INTEGRATED SAFEGUARDS DATA SHEET
ADDITIONAL FINANCING

Report No.: ISDSA13035

Date ISDS Prepared/Updated: 11-May-2015

Date ISDS Approved/Disclosed: 11-May-2015

I. BASIC INFORMATION

1. Basic Project Data

Country:	Argentina	**Project ID:**	P154431
		Parent Project ID:	P106735
Project Name:	AF for AR Provincial Public Health Insurance Development Project (P154431)		
Parent Project Name:	Provincial Public Health Insurance Development Project (P106735)		
Task Team Leader(s):	Andrew Sunil Rajkumar,Vanina Camporeale		
Estimated Appraisal Date:	18-May-2015	**Estimated Board Date:**	07-Jul-2015
Managing Unit:	GHNDR	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (90%), Public administration- Health (10%)		
Theme(s):	Health system performance (46%), Child health (18%), Injuries and non-communicable diseases (18%), Gender (18%)		
Is this project processed under OP 8.50 (Emergency Recovery) or OP 8.00 (Rapid Response to Crises and Emergencies)?	No		
Financing (In USD Million)			
Total Project Cost:	260.61	Total Bank Financing:	200.00
Financing Gap:	0.00		

Financing Source	**Amount**
Borrower	60.61
International Bank for Reconstruction and Development	200.00
Total	260.61

Environmental Category:	B - Partial Assessment
Is this a Repeater project?	No

2. Project Development Objective(s)

A. Original Project Development Objectives – Parent

The PDOs are to: (a) increase utilization and quality of key health services for the uninsured target population; and (b) improve institutional management by strengthening the incentives for results in Participating Provinces and among Authorized Providers.

B. Proposed Project Development Objectives – Additional Financing (AF)

3. Project Description

3. Project Description

The proposed AF would continue to finance some of the activities under the three components of the parent Project, introducing some new activities and/or scaled up activities, as described below:

A. New Activities under Component 1 of Parent Project (Supporting Provincial Public Health Insurances)

i. Capitation payments for adult men (US$52 million), to be financed under Category 3 of AF LA: Adult men aged under 65 without formal health insurance would be included as an additional eligible population sub-group for capitation payments from the National Ministry of Health (MSN) to the Provincial Ministries of Health (MSP) supporting general health interventions (GHIs) with a specific health benefit plan defined for this population sub-group (Nomenclador Unico-C).

ii. Capitation Pilots (US$2 million), to be financed under new Category 6 of AF LA: This would support pilot testing of different approaches to achieve effective Universal Health Coverage (UHC). The pilots would continue to be based on the concept of provincial public health insurances with results-based capitation payments testing different modalities for payment mechanisms from Provinces to health service providers.

B. Scaled-Up Activities under Component 1 (Supporting Provincial Public Health Insurances)

i. Capitation payments for GHIs for beneficiary groups already covered under Parent Project – uninsured children, youth and adult women aged under 65 (US$75 million), to be financed under Category 3 of AF LA. To the extent possible, a single unique capitation payment amount would be calculated for all groups (existing beneficiary groups as well as the new group of adult men), in effect treating them all as part of a single risk pool.

ii. Selected health interventions for catastrophic diseases (SHICD) (US$8 million), to be financed under Category 4 of AF LA.

C. Scaled-Up Activities under Component 2 (Institutional and Management Strengthening of the National and Provincial Ministries of Health)

The AF would finance the same activities that were already supported by Component 2 of the Parent Project, under Categories 2 and 5 of the AF LA, with an emphasis placed on certain specific sub-activities as follows:

i. Sub-Component 2.1: Improving the institutional capacity of national and provincial Ministries of Health (US$5 million): This sub-component would provide additional financing for consultant TA/

training services for the MSN and participating MSPs, mainly to support: (a) development of integrated information systems, instruments, and skills to run the PHIP – including administrative and billing data systems and the promotion of electronic medical records, new contracts and payment systems (with the service providers), (b) outreach and service delivery strategies and mechanisms for rural and indigenous peoples and other excluded populations (promoting community participation, user rights, and services sensitive to appropriate cultural services for the inclusion of indigenous populations; (c) studies that would help MSN and the MSPs to devise policies for the achievement of effective UHC, including mechanisms for integrating other public health programs with risk pooling elements – especially Incluir Salud - into the framework of the Sumar Program; and (d) improved communication strategies for disseminating information about health plans, changing behavior among beneficiaries and staff, and promoting social participation.

ii. Sub-Component 2.2: Supporting management, monitoring and evaluation (US$20.5 million). This sub-component would provide additional financing for the PCU and Provincial Health Insurance Unit (PHIU) contractual staff, consulting services, operating costs, office equipment, and in-country travel required for Project management, as well as financial management and procurement services. In addition, it would finance the costs of the independent technical audit, as well as the costs of Project evaluation activities, including impact evaluations and end-of-Project evaluations.

