Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 15-Mar-2018 | Report No: PIDISDSA23811

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Sri Lanka	P163721	Sri Lanka: Primary Health Care System Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	12-Mar-2018	31-May-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Democratic Socialist Republic of Sri Lanka	Ministry of Health, Nutrition and Indigenous Medicine	

Proposed Development Objective(s)

The project development objective is to increase the utilization and quality of primary health care services, with an emphasis on detection and management of non-communicable diseases in high-risk population groups, in selected areas of the country.

Components

Implementation of the PHC Reorganization and System Strengthening Strategy
Project Implementation Support and Innovation Grants
Contingency Emergency Response Component
Front End Fee
Reimbursement of the Project Preparation Advance

Financing (in USD Million)

Financing Source	Amount
Asian Development Bank	40.00
Borrowing Agency	4,219.00
International Bank for Reconstruction and Development	200.00
Total Project Cost	**4,459.00**

Environmental Assessment Category

C - Not Required

Decision

The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **Sri Lanka is a Lower Middle-Income country with a GDP per capita of USD 3,835 in 2016 and a total population of 21.2 million people.** Since the end of the 26-year civil war in 2009, Sri Lanka's economy has enjoyed a rapid growth at an average rate of approximately 6.2% between 2010-2016, reflecting a peace dividend and a determined policy thrust towards reconstruction and growth; although there were some signs of a slowdown in the last three years. The economy is transitioning from a previously predominant rural-based economy towards a more urbanized economy oriented around manufacturing and services. Social indicators rank among the highest in South Asia and compare favorably with those in middle-income countries. The current Government that came to power in 2015 envisions promoting a globally competitive, export-led economy, with an emphasis on governance and inclusion.

2. **The country has made significant progress in its socio-economic and human development.** The country comfortably surpassed most of the Millennium Development Goal targets set for 2015 and was ranked 73rd out of 188 countries in Human Development Index in 2015. Economic growth has translated into shared prosperity with national poverty headcount ratio declining from 15.3 percent in 2006/07 to 4.1 percent in 2015/16. Extreme poverty is rare and concentrated in some geographical pockets; however, a relatively large share of the population subsists on little more than the poverty line.

Sectoral and Institutional Context

3. **Sri Lanka's health system has a track record of strong performance.** This is demonstrated by almost universal coverage of Maternal and Child Health (MCH) services, infectious disease control and much better MCH outcomes than would be predicted by its income level. In 2015, the country's under-5 mortality stood at 9.6 per 1,000 live births while maternal mortality ratio was 30 per 100,000 live births (WDI, 2015). The country is also close to eliminating communicable diseases such as malaria, polio, tetanus, and measles. But challenges in malnutrition remain, especially in the estates sector. Life expectancy at birth increased from 70 in 1990 to 75 in 2014 and compares favorably with both the 2014 average for South Asia (68) and countries in Sri Lanka's income group (67) (WDI, 2015).

4. **Now, the country's main health sector challenge has become the need to address the ongoing demographic and epidemiological transition.** The share of the population over 60 will nearly double over the 25-year period (2015 to 2040), to over one-quarter of the population, with implications for the country's epidemiological profile.[1] Non-communicable diseases (NCDs) already account for 81

[1] Its population is aging at a faster rate than the average for lower-middle-income countries and the average for South Asia.

percent of total deaths and 77 percent of disability-adjusted life years (DALYs), a summary measure of years of life lost to death and disease (IHME, 2017). Because of years lived with morbidity and disability, healthy life expectancy at birth in Sri Lanka in 2012 was 10 years lower than life expectancy at birth (75) (WHO, 2015). This is partly a result of non-communicable diseases.

