is to provide assurances to ADB that the financial statements of the program for secondary healthcare present a true and fair view and are free from misstatements as a result, the, audit report will include the following separate audit opinions:

95. whether the program financial statements present a true and fair view or are presented fairly, in all material respects, in accordance with the applicable financial reporting framework;
i. the level of compliance for each financial covenant contained in the legal agreements for the program (if any); and,
ii. whether the aggregate amount of ADB disbursement proceeds under the RBL modality does not exceed the amount of the total program expenditures on goods, works, and services.

20. The audit reports and the audited program financial statements will be submitted in the English language to ADB within ***nine*** months after the end of the fiscal year and will be accompanied by separate management letters outlining any identified internal control issues, audit recommendations as well as priority. The management letter should also include management's response to the audit observations should be reflected in the management letter. From the second year onward, the management letter must also include a follow-up on previous years audit observations.

21. **Management letter.** The auditor will prepare and submit along with the audit report, a separate Management letter for the program. The management Letter will elaborate the findings of the audit and contain recommendations for improvements in internal control and other matter coming to the attention of the auditor during the audit examination. The management letter will include the matters such as the following:

i. Observations on deficiencies/ weakness on the accounting records, systems and controls that were examined during the course of the audit and management's response to these together with specific recommendations for improvement.
ii. Bring to Management's attention any matters that might have a significant impact on the implementation of the Program or that the auditor considers necessary and pertinent.
iii. Report of the status of the progress of the program action plan agreed by MOHMM and Provinces in respect of Procurement and Financial Management action points.
iv. Adequacy of FM staffing.
v. Adequacy of compliance with previous audit findings and recommendations outlined in the Audit Report and/or the Management Letter and status of any issues which remain to be addressed and any issues which recurred.
vi. Adequacy of compliance with Internal audit findings.
vii. Bring to the government and development partner attention any other matters that the auditor considers pertinent.

22. Serious Issues, which affect the auditor‘s opinion as to whether the financial statements give a true and fair view should be referred to in the audit opinion. The Management Letter should include only those issues which do not affect the fairness of the financial statements.

23. The Management letter to be issued separately for each province agency and MOHMM. If no major internal control issues are identified, a statement negating control issues should be prepared. From the second year onward, the management letter must also include a follow-up on previous years audit observations.

24. **Timeline for submission of audit reports.** The audits should be carried out annually. The first audit will include prior results achieved 12 months prior to the loan signing date and the first APFS will cover the date from when eligible expenditure is permitted under retroactive financing and end on 31 December of a loan signing year. Following audits are expected to cover fiscal year of Sri Lanka ending December 31. The audits will be conducted in a timely manner so that the audited program financial statements along with the management letter

are submitted to ADB within 9 months of the end of each fiscal year. The Audited program financial statement will be disclosed on the ADB website.

25. **General**. The auditor will be given access to all program related books, records, reports and information required for the purposes of conducting the audit. The information made available to the auditors will include the relevant loan agreement, program action plan, the program implementation document, program fiduciary assessment, the minutes of the loan negotiations. The documents are available on ADB's website and/or will be provide by MOHMM/ PMOHMM /PDHS. Confirmation should also be obtained of amounts disbursed and outstanding with ADB and the government.

26. ADB reserves the right to commission supplementary audit, if NAO considers it unfeasible to satisfy specific donor audit needs as part of its constitutional statutory audit. In case an external auditor needs to be commissioned for a supplementary audit, the auditor should be given access to all legal documents, correspondences, and any other information associated with the commission and deemed necessary by the auditor.

Note: This is a statement of audit needs of ADB and does not in any way intend to limit the scope of the statutory audit.

APPENDIX 4.1 INDICATIVE TEMPLATES FOR AUDITORS' OPINION ON PROGRAM FINANCIAL STATEMENTS OF THE MOHMM/ (AGGREGATED) REPORT OF PMOHMM/ PDHS AT THE NINE PROVINCIAL LEVEL ACCOUNTS

NAO LOGO

AUDITOR GENERAL'S REPORT
Auditor General of Sri Lanka
[Appropriate Addressee]

Report of the Auditor General on the (AGGREGATED)/ Program Financial Statements of the government program for Strengthening Integrated Health Care and Governance for UHC supported by the ADB Results Based Lending (Loan No...) for the year ended 31 December 20XX–MOHMM/ nine provincial institutions