D. Scaled-Up Activities under Component 3 (Building capacity of the National and Provincial Ministries of Health to deliver services)

AF of US$ 37 million would be provided, under Category 1 of the AF LA, to finance goods to support improvements in the supply capacity of the public health care system at the MSPs and MSN – mainly to complete the IT and medical equipment needs for improved Program execution, including the needs related with the newly eligible population group (uninsured under-65 adult men).

4. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The Project general location is nationwide. Based on the information available at this stage, the Project would not involve natural habitats, forests or cultural property. All Project investments are planned to take place in existing infrastructure.

5. Environmental and Social Safeguards Specialists

Isabel Tomadin (GSURR)

6. Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The parent Project was classified as Category C given the limited environmental impact expected from Project activities, especially those related to the coverage of immunization services and congenital heart disease interventions. However, based on the findings of the Environmental Assessment carried out in March 2015, the Project has triggered the OP/BP 4.01 on Environmental Assessment due to the potential environmental concerns around: (i) the handling of health care waste resulting mainly from the handling of health care waste resulting mainly from the inclusion of new high-complexity

		interventions within the Project's benefit plan, as well as from the expansion of already-included high-complexity health interventions to new sub-groups of beneficiaries; and (ii) the disposal of old IT equipment. Therefore, the Project's Environmental Category was upgraded from C to B.
Natural Habitats OP/BP 4.04	No	The ESMF includes screening criteria to prevent the potential storage or disposal of medical or hazardous waste in areas that could lead to a potential degradation or impact natural habitats.
Forests OP/BP 4.36	No	The Project would not affect the health or management of forests nor would affect any forest dependent communities.
Pest Management OP 4.09	No	The Project would not finance the procurement of pesticides nor would support activities leading to the increased use of pesticides or other hazardous chemicals.
Physical Cultural Resources OP/BP 4.11	No	No modifications would be made to existing buildings of historical or cultural importance. The ESMF includes screening criteria to ensure that no activities would be eligible for financing if it affects Physical Cultural Resources.
Indigenous Peoples OP/ BP 4.10	Yes	For social safeguards, the OP/BP 4.10 on Indigenous Peoples policy was triggered under the parent Project, and an Indigenous Peoples Planning Framework (IPPF) was developed and published in 2010. In order to reflect the scaling-up of Project's activities, the IPPF was updated and re-consulted on April 9th, 2015. Disclosure of IPPF at the MSN webpage and the World Bank Group external website took place on April 23th and May 7th, 2015, respectively. A draft of the updated IPPF was delivered to the representatives of indigenous peoples from the provinces where Indigenous Peoples are present one week prior to the consultation. Changes to the IPPF are mainly related to the expansion of the eligible population to incorporate uninsured men under 65 and the inclusion of selected health interventions for this group within the Project benefit plan. The objective of the updated IPPF continues to be to promote indigenous peoples' access to Project benefits and adapt the services in a culturally appropriate manner.
Involuntary Resettlement OP/BP 4.12	No	The Project would not support any activity requiring the involuntary taking of land or restrictions in access to protected areas.
Safety of Dams OP/BP 4.37	No	The Project would not support the construction or rehabilitation of dams.

Projects on International Waterways OP/BP 7.50	No	The Project would not finance activities involving the use or potential pollution of international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The Project would not be implemented in disputed areas.

II. 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 scaling-up of Project's activities would have a positive social impact, as it supports Argentina in its effort strategy towards achieving universal health coverage by expanding the eligible population and health services covered by the Provincial Health Insurance Project (PHIP). The current eligible population includes uninsured children, youths and women, and would be expanded to introduce uninsured men under 65. Therefore, the benefit plan would also be adjusted to include general health interventions for this group.

Indigenous People

The OP/BP 4.10 on indigenous peoples was triggered by the parent Project because several communities of indigenous peoples are present in several of the provinces that participate in the Project. For the parent Project an Indigenous Peoples Planning Framework (IPPF) was developed and disclosed in 2010. In order to reflect the scaling-up of Project's activities, the IPPF was updated and re-consulted on April 9th, 2015. A draft of the updated IPPF was delivered to the representatives of indigenous peoples from the provinces where Indigenous Peoples are present one week prior to the consultation. Disclosure of IPPF at the MSN webpage and the World Bank Group external website took place on April 23th and May 7th, 2015, respectively. The objective of the updated IPPF continues to be to promote indigenous peoples' access to Project benefits and adapt the services in a culturally appropriate manner. The project would continue fostering that screening, enrollment, and services are provided in ways that meet the special needs of these groups. Changes to the IPPF are mainly related to the expansion of the eligible population to incorporate uninsured men under 65 and the inclusion of selected health interventions for this group within the Sumar Program's benefit plan.

