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

Appraisal Stage | Date Prepared/Updated: 16-Jul-2018 | Report No: PIDISDSA24572

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
St. Lucia	P166783	Saint Lucia Health System Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	17-Jul-2018	27-Sep-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance, Economic Growth, Job Creation, External Affairs and Public Service	Ministry of Health and Wellness, Saint Lucia	

Proposed Development Objective(s)

The development objective is to improve the accessibility, efficiency, and responsiveness of key health services.

Components

Component 1: Design and Implementation of an Essential Benefits Package
Component 2: Strengthening Service Delivery in Support of the Essential Benefits Package
Component 3: Institutional Capacity Building, Project Management and Coordination
Component 4: Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	20.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	20.00

IDA Credit	20.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Saint Lucia is an upper-middle income country which has been challenged by relatively low levels of economic growth and high unemployment in recent years.** The country has a population of 180,000, nearly 30 percent of which reside in Castries Quarter, where the capital (also called Castries) is located. The country is a mountainous island with a tropical, humid climate and ranks high on the United Nations Development Programme's (UNDP) Human Development Index (HDI). Gross National Income (GNI) per capita is US$7,350, life expectancy at birth is 75 years, and the Under-Five Mortality Rate is 14 per 1,000 live births. The country is politically stable, and held national elections in 2016 where a peaceful transition in political power was seen.

2. **Following the 2008 financial crisis, the country has struggled to regain pre-crisis growth levels, while unemployment remains high as does the share of the labor force who are informally employed.** Gross Domestic Product (GDP) growth rates have been below 2 percent in recent years though this is expected to increase to almost 3 percent in 2018. Debt levels continue to remain high and were approximately 67 percent of GDP in 2017. Recent poverty estimates are not available, but a poverty assessment conducted in 2005 found that almost 29 percent of the population live in poverty. Unemployment rates are high at around 20 percent in early 2017. Among the employed, 57 percent earn less than EC$1,500 (US$555) per month while approximately 46 percent of the population is classified as not having decent work. There is a large share of employment in the informal sector, mainly in small and microbusinesses.

3. **The economy has limited diversity and is heavily reliant on tourism.** An upward trend in tourist arrivals has been observed in Saint Lucia, with the tourism sector estimated to have contributed up to 40 percent of GDP and 47 percent of employment in 2016 through direct, indirect and induced contributions. These figures are projected to increase going forward, reaching over 50 percent of GDP and 60 percent of jobs by 2027. However, these figures may be affected by extreme weather events.

4. **The country faces challenges in the form of natural disasters and climate change, which may have health implications.** Hurricanes are the most threatening natural hazard facing the country, posing significant destructive potential due to high wind speeds, heavy rains, and powerful storm surges that produce flooding. Saint Lucia was badly affected by Hurricane Tomas in 2010, which resulted in losses of up to 43 percent of GDP and saw fourteen deaths. The December 2013 trough also resulted in economic losses, though to a lesser degree.

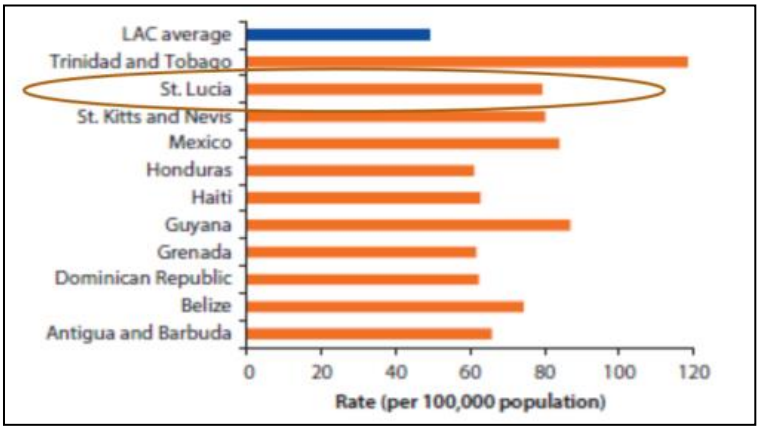
Beyond concerns related to natural disasters, the country is prone to the adverse impacts of climate change. Climate change leads to rising temperatures, changes in rainfall patterns, and more and longer periods of extreme weather, with implications for water-borne and vector-borne diseases and food security.