5. **Despite a strong MCH services base, there is limited capacity in the primary care system to provide comprehensive primary health care, making the country less prepared for the changing burden of diseases and potential health emergencies.** First, because of supply shortages and inefficient distribution, the frontlines have a critical gap in physicians to help manage chronic NCDs and other forms of curative care. While the size of the country's health workforce is broadly like other Asian countries (with almost one doctor and two nurses per 1,000 population), it falls far short of levels in advanced health systems, especially in some staff categories such as medical laboratory technologists.[2] Moreover, the geographic distribution of existing health care workers is skewed towards urban areas (especially Colombo and Kandy districts) and higher levels of care. Furthermore, Medical Officers' training is focused on MCH services and communicable disease management rather than the prevention and management of NCDs. Second, primary care facilities are characterized by limited availability of laboratory services, drugs and equipment for NCD screening. Until recently, many essential NCD drugs could not be dispensed at lower levels of care. While this has changed lately, these facilities dispense these drugs for only two weeks, needlessly requiring patients to visit facilities twice a month. Underinvestment in lower levels of care is also contributing to a growing need to pay out-of-pocket for drugs and lab tests even when using public facilities. Consequently, patients bypass these under-funded lower levels of care[3] and go directly to larger hospitals, leading to an under-use of the primary care institutions and overcrowding at secondary and tertiary care institutions.[4]

6. **Issues in supply chain management of drugs could detract utilization of NCD care at PHC facilities and compromise health sector objectives.** As indicated earlier, the unavailability of drugs in public PHC facilities is one reason for the rising burden of out-of-pocket payments. Several supply chain management issues contribute to this, including limitations in planning and estimation as well as inefficient procurement processes at the central level. In 2015, Sri Lanka launched the Medical Supplies Management Information System (MSMIS) which is being used by higher level medical institutions to request medical supplies and to forward consumption related data to the Medical Supplies Division.[5] Primary Medical Care Institutions (PMCIs) are yet to utilize this technology. Fully utilizing this technology across the health sector has the potential to yield big savings and help the health sector achieve its objectives. Untimely stock reviews, shortage of storage space, poorly maintained storage facilities altogether compromise quality and lead to waste and stock-outs. This also leads to 'urgent procurement' as officials attempt to bridge the resulting gap between

[2] The country has relatively few cardiologists, oncologists and geriatricians.

[3] Most of the government's low level of health spending goes to higher level facilities -- only 15 percent is spent on primary care.

[4] In 2012, outpatient clinic visits were divided roughly equally across the primary, secondary, and tertiary-level facilities in the health system, whereas, ideally, 70 to 80 percent of all care should have been delivered at the primary care level, 10 to 15 percent at the secondary level, and the remaining (most advanced) cases treated at the tertiary level.

[5] But even those who currently utilize MSMIS currently use it only for submitting estimates and to make requisitions.

institutional demand and main order supply. Strengthening data collection in MSMIS will aid better forecasting and help reduce the inefficiency in 'urgent procurement'. The 'standard pharmaceutical procurement' procedure itself can be improved by reducing the lead time in various steps of procurement. A recent NCD drugs supply chain assessment in the health sector showed lead times of up to 18 months, which can be shortened by implementing framework contracts, and improving systems and infrastructure.

7. **The curative side of the public health system is not well-suited to dealing with the overwhelming burden of NCDs which require coordinated and people centered care.** Currently, primary level facilities do not routinely initiate NCD care. While opportunistic NCD screening of women seems to happen during reproductive health care visits, adult men are left oblivious to their health circumstances. As such, the absence of a routine initiation of NCD care appears to particularly harm working adult men. Although 'healthy lifestyle centers' (HLCs) were recently introduced to help address NCDs, the population has yet to embrace this model. Each year only about 10 percent of the adult population visits an HLC. The curative sector needs to adopt the successful approaches of the preventive Medical Officer of Health (MOH) sector, such as community outreach by public health nurses and identification and follow-up of patients who are at risk. Although the health system has been largely effective in the provision of episodic and curative care, it does not provide continuous and coordinated care. A strong doctor-patient relationship is crucial to the effectiveness of NCD treatments and to enable patients become partners in managing their health. Currently, patients cannot choose between doctors in public facilities but are assigned to whomever is available during their visit. Doctor-patient familiarity can be established more easily in PHC facilities as these are closer to where the patient lives.