Implementation arrangements for the Indigenous People safeguard would remain the same as under the parent Project. The protocol for implementing the IPPF in each community focuses on four areas: (a) conducting social assessments and initial consultations to present the Project to the communities: the initial screening of beneficiaries includes a needs assessment through free consultations on the socio-economic and cultural characteristics affecting the community's health and on its epidemiological profile and main health care concerns; (b) enrolling beneficiaries, which includes screening indigenous beneficiaries (done by members of their community) and training health teams to complete those parts of the enrollment form that refer to ethnic variables; (c) disseminating information and creating a communications scheme, which would include producing materials in the indigenous languages and devising ways to hold consultations and address grievances at the national and provincial levels; and (d) training health teams on issues related to inter-cultural health practices and health education.

The IPPF requires each Province to prepare an Indigenous Peoples' Plan (IPP) that includes culturally appropriate mechanisms to reach this group. IPPs developed under the parent Project

would have to be updated, re-consulted and re-disclosed to reflect the new eligible population group as well as the new health services covered by the Project. This would be done as part of the update of the Annual Performance Agreements to be signed between each participating province and the MSN. Provinces would not be able to start a new activity not covered under the parent project before updating and consulting the IPP. The scope of each IPP depends on specific needs in each province and on the level of commitment and available financing. The PCU's Technical Assistance and Training area would continue being responsible for monitoring the screening, certification, and enrollment in indigenous areas, and for launching the IPPs in the provinces. Also, this area would continue supervising the implementation of the IPPs, along with the following activities: promoting and collaborating with other health programs to develop and strengthen health policies for indigenous peoples and health teams, including health care practices consistent with the needs of indigenous peoples (e.g. visits of health agents to rural and indigenous areas), full medical check-ups, field screening of indigenous people at high risk to confirm diagnosis and treatment, and workshops covering therapeutic and traditional practices among indigenous peoples.

Environment

The OP/BP 4.01 on the Environmental Assessment is triggered due to the scaling-up of Project's activities. The parent Project was classified as Category C given the limited scope and severity of environmental impact expected from Project activities, especially those related to the coverage of immunization services and congenital heart disease interventions. However, based on the findings of the Environmental Assessment carried out in March 2015, the Project has triggered the OP/BP 4.01 on Environmental Assessment due to the potential environmental concerns around the: (i) handling of health care waste resulting mainly from the inclusion of new high-complexity interventions within the Project's benefit plan, as well as the expansion of already included high-complexity health interventions to new sub-groups of beneficiaries; and (ii) disposal of old IT equipment Since the start of the Project, new high-complexity interventions that have been incorporated into the Project's benefit plan include interventions to address high-risk pregnancies, high-complexity neonatal services and congenital heart surgeries for children under 6. In 2014, the benefit plan was expanded to cover congenital heart surgeries for youth aged under 20, as well as congenital malformations. Therefore, the Project's Environmental Category was upgraded from C to B because -while there are potential environmental impacts from IT hardware and medical waste disposal- they present a low to moderate risk and are readily manageable with known technology.

Implementation arrangements for this safeguard would remain the same as under the parent Project. Under the parent Project it was envisioned that environmental issues would be supported by the Environmental Unit of the Second Essential Public Health Functions and Programs (EPHF) II Project (P110599), which has a proven Environmental and Social Management Framework (ESMF) that focuses on health care waste management nationwide, including electronic waste. This ESMF has recently been updated to include the design of an integrated management system of electrical and electronic waste equipment. This approach was found appropriate for the Project's scaling-up. Therefore, the Project would use an ESFM that was built upon EPHF II experience to address any potential environmental issue generated by the PHIP, and the "Guide to Rational Vaccine Waste Management" developed under the H1N1 Prevention and Management of Influenza Type Illness (P117377) Project. The ESMF was slightly adjusted to include a satisfactory description of the Project and was disclosed both at the MSN and the World Bank Group external webpage on April 24th and May 7th, 2015, respectively. Activities related to the application of the ESMF would be carried out by the EPHF II Environmental technical staff in

liaison with the Technical Assistance and Training area of the PHIP. Once the EPHF II is completed, the Environmental Unit of the EPHF II will continue working under the Protecting Vulnerable People Against Noncommunicable Diseases Project (P133193) which is planned for Board discussion in June 2015. EPHF II Closing Date is June 30th, 2016.