The audit of the financial statements of the **Government program for Strengthening Integrated Health Care and Governance for UHC supported by the ADB Results Based Lending (Loan No...)….**("The RBL program") for the year ended 31 December 20XX as from the Central Appropriation Accounts of [give THE NAMES AND NUMBERS OF THE APPROPRIATION ACCOUNTS], AND/OR the nine Provincial Appropriation Accounts Sector [GIVE THE NAMES AND NUMBERS OF THE PROVINCIAL LEVEL APPROPRIATION ACCOUNTS] which comprise the Statement of Financial Position, Statement of Financial Performance; and Statement of Cash Flow and a summary of significant accounting policies and related explanatory notes as at 31 December 20XX, was carried out under my direction in pursuance of provisions in Article 154(1) of the Constitution of the Democratic Socialist Republic of Sri Lanka read in conjunction with provisions in the Loan agreement No……. dated….. entered into between the Democratic Socialist Republic of Sri Lanka and the Asian Development Bank.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation of financial statements that give a true and fair view in accordance with ***Sri Lanka Accounting Standards / Sri Lanka Public Sector Accounting Standards (As applicable)***, and for such internal control as management determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. Those charged with governance are responsible for overseeing the Program's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Sri Lanka Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. As part of an audit in accordance with Sri Lanka Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for

my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the program's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the management.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Opinion

In my opinion, the accompanying financial statements [give a true and fair view of the financial position OR give a true and fair view subject to my observations in listed below or do not give a true and fair view] of the Program as at 31 ***December 20XX***, and of its financial performance/ statement of expenditure *(as the case may be)* and its cash flows for the year then ended in accordance with ***Sri Lanka Accounting Standards / Sri Lanka Public Sector Accounting***

Standards (As applicable).
[Alternatively: —Except for the matters given below, in our opinion ….]

Basis for Opinion

I conducted my audit in accordance with Sri Lanka Auditing Standards (SLAS). My responsibilities, under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Report on Other Requirements of the Donor Agency

As required by the Asian Development Bank, I state the followings:

a. The basis of opinion and scope and limitations of the audit are as stated above.
b. In my opinion the following covenants have been complied with [list financial covenants individually here], and the following covenants have not been complied with [list financial covenants individually here]
c. In my opinion**,** the total ADB disbursement of [Insert the amount] to date, including [Insert the amount]. during this reporting period, DOES NOT / DOES exceed the aggregate[24] program expenditure of [Insert the amount] to date, including [Insert the amount] during this reporting period.

Auditor General

[24] Aggregate expenditure includes expenditures incurred under the agreed budget heads by the MOHMM and nine PDHS/PMOHMM

APPENDIX 4.2: Guidance on notes disclosure - budget heads and codes applicable to the RBL program for MOHMM

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
MOHMM	111	Ministry of Health and Mass Media	01- Operational Activities	05- Hospital Operations	11-17	Recurrent	4.86		16.5	Total expenditures under this budget code are to be adjusted to reflect estimated expenditures incurred as part of Strengthening Integrated Health Care and Governance for UHC by multiplying the figure with the beds ratio calculated as number of beds for secondary care hospitals divided by total number of beds operated by MOHMM
					20-25	Capital	4.85		16.4	
			02 - Development Activities	17 - Medical Research	11-17	Recurrent	0.68		2.3	100% of eligible expenditure
					20-25	Capital	0.21		0.7	
				20 - Human Resource Development	11-17	Recurrent	2.28		7.7	
					20-25	Capital	1.48		5.0	
				25 - Medical Supplies	11-17	Recurrent	1.16		3.9	
					20-25	Capital	2.82		9.6	
				26 - Prevention and Control of Communicable & Non Communicable Diseases	11-17	Recurrent	5.60		19.0	
					20-25	Capital	7.11		24.1	
TOTAL - MOHMM							**31.06**		**105.3**	

Note: The proportionate beds ratio will be used only for MOHMM budget head 111 – program code 01 -project code 05. For all other program and project code 100% of eligible expenditure will be considered.