8. **Although still the dominant source of care (largely due to its free provision), the public sector is increasingly being supplemented by a thriving private sector due to capacity limitations and differences in 'consumer experience'.** The public health system provides nearly 100 percent of the country's preventive services and as much as 90 percent of inpatient services. However, despite accessible and freely provided government services, outpatient care is equally split between public and private providers.6 Gaps in the supply of diagnostic and laboratory services (especially at lower levels of public care) and differences in 'consumer experience' are reasons for the relevance of the private sector in Sri Lanka's context. These private providers of laboratory and diagnostic services provide these services without an effective quality control. Private practices, staffed for the most part by off-duty government doctors7, are preferred by the better-off for their superior 'consumer experience', specifically a) more convenient opening hours, b) much shorter waiting times (an outpatient visit to a government hospital typically lasts at least twice as long as a consultation with a private doctor), c) presence of provider choice (in the government sector patients are typically

[6] Households are on average just 2.5 kilometers from a maternity clinic, 4 kilometers from a government dispensary, and 6.5 kilometers from a hospital and about 93 percent of the population is within 15 kilometers of a hospital.

[7] The public sector employs more than 90 percent of all doctors and nurses, consisting of nearly 120,000 staff across the country (Department of Census and Statistics, 2013). There are 87 medical officers, 202 nurses, and 42 midwives per 100,000 population (Ministry of Health, 2015). As of 2011, the private sector's share in total number of hospitals and hospital beds was 17 and 6 percent, respectively (Rannan-Eliya et al. 2012).

assigned to whomever is available when they reach the front of the queue), and d) more responsive/attentive staff. Reconfiguring service delivery to better manage chronic NCDs and empowering citizens to actively engage in and interact with the management of public health services appear to be necessary steps to narrow the existing gap in 'consumer experience'.

9. **The health system's ability to ensure provision of tailored and coordinated services hinges on improvement of the existing health information systems.** People with NCDs can experience obstacles at various stages of care from getting a diagnosis, being directed to care, and starting and adhering to treatment. Ensuring the continuum of care is vital as all of these stages affect the chance of disease control. This would be possible if the health information system allows to uniquely identify patients, track them overtime and share patient information across providers and databases. The absence of electronic medical information system makes it difficult to track patients across levels of care and hinders provision of patient-centered coordinated care. In this regard, the recent move by HLCs to provide patients with health records is commendable and should be scaled up. This will facilitate the provision of coordinated care as people seek care from both public and private providers and different levels within the public system.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective is to increase the utilization and quality of primary health care services, with an emphasis on detection and management of non-communicable diseases in high-risk population groups, in selected areas of the country.

Key Results

10. The following results indicators will be used to measure progress towards the achievement of the two key elements – utilization and quality of PHC services – contained within the PDO:

    a. The number of women at age 35 and at age 45 years who are screened for cervical cancer at public health facilities (utilization);

    b. The percentage of screened adults (disaggregated by men and women) with high risk for non-communicable diseases who are registered and actively followed-up at PMCIs (utilization); and

    c. The number of PMCIs with the necessary capacities to provide more comprehensive and quality care (quality).

11. By completion, the Project is expected to achieve an increase of at least 62% in the number of women screened for cervical cancer; the registration and active follow-up of at least 25% of the adults with high risk for a severe or catastrophic NCD event at the primary health care level in the communities supported by the project; and the standardization, upgrade and maintenance of quality of PMCIs

serving about 50% of the communities in Sri Lanka. All the while, the Project is designed to support the achievement of this objective by strengthening the Sri Lanka PHC system and preparing it for a more integrated, coordinated, and patient-centered service delivery.

D. Project Description

12. The Project supports the implementation of the government's new strategy to strengthen PHC. Implementation will take place in each of the 9 provinces of the country but in selected communities of those provinces. This will be done in a phased approach scaling from 50 communities in year 2 to 550 communities by year 5. The selected communities where the project will initially be implemented are expected to be in the rural or peri-urban areas. The primary beneficiaries of the project will be the users of public primary health care institutions in the selected communities[8] of the country.