The Project would leverage EPHF II aim to build and promote health care waste regulations by: (i) using the PHIP's e-Learning platform to disseminate good practices for the management of health care waste, and (ii) expanding the number of hospitals (200 under EPHF II) that apply the "Guide to Self-Diagnosis on Waste Management of Health Care" to include the referral and treatment hospitals and maternities currently under the PHIP. In addition, PHIP's E- Learning platform would be used to deliver the second introductory course on Vaccination developed by the National Directorate of Vaccine-Preventable Disease (DiNaCEI). This course includes a module on safe disposal of health care waste. Overall, the project would keep serving as an additional communications channel for EPHF II environmental management efforts.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

No negative indirect or long term impacts are expected from the activities in the Project areas. Improved health should entail positive benefits for both the human and natural environment.

Indigenous People
This Project would continue benefitting from Argentina's broad experience in the management of IP safeguards, particularly with the EPHF I and II (P090993 and P110599), Plan Nacer I and II (P071025 and P095515), and the current ongoing Project. Under these projects the Government has developed indigenous people frameworks and provincial indigenous peoples plans, which have been found to be well elaborated by different Bank evaluations, and are considered good practice in the region.

Environmental
The ESMF incorporates capacity building and institutional measures for preparation, supervision, and monitoring of the Project from an environmental and social standpoint. Health Care Waste Management Plans may also be utilized based on types of activities. The management of the environmental issues would benefit from the lessons learned from EPHF I & II Project implementation. The Project is fully mainstreamed with EPHF II in the national health waste management and is supporting preparation of the environmental safeguards. Therefore, the project is expected to cause positive environmental impacts at the sectoral level beyond the project implementation period.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

N/A

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.

Indigenous People
The project builds on the experience of the IPPs implemented by 15 provinces where indigenous peoples live (Catamarca, Chaco, Chubut, Formosa, Jujuy, La Pampa, Mendoza, Misiones, Neuquén, Río Negro, Salta, San Juan, Santiago del Estero, Tierra del Fuego, and Tucumán). These Plans were prepared under the Plan Nacer I and II (P071025 and P095515) and updated under this Project. In addition, since the start of the Project five new provinces have triggered the OP 4.10

(Córdoba, Entre Ríos, La Rioja, San Luis and Santa Cruz). These provinces have conducted the IP Social Assessment and prepared IPPs which have been reviewed and found acceptable by the Bank.

The PCU through the Technical Assistance and Training area has adequately monitored the preparation and carrying out of the IPPs and their consultation (21 indigenous people groups have been consulted between 2013 and 2014). IPPs comprises: (i) the development of strategic actions, including training, dissemination and outreach activities mainly on intercultural health service delivery; and (ii) targets to be achieved by health facilities in terms of effective coverage, and delivery of selected health interventions for this group (initial screening to identify at risk indigenous people, and in-field medical checkups). Findings from the PHIP's Mid Term Review (MTR) show that while almost all provinces have successfully carried out the strategic actions included in their IPPs, results in terms of effective coverage lagged behind the Project's target. This situation is also reflected by the low performance of the Project's Intermediate Result (IR) indicator referred to "Proportion of eligible indigenous population with effective coverage" (IR Indicator 2). Although this indicator has improved steadily since the start of the Project, the actual value achieved of this indicator in 2014 is far behind its target value of 20 percent (7 percent compared to 20 percent).

Lessons from Project Implementation. The MTR found that there are several factors that explain this, mainly: (a) cultural barriers that hamper indigenous people's willingness to identify themselves as indigenous at the health facility; (b) limited incentives for provinces to adequately reach out to this group, given the existing incentive structure; and (c) there are methodological difficulties in estimating the size of the eligible indigenous population. With respect to point (a) the difficulty is that indigenous people often have a collective (group) approach towards the use of health services, and do not seem to respond well to the concept of individual or family insurance coverage requiring individual registration. This is compounded by a lack of incentives to identify themselves as indigenous at the health facility, and a fear of being discriminated against by the health facility staff. Regarding point (b), the Sumar Program's Project Coordination Unit (PCU) works with the provinces, through the implementation of the Indigenous People Plans (IPPs), to provide (and encourage the use of) tools that help increase access to health services, especially for this vulnerable group. However, the impact of these activities varies across provinces, and depends very much on the institutional capacity and political will within each province. On point c), methodological difficulties are mainly linked to the approach used to estimate the size of the eligible indigenous population. This estimation was based on data from the 2010 Census which used a sample-based. The selection of samples was guided by the limited and scarce information provided by the National Institute of Indigenous People's Affairs (INAI - Instituto Nacional de Asuntos Indígenas) which maintains registers of indigenous people at the community level. However, a major difficulty is that these data are based on self-reporting of those interviewed as part of the census (which results in many inaccuracies and incomplete information). In addition, those that are considered indigenous by the Sumar Program are those that self-identify as such, while the 2010 Census considers also the ones who are a first-grade descendant of indigenous people. This difference of criteria suggests that the estimated eligible population could be overestimated. Thus, estimations are subject to sample errors and substantial differences of criteria.