Sectoral and Institutional Context

5. **The health sector has recently been affected by new and emerging diseases, which have highlighted gaps in public health preparedness and response.** The country saw the first case of Chikungunya in 2014 and the first case of Zika in 2016. By the end of 2017, there were two cases of congenital microcephaly. Meanwhile, conditions such as dengue and leptospirosis remain endemic. An assessment on preparedness by the Caribbean Regional Public Health Agency (CARPHA) following the West Africa Ebola outbreak in 2015 found mixed results for Saint Lucia, though in general the country scored above the regional average. Areas assessed included risk communication, preparedness, points of entry, transportation, health system, general infection prevention and control and laboratory services. A follow-up assessment conducted in the wake of the Zika outbreak in 2017 found that these gaps in preparedness persisted two years later, and that there were also gaps in response and research. Therefore, while Saint Lucia performs well in some areas of preparedness and response, progress to address the remaining gaps has been slow.

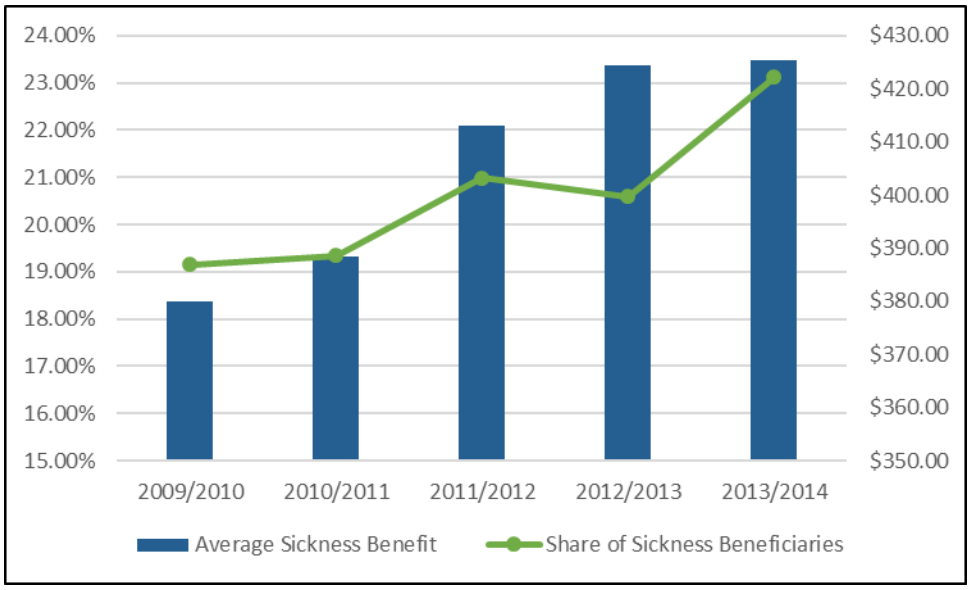
6. **Despite the increase in new and emerging diseases, noncommunicable diseases (NCDs) continue to be responsible for a growing burden of disease.** Life expectancy has continued to increase in recent years, and reached 75 years in 2015, but has been coupled with an increase in NCDs. The prevalence of NCDs such as diabetes and heart disease have been increasing for several years, and remain a top priority for the government. The mortality rate from diabetes, for example, is approximately 60 percent higher than the regional average (Figure 1). The majority of deaths (80 percent) are due to NCDs, which also accounted for almost three quarters of the years of life lost (YLL) in Saint Lucia in 2012. In 2013, ischemic heart disease, cerebrovascular disease, and diabetes were the leading causes of mortality, resulting in 6.3 percent, 5.8 percent, and 7.15 percent of total disability-adjusted life years (DALYs), together accounting for almost 20 percent of total DALYs (Global Burden of Disease study 2013). These result in major productivity losses, while consuming a substantial share of the health budget. Analysis of claims data from the National Insurance Corporation (NIC), of which 70 percent of the employed are active members, show that since 2009, the share of claimants paid for sickness benefits have increased, as has the average amount of sickness benefit paid (Figure 2). This implies that there could be a substantial productivity loss in the economy due to illness. Further, the annual per capita cost of treatment for diabetes in 2011 was US$794, nearly 50 percent more than per capita health spending of that year.