APPENDIX 4.3: Guidance on notes disclosure - budget heads and codes applicable to the RBL program for Provinces

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
Western Province	113	Department of Health Services	70 - General Health Services	01 - General Administration & Establishment Services	11-17	Recurrent	1.15		3.91	100% of eligible expenditure
					20-25	Capital	0.02		0.08	
			71 - Hospital Services	01 - Patient care Services	11-17	Recurrent	13.71		46.48	
					20-25	Capital	5.77		19.54	
			72 - Public Health Services	01 - Community Health Services	11-17	Recurrent	2.16		7.33	
					20-25	Capital	0.06		0.19	
TOTAL							**22.87**		**77.53**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
Sabaragamuwa Province	811	Department of Health Services	70 - General Health Services	01 - General Administration & Establishment Services	11-17	Recurrent	0.75		2.53	100% of eligible expenditure
					20-25	Capital	-		-	
			71 - Hospital Services	01 - Patient care Services	11-17	Recurrent	11.73		39.75	
					20-25	Capital	2.95		9.99	
			72 - Public Health Services	01 - Community Health Services	11-17	Recurrent	2.30		7.81	
					20-25	Capital	1.24		4.20	
TOTAL							**18.96**		**64.28**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								

Southern Province	305	Department of Health Services	70 - General Health Services	02 - General Administration & Establishment Services	11-17	Recurrent	1.60		5.41	100% of eligible expenditure
					20-25	Capital	0.10		0.34	
				03 - Bio Medical Engineering Service	11-17	Recurrent	0.30		1.01	
					20-25	Capital	-		-	
			71 - Hospital Services	02 - Patient care Services	11-17	Recurrent	10.04		34.03	
					20-25	Capital	0.14		0.47	
			72 - Public Health Services	02 - Community Health Services	11-17	Recurrent	1.51		5.13	
					20-25	Capital	0.08		0.27	
				03 - Management of Information & Health Education	11-17	Recurrent	0.03		0.11	
					20-25	Capital	0.00		0.01	
TOTAL							**13.80**		**46.77**	

Institution	**Budget Head**		**Program Code**	**Project Code**	**Object Codes**	**Budget item**	**Total Expenditure 2025-2030 (SLR billion)**	**%**	**$ million**	**Instructions for Program Financial Reporting**
	Budget Head	**Description**								
Northern Province	450	Department of Health Services	03 - Provincial Administration	08 - General Administration & Finance	11-17	Recurrent	0.14		0.49	100% of eligible expenditure
					20-25	Capital	-		-	
			09 - Human Resources Management	03 - Health and Training	11-17	Recurrent	0.06		0.19	
					20-25	Capital	-		-	
			70 - General Health Services	04 - General Health Services	11-17	Recurrent	1.40		4.73	
					20-25	Capital	0.29		0.99	
			72 - Public Health Services	05 - Patient Care Services - Curative	11-17	Recurrent	9.43		31.96	
					20-25	Capital	4.36		14.78	
				06 - Patient Care Services - Cancer Unit	11-17	Recurrent	0.26		0.89	
					20-25	Capital	-		-	
TOTAL							**15.94**		**54.03**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
Eastern Province	951	Department of Health Services	03 - Provincial Administration	02 - General Administration & Finance	11-17	Recurrent	0.33		1.11	100% of eligible expenditure
					20-25	Capital	0.36		1.21	
			70 - General Health Services	01 - General Administration & Establishment Services	11-17	Recurrent	1.35		4.59	
					20-25	Capital	0.65		2.20	
			71 - Public Health Services	01 - Patient Care Services (Curative)	11-17	Recurrent	6.57		22.28	
					20-25	Capital	2.39		8.11	
			72 -General Health Services	01 - Community Health Services (Preventive)	11-17	Recurrent	1.01		3.42	
					20-25	Capital	0.90		3.06	
TOTAL							**13.56**		**45.98**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
Uva Province	710	Department of Health Services	03 - Provincial Council Services	01 - General Administration & Establishment Services	11-17	Recurrent	1.02		3.46	100% of eligible expenditure
					20-25	Capital	0.02		0.06	
			71 - Public Health Services	PSDG	11-17	Recurrent	-		-	
					20-25	Capital	4.22		14.29	
				03 - Patient care Services	11-17	Recurrent	6.58		22.30	
					20-25	Capital	-		-	
			72 - General Health Service	01 - General Health Services	11-17	Recurrent	0.99		3.35	
					20-25	Capital	-		-	
TOTAL							**12.82**		**43.46**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
North - Central Province	811	Department of Health Services	72 - General Health Services	01 - General Administration & Establishment Services	11-17	Recurrent	1.30		4.41	100% of eligible expenditure
					20-25	Capital	0.87		2.94	
				Health Service (Ministry Interventions)	20-25	Capital	0.20		0.66	
			70 - Hospital Services	01 - Patient Care Services	11-17	Recurrent	5.29		17.94	
					20-25	Capital	3.20		10.84	
			72 - Public Health Services	Public Health & Prevention of Diseases	20-25	Capital	0.23		0.78	
				01 - Community Health Services	11-17	Recurrent	1.48		5.03	
					20-25	Capital	0.20		0.67	
TOTAL							**12.77**		**43.27**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	Description								
Central Province	561	Department of Health Services	01 - General Administration	04 - General Administration & Establishment Services	11-17	Recurrent	1.18		3.99	100% of eligible expenditure
					20-25	Capital	-		-	
			71 - Hospital Services	01 - Patient care Services (Curative)	11-17	Recurrent	5.85		19.82	
					20-25	Capital	-		-	
			74 - Research & Development Activities	01 - Health Services	20-25	Capital	1.81		6.14	
			72 - Public Health Services	06 - Community Health Services	11-17	Recurrent	1.60		5.43	
					20-25	Capital	-		-	