In this context, the Sumar Program has launched a new strategy to address the problem of low utilization of health services among indigenous people – concentrating its efforts on 54 priority health facilities. The choice of these health facilities was based on the high proportion of

indigenous people in their catchment areas (totaling 48 percent of the entire population of indigenous people in the country). The strategy involves the carrying out of an action plan that comprises four stages: (i) a diagnostic at the health facility to identify barriers that hinder indigenous people from accessing health services; (ii) the design of a plan for improvement based on the findings of the diagnostic, (iii) implementation of the plan; and (iv) Monitoring and Evaluation of the progress regarding this implementation. Also, prioritized health facilities will be allowed to have a special benefit plan for indigenous beneficiaries with higher unit fees, to help them in their efforts. In addition, the PCU will revise the estimation of the size of indigenous people to address the abovementioned issues.

As a result, performance of this indicator is expected to improve substantially. Even so, the IR indicator 2 current targets are estimated to be too high, and would be lowered. In addition, the following new intermediate result indicator would be added to track progress on the above mentioned action plan: “Proportion of health facilities with a high proportion of indigenous people in their catchment areas that comply with their work plan”.

Environmental
Under EPHF II, 200 hospitals conducted an environmental diagnoses for hospital waste and adopted waste management mechanisms. Argentina has comprehensive national legislation in place to guide health care waste management practices. The team in charge of implementing the ESMF have demonstrated good capacity.
In addition, the PHIP, through its Technical Assistance and Training area, contributed with the disclosure and dissemination of the first introductory course on Vaccination developed by the ProNaCEI (current DiNaCEI) which included a module on "Safe Disposal". Between 2012 and 2014, 1682 health staff completed this training and the "Guide to Rational Vaccine Waste Management" was distributed to vaccination centers.

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

Consultation and participatory evaluation: Under Plan Nacer a User Satisfaction Survey was carried out in 2009, as well as a Qualitative Study which was based on the incentives for and accountability of health providers. The latter showed that the use of resources promoted autonomy in primary care centers and was a key factor in improving the integration between Plan Nacer and Provincial Health Ministries, strengthening the provision of technical assistance regarding management issues at the health care provider level.

Mechanisms were developed under the Project to disseminate information to stakeholders and beneficiaries as a preventive measure and to avoid conflict. Complaints and suggestions follow the channels created at the provincial health ministries. In addition, the PHIP has its own mechanisms for grievance redress through a 0800 phone line of the MSN. This communication channel was started in 2010, not only to address complaints but also to respond to information requests from the Project’s beneficiaries.

In terms of the OP 4.10 on indigenous peoples, the PHIP has benefited from on-going consultations carried out as part of the implementation of the IPPs at the provincial level, and related lessons learned and recommendations have been considered. The IPPF of the PHIP was consulted jointly with the EPHF project two times during July 2nd and 22nd 2010, and was updated on April 9th, 2015.
In terms of environmental issues the main counterpart of the project related with ensuring proper

healthcare waste management are the national and provincial level authorities working on and cooperating with the EPHF and this project. In practice, key stakeholders are the overall staff of the participating health care units, as well as provincial authorities responsible for waste management.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	26-Apr-2015
Date of submission to InfoShop	07-May-2015
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	////
"In country" Disclosure	
Argentina	24-Apr-2015
Comments: http://www.ufisalud.gov.ar/	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	24-Apr-2015
Date of submission to InfoShop	07-May-2015
"In country" Disclosure	
Argentina	24-Apr-2015
Comments: http://www.ufisalud.gov.ar/	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [ ] No [ ] NA [×]
OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes [×] No [ ] NA [ ]
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?	Yes [ ] No [ ] NA [×]
The World Bank Policy on Disclosure of Information	

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] 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?	Yes [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

III. APPROVALS

Task Team Leader(s):	Name: Andrew Sunil Rajkumar,Vanina Camporeale	
Approved By		
Practice Manager/ Manager:	Name: Daniel Dulitzky (PMGR)	Date: 11-May-2015