Figure 1. Age-standardized Mortality Rates from Diabetes, Selected Countries and Regional Average



Source: Estimates based on WHO 2008 data on the Global Burden of Disease.
Note: LAC = Latin America and the Caribbean

Figure 2. Share of Beneficiaries Claiming Sickness Benefits and Benefits Among National Insurance Corporation Members

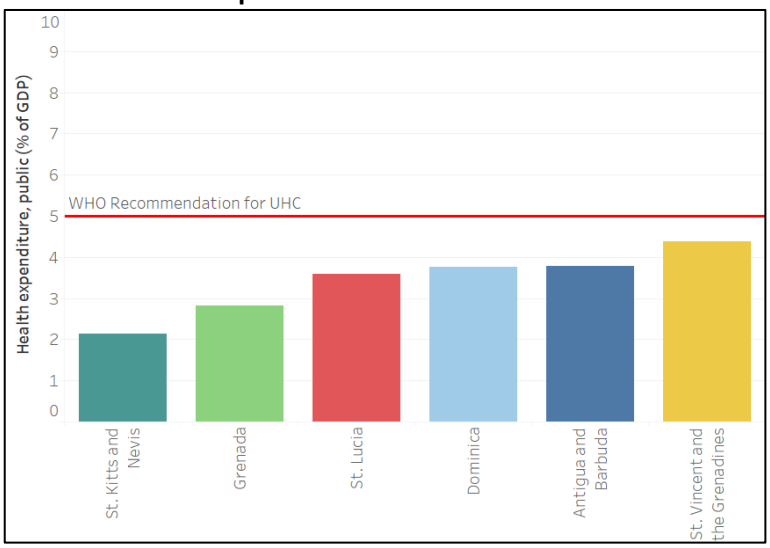


Source: Authors' calculations based on National Insurance Corporation data

7. **Total and public sector expenditures on health as a share of GDP in Saint Lucia are comparable to regional averages, but public sector expenditure in health is still below the threshold recommended by the World Health Organization (WHO) (Figure 3; Table 1).** Total and public sector expenditures on health as a share of GDP are 6.7 and 3.6 percent, respectively, comparable to regional averages (2014), but public sector expenditure in health is below the WHO target of 5 percent of GDP. The Ministry of Health and Wellness (MOHW) and the NIC provide the main revenue streams for the operation of public health services. The MOHW budget for 2017 was EC$110 million (US$41 million), representing the majority of financing for the sector.

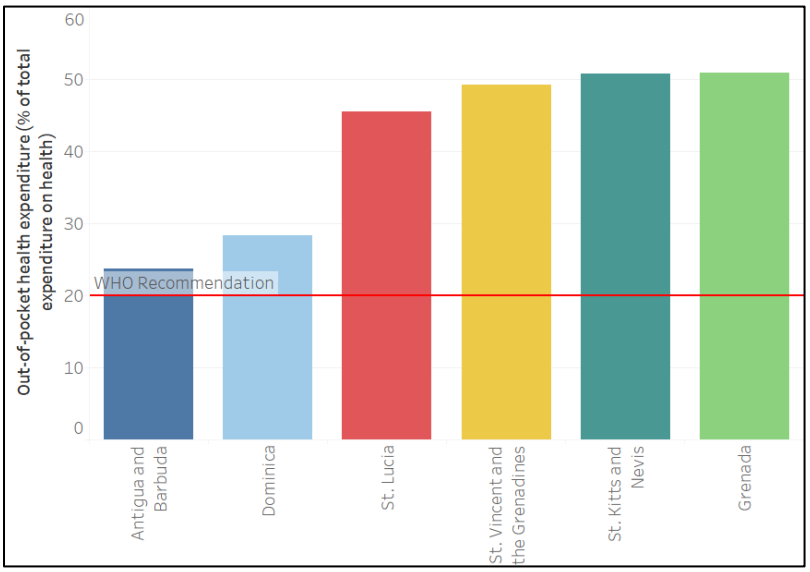
Meanwhile, although the focus of NIC is the provision of pensions (pensions made up 63.4 percent of total benefits paid in 2013) and disability insurance, the NIC pays a flat amount (EC$5.5 million (US$2 million) in 2013 or 8 percent of total benefits paid) annually to the MOHW to cover hospital services provided to its members at Victoria Hospital and Saint Jude Hospital. The NIC covers 50,000 formal sector workers (or about half the estimated labor force), collecting a 10-percent payroll tax on salaries (5 percent from employer, 5 percent from employee), up to EC$5,000 (US$1,851) per month.