13. **The Project will be implemented over a period of 5 years and has three components.**

Component 1. Reorganizing PHC Strategy Implementation (US$185.00 million Bank Financing)

1. **Component 1 will support the MoH and the provinces to implement the PHC Reorganization Strategy through the routine sector planning and budget execution systems.** For this component, a total of US$185 million has been allocated for disbursement upon achievement of disbursement linked results (DLRs), which are organized by five results areas. Some of the DLRs (DLR 1.1, 1.2, 1.3, 1.4 2.1 7.1 and 7.2 are time bound, given that the achievement of these DLRs is critical for successful implementation of subsequent activities (Table 1). The five results areas include four actionable areas focused on changes to be implemented and one intermediate outcome area demonstrating improved service delivery and utilization.

2. **The first Results Area is the definition of PHC policy and standards to support implementation.** This will provide the overall strategic focus for PHC reorganization, as well as detailed policies, standards and implementation guidelines. It will provide the necessary foundation for provincial level implementation that will be supported under Results Area 2. There are two DLIs in this Results Area: i) endorsement by the MoH and by the Provinces of policies and standards for reorganizing PHC system and ii) adoption and update by MoH of clinical protocols for selected health conditions. The allocation of funds across MoH and Provinces is given under Table 1.

3. **The second Results Area is the strengthening of PMCI *capabilities* and *services* for more comprehensive and quality care.** There are two DLIs under this Results Area: i) PMCIs have required capabilities for providing comprehensive and quality care and ii) PMCIs provide enhanced patient friendly services.

4. **The third Results Area relates to the development of supportive systems to facilitate improved PHC delivery, with a focus on NCDs.** This Results Area will support two systems that are determined essential for the ability of PMCIs to provide improved patient care, particularly for NCD patients. The first system is the definition, development and scaling up of health information systems that will

[8] The communities may be the same as municipality boundaries or they may not. It will depend on the empanelment process.

facilitate coordinating patient care over time using personal health records and eventually, a web-based referral network. The second system is the improved efficiency of the national procurement and supply chain management system to ensure timely, appropriate and efficient supply of drugs. There are two DLIs under this Results Area: i) personal health are used to coordinate patient care overtime and through the referral chain and ii) procurement and supply chain management efficiency is increased. The latter includes shortening procurement lead times, roll-out of the Medical Supplies Management Information System (MSMIS) to the PMCI and reducing urgent procurement of medical supplies.

5. **The fourth Results Area focuses on the development of empowering and responsive health system (i.e. to the demands of the population).** It will strengthen the engagement between the public health care system and the citizens. The DLI under this Results Area is the operationalization of community engagement mechanisms for health sector, including grievance redressal.

6. **The fifth Results Area relates to the increase in utilization of PHC Services, with a focus on NCD detection and active follow-up.** This Results Area ensures the focus on the service delivery progress that is expected to be achieved following the implementation of actionable results areas (1-4). There are two DLIs under this Results Area: i) women aged 35 and 45 are screened for cervical cancer at a network of public health facilities and ii) adults determined to have high-risk for NCDs registered and actively followed up at PMCIs.

Table 1. Disbursement Linked Indicators

	Amount allocated to MoH-level results	Amount to provincial-level results	Results Area
DLI 1. Endorsement by the MoH and by the Provinces of policies and standards for reorganizing PHC system	US$3,850,000	US$5,400,000	Results Area 1
DLI 2. MoH adopts and updates clinical protocols for selected health conditions	US$9,250,000	-	
DLI 3. PMCIs have required capabilities for providing comprehensive and quality care	-	$33,050,000	Results Area 2
DLI 4. PMCIs provide enhanced patient-friendly services	-	$16,650,000	
DLI 5. Personal health records are used to coordinate patient care overtime and through the referral chain	$5,060,000	$15,290,000	Results Area 3
DLI 6. Procurement and supply chain management efficiency is improved	$24,050,000	-	
DLI 7. Community engagement mechanisms for health sector operational, including citizen feedback mechanism and community committees at the PMCIs	$7,275,000	$20,475,000	Results Area 4
DLI 8. Women aged 35 and 45 are screened for cervical cancer at a network of public health facilities	$1,075,000	$21,125,000	Results Area 5