TOTAL	**10.44**		**35.39**	

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure 2025-2030 (SLR billion)	%	$ million	Instructions for Program Financial Reporting
	Budget Head	**Description**								
North – Western Province	811	Department of Health Services	70 - Provincial Administration	01 - General Administration	11-17	Recurrent	0.98		3.34	100% of eligible expenditure
					20-25	Capital	0.02		0.08	
			71 - Hospital Services	01 - Patient Care Services	11-17	Recurrent	8.71		29.54	
					20-25	Capital	0.03		0.12	
			72 - Public Health Services	01 - Community Health Services	11-17	Recurrent	1.19		4.04	
					20-25	Capital	0.02		0.06	
TOTAL							**10.96**		**37.17**	

SAMPLE NOTE DISCLOSURE REQUIRED BY ADB TO BE INCLUDED IN THE PROGRAM FINANCIAL STATEMENTS

1. Statement of expenditures by the selected budget heads and program/project codes and prorated _____for the year in question

Institution	Budget Head		Program Code	Project Code	Object Codes	Budget item	Total Expenditure		Program Expenditure		
	Budget Head	Description					For the fiscal year	Cumulative (from 1.1.2025)	Number of bed ratio to be used	For the fiscal year	Cumulative (from 1.1.2025)
MOHMM	111	Ministry of Health and Mass Media	01-Operational Activities	05-Hospital Operations	11-17	Recurrent			Total expenditures under this budget code are to be adjusted to reflect estimated expenditures incurred as part of Strengthening Integrated Health Care and Governance for UHC by multiplying the figure with the beds ratio calculated as number of beds for secondary care hospitals divided by total number of beds operated by MOHMM		
					20-25	Capital					

GUIDELINES TO PREVENT OR MITIGATE FRAUD, CORRUPTION, AND OTHER PROHIBITED ACTIVITIES IN RESULTS-BASED LENDING FOR PROGRAMS

A. Purpose and General Principles

1. The developing member country (DMC) is responsible for the implementation of programs supported by results-based lending (RBL). The Asian Development Bank (ADB) has a fiduciary responsibility to ensure that its loans and other forms of financing used only for the purposes for which they were granted, in accordance with the Agreement Establishing the Asian Development Bank (the Charter).[25] To uphold that obligation, ADB presents these guidelines to prevent or mitigate fraud, corruption, and other prohibited activities (referred to as "integrity violations" in ADB's Investigation and Enforcement Framework (2024) as amended from time to time, or the IPG for brevity) in RBL operations financed in whole or in part by ADB. These guidelines build upon the legal obligations presented in the loan agreement and apply to operations funded by the RBL (the programs).[26]

2. These guidelines do not limit any other rights, remedies, or obligations of ADB or the DMC under the loan agreement or any other agreement to which ADB and the DMC are both parties.

3. All persons and entities participating in the programs are bound by ADB's Anticorruption Policy (1998, as amended from time to time) and the IPG, and as such must observe the highest ethical standards; take all appropriate measures to prevent or mitigate fraud, corruption, and other integrity violations; and refrain from engaging in such actions in connection with the programs.