DLI 9. Adults determined to have high-risk for NCDs registered and actively followed up at PMCIs	$2,950,000	$19,250,000	

Component 2. Project Implementation Support and Innovation Grants (US$14.00 million Bank Financing)

7. The objective of the second component is to provide support to the MoH and through the MoH to the provinces for direct investments necessary to facilitate the implementation of the PHC reorganization strategy. The activities are grouped into four subcomponents. Subcomponent 2.1 will provide support for project management, coordination, and routine project monitoring. Subcomponent 2.2 will provide support for the results verification as well as household and facility surveys that are deemed appropriate for assessing the health needs, demand, utilization and quality of basic health service delivery. Subcomponent 2.3 will provide capacity building at the central and provincial level aimed at building strategic, managerial and technical capacity for the benefit of the health sector. Subcomponent 2.4 will support service delivery innovations through a competitive small grant mechanism.

Component 3. Contingent Emergency Response Component (Project Costs US$0 million of which Bank Financing US$0 million)

8. The objective of this component, with a provisional zero allocation, is to improve the country's response capacity in the event of an emergency, following the procedures governed by OP 10.0, paragraphs 12-14, regarding "Projects in Situations of Urgent Need of Assistance or Capacity Constraints." In anticipation of a natural or man-made disaster or crisis, the contingent emergency response component (CERC) provides the country with rapid reallocation of undisbursed funds of component 2 following an emergency to address immediate financing needs to mitigate, respond and recover from the potential harmful consequences arising from such emergency.

E. Implementation

Institutional and Implementation Arrangements

9. The Project's institutional and implementation arrangements were agreed after wide consultation with the involved organizations, including the Ministry of Health, Nutrition and Indigenous Medicine (MoH), the Department of National Planning (NPD), the Department of External Resources (ERD), the Department of Project Monitoring and Management (PMM) team and Ministry of Provincial Councils and Local Governments (MoPCLG).

10. The Ministry of Health, Nutrition and Indigenous Medicine (MoH) is responsible for setting policy, standards and updating protocols for strengthening the Primary Health Care (PHC) system with the aim of streamlining access to quality people-centered health services, increasing efficiency of these services, and ensuring a continuum of primary care for people throughout their life cycles. It is also responsible for monitoring and evaluating the performance of PHC services, fully utilizing data at the

population level and facility level. As such, the MoH will be the primary organization from the Government of Sri Lanka responsible for implementing the Project.

11. The Ministry of Provincial Councils and Local Governments (MPCLG) provides oversight and coordination for provincial level activities. Nine provinces are responsible for adopting protocols, and planning and implementing the PHC reorganization per the set standards. Therefore, the MoH will be working closely with the MPCLG, including in the Project Management structures. The Provinces will receive funds through and report to the MPCLG.

12. A Project Steering Committee (PSC) will be established and will meet at least annually to provide oversight, monitor the implementation progress, and provide overall guidance. The Committee will be chaired by the Secretaries of the MoH and MPCLG. The additional members will consist of: Secretary Finance Commission, 9 Provincial Secretaries and others as per Management Circular 1/2016.

13. Under the Ministry of Health, there will be a specific Component 2 review committee under the leadership of the Director General of Health which will be responsible for approving the budget and activity plans, approving the capacity development plan and the operational guidelines for the innovation grants, review progress and approve any high-level contracts or expenditures.

14. A Project Management Unit (PMU) has been established and will consist of at least the following key positions: Project Director, Deputy Project Directors (MoH and MPCLG), Project Officers, Procurement Specialist and Officer, FM Specialist, Accountants (MoH and MPCLG), Internal Auditor, Monitoring and Evaluation Officers (MoH and MPCLG), Communication and Information Management Officers, Provincial Project Managers and Officers, and Regional Project Coordinators with other relevant administrative and technical support staff. The staffing structure will be reviewed and updated from time to time to ensure that the staffing is consistent with the workload and requirements.

15. The MoH will submit to the Bank for approval Annual Work Plans and Budgets for Component 2. A midterm review of the project will be conducted by the second quarter of 2021.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

While the project will be national in scope, physical investments, such as infrastructure, are not currently envisioned and no other forms of goods, works or services will be procured via the project. Therefore, no environmental or social impacts are anticipated due to project interventions. The environmental assessment category will be "C" and no further assessment will be required.

G. Environmental and Social Safeguards Specialists on the Team

Bandita Sijapati, Social Safeguards Specialist
Mokshana Nerandika Wijeyeratne, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	No	The proposed project design predominantly includes soft interventions aimed at systemic improvements to health service delivery. No physical investments, such as infrastructure are envisioned at this stage and no other forms of goods, works or services will be procured via the project. Therefore, no major environmental impacts are anticipated due to project interventions. The environmental assessment category will be "C" and no further assessment will be required.
Natural Habitats OP/BP 4.04	No	Project interventions are not expected to have any significant impacts on the natural habitats in relation to the proposed project activities.
Forests OP/BP 4.36	No	No impacts due to the proposed project are envisioned on forests.
Pest Management OP 4.09	No	Not applicable as no project interventions are made where significant use of pesticides and other such substances are utilized.
Physical Cultural Resources OP/BP 4.11	No	Project interventions do not involve any physical interventions, thus there are not impacts expected any physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	Not applicable since: (i) there is no evidence/information available that establishes the presence of indigenous people in the project area; and (ii) the project does not include any interventions that would lead to adverse impacts on local communities and groups.
Involuntary Resettlement OP/BP 4.12	No	Not applicable since the project design includes systemic interventions that focus on increasing the utilization and quality of primary health care services. Physical investments that require land taking or any civil works, are also not envisaged under the project.

Safety of Dams OP/BP 4.37	No	No dams will be affected via project interventions.
Projects on International Waterways OP/BP 7.50	No	The proposed project activities do not have any impacts on international waterways and therefore this policy is not triggered.
Projects in Disputed Areas OP/BP 7.60	No	There are no disputed areas where project interventions in Sri Lanka and therefore this policy is not triggered.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The project is categorized as Environmental Category C and will not trigger any specific environmental or social safeguard policies. None of the project components will finance physical investments such as the construction of new infrastructure and/or the rehabilitation of existing ones. Project activities will mainly support soft interventions aimed at systemic improvements to health service delivery. Further, no major environmental or social impacts are attributed to any of the project interventions and hence, further environmental or social assessments will not be warranted.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
The project does not involve any physical interventions or other interventions that will have indirect and/or long term impacts anticipated.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
No alternatives have been considered.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
A comprehensive policy and regulatory framework for the conservation of natural resources and environmental management in in existence Sri Lanka. The Central Environmental Authority (CEA) is the key regulatory body that is mandated by the National Environmental Act (NEA) to implement all regulatory provisions outlined in its statutes. All development projects, that fall in to a set of prescribed categories are required to conduct a comprehensive environmental screening and mitigation planning process (EIA or IEE). These processes are largely consistent with the Bank's safeguard policy on Environmental Assessment. With over three decades of experience the CEA demonstrates the technical expertise in evaluating environmental impacts of development projects. However even with an enabling legal environment and abled CEA, field level enforcement of legal instruments and subsequent monitoring of environmental management activities has been very low.

In the context of the project there are no safeguard instruments or actions to be implemented as the project does not involve any physical interventions.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

With its focus on increasing the utilization and quality of primary health care services, including detection and management of non-communicable diseases, adverse impacts on individuals and communities are not expected. Thus, stakeholders and mechanisms for consultation and disclosure on matters relating to safeguards is not required under the project.

B. Disclosure Requirements

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
NA
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
NA

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
NA
Have costs related to safeguard policy measures been included in the project cost?
NA
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
NA
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
NA

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