B. Definitions

4. These guidelines address the following practices as defined by ADB:
   (i) A "corrupt practice" is the offering, giving, receiving, or soliciting, directly or indirectly, anything of value to influence improperly the actions of another party.
   (ii) A "fraudulent practice" is any act or omission, including a misrepresentation, that knowingly or recklessly misleads, or attempts to mislead, a party to obtain a financial or other benefit, or to avoid an obligation.
   (iii) A "collusive practice" is an arrangement between two or more parties designed to achieve an improper purpose, including influencing improperly the actions of another party.
   (iv) A "coercive practice" is impairing or harming, or threatening to impair or harm, directly or indirectly, any party or the property of the party to influence improperly the actions of a party.

5. In addition, ADB may investigate conflicts of interest and abuse, as defined below, as well as other integrity violations enumerated and defined in the IPG:
   (i) A "conflict of interest" is a situation in which a party has interests that could improperly influence a party's performance of official duties or responsibilities, contractual obligations, or compliance with applicable laws and regulations. To the extent that conflicts of interest may provide an unfair competitive advantage or compromise the integrity of financial and governance systems, conflicted persons and entities must be excluded from participating in relevant program activities.
   (ii) "Abuse" is theft, waste, or improper use of assets related to an ADB-related activity, either committed intentionally or through reckless disregard.

[25] ADB. 1966. *Agreement Establishing the Asian Development Bank*.
[26] ADB may support a part (or a slice) of a government program or the entire government program through RBL. The program or the part that is supported by the RBL is referred to as the RBL program.

C. Developing Member Country's Actions to Prevent Fraud, Corruption, and Other Integrity Violations in Results-Based Lending for Programs

6. Unless otherwise agreed in writing by the DMC and ADB, the DMC will take timely and appropriate measures to

(i) ensure that the program is carried out following these guidelines;
(ii) avoid conflicts of interest in the program;
(iii) prevent fraud, corruption, and other integrity violations from occurring in the program, including adopting, implementing, and enforcing appropriate fiduciary and administrative practices and institutional arrangements to ensure that the proceeds of the loan and grant are used only for the purposes for which the loan and grant was granted;
(iv) promptly inform ADB of allegations of fraud, corruption, and other integrity violations found or alleged related to a program;
(v) investigate allegations of fraud, corruption, and other integrity violations and report preliminary and final findings of investigations to ADB;
(vi) respond to, mitigate, and remedy fraud, corruption, or other integrity violations that are found to have occurred in a program and prevent its occurrence;
(vii) cooperate fully with ADB in any ADB investigation into allegations of fraud, corruption, and other integrity violations related to the program, and take all appropriate measures to ensure the full cooperation of relevant persons and entities subject to the DMC's jurisdiction in such investigation, including, in each case, allowing ADB to meet with relevant persons and to inspect all of their relevant accounts, records and other documents and have them audited by or on behalf of ADB; and
(viii) ensure that persons or entities sanctioned or suspended by ADB do not participate in RBL programs in violation of their sanction or suspension.

D. ADB's Actions to Prevent Fraud, Corruption, and Other Integrity Violations in Results-Based Lending for Programs

7. Unless otherwise agreed in writing by the DMC and ADB, ADB will:

(i) inform the DMC of credible and material allegations of fraud, corruption, and other integrity violations related to a program, consistent with ADB's policies and procedures;
(ii) have the right to investigate allegations, following the IPG, independently or in collaboration with the DMC, including, in each case, meeting with relevant persons, and inspecting all of their relevant accounts, records, and other documents and having them audited by or on behalf of ADB;
(iii) inform the DMC of the outcome of any investigation, consistent with ADB policies and procedures;
(iv) have the right to impose sanction and other remedial action on any individual or entity for engaging in practices defined above, or to suspend any individual or entity during the course of an investigation, following ADB's policies and procedures; sanctions and suspensions may result in that party's exclusion from participating in an RBL-financed activity or any other ADB-related activity indefinitely or for a stated period of time;[27]
(v) assess ways to respond pursuant to the Anticorruption Policy and other ADB policies and procedures, and may refer the case to appropriate authorities of a concerned DMC, if investigative findings indicate that a government official has engaged in fraud, corruption, and other integrity violations related to a program; and

[27] Pursuant to ADB's Investigation and Enforcement Framework (2024, as amended from time to time), if a sanctioned party has an ongoing contract financed by ADB, the debarment or suspension may not affect existing contractual obligations. However, any contract variation must be endorsed by OAI to ensure that a contract variation involving a sanctioned or suspended party is not an attempt to circumvent the sanction.

(vi) recognize sanctions determined by other multilateral development banks in accordance with the Agreement for Mutual Enforcement of Debarment Decisions.