Figure 3. Public Health Expenditures in Selected Caribbean Countries (2014)



Source: World Development Indicators

Figure 4. Out of Pocket (OOP) Health Expenditures in Selected Caribbean Countries (2014)



Source: World Development Indicators

8. **Compared to regional averages, Saint Lucia stands out as having a large share of total health expenditures coming from Out of Pocket (OOP) payments.** Saint Lucia's OOP payment are at almost 46 percent, nearly two and a half times higher than the WHO recommended target of less than 20 percent (Figure 4; Table 1). These high levels of OOP expenditures are of concern, as they are regressive, result in a lack of financial protection, and may serve as a barrier to access particularly among the lower income quintiles, who are also more likely to be affected by risk factors leading to poor health. While those with NCDs spend an average of 36 percent of their household expenditure annually on health care, this figure varies widely by income level - the poor spend close to 50 percent of their per capita expenditure and the rich spend less than 20 percent (2006). Less than ten percent of the population has private health insurance, which is concentrated among the higher income quintiles (MOHW 2014). Those who do not have health insurance or who have exhausted their insurance coverage rely on the Medical Fund, which has an annual budget of EC$800,000 (US$296,296) and is limited at EC$10,000 (US$3,703) per person.[1]

Table 1. Key Health Expenditure Data for Saint Lucia and Regional Comparators[2]

	Saint Lucia		Caribbean Small States		Latin America & the Caribbean	
	1995	2014	1995	2014	1995	2014
Health expenditure, total (% of GDP)	**6.1**	**6.7**	5.3	6.2	6.3	7.2
Health expenditure, public (% of GDP)	**3.0**	**3.6**	2.8	3.3	3.0	3.7
Public sector expenditure in health (% of total)	**50.0**	**53.6**	53.4	53.4	47.4	51.2
Out-of-pocket health expenditure (% of total)	**49.1**	**45.6**	30.9	32.1	39.6	31.7

9. **Coverage options for different segments of the population are described below (Table 2), and each option presents its own challenges.** Of note is the resettable lifetime limit set by private insurance companies, which lasts for three years. In-depth understanding of the health financing landscape in Saint Lucia is limited by the lack of National Health Accounts and the fact that a household expenditure survey has not been conducted in some time, making information on health expenditures, particularly in the private sector, difficult to accurately estimate. Nonetheless, a close look at the MOHW budget for 2014/2015 provide some useful insights, and suggests that the amount collected in private health insurance premiums is between 20 and 25 percent of the MOHW budget.[3]

[1] Once resources from the Medical Fund are exhausted, or in cases of catastrophic or overseas expenditures, applications are made on a case-by-case basis (requiring CMO and Cabinet approval) for medical expenses covered through the General Budget.
[2] The World Bank. (n.d.). *Indicators*. Retrieved from The World Bank: http://data.worldbank.org/indicator?tab=all
[3] The MOHW budget in 2014/2015 was EC$122.7 million, which consisted of EC$99.4 million of recurrent expenditure and

Table 2. Current coverage options for different population groups in Saint Lucia

Population	Services covered	Number covered and challenges
General population	• Public primary care (no user fees) • Public hospitals[4] (user fees) • Care at private facilities are not covered (OOP payments) • Overseas care possible but assessed on a case-by-case basis with application to Cabinet needed once funds within MOHW exhausted	• Even after accessing public primary care services, patients may still need to pay out-of-pocket for pharmaceuticals, etc. • Higher-level care may not be accessible for some due to user fees • OOP payments for accessing private facilities range between EC$100-EC$200 for a primary care visit, though accompanying costs and secondary/tertiary care may be high
Active members of the National Insurance Corporation	• Public primary care (no user fees) • Public hospitals (no user fees) though surgeon and private attending physician fees are charged separately • Care at private facilities (OOP payments) and overseas care are not covered	• Covers approximately 50,000 formal sector workers (about half the labor force) • The NIC transfers a flat fee (EC$5.5 million in 2013) to Victoria and St. Jude Hospitals to cover hospital services provided to its members. • The NIC does not cover additional primary care expenditures, pharmaceuticals or offshore medical care.
Those with private insurance	• Public and private sector visits are covered. • Coverage is quite comprehensive in terms of range of services covered, including physician, hospital, diagnostic, overseas care, prescription drugs, with options for dental, optical and life insurance. • Controlled through fee-for-	• Covered 17,371 people in 2014 through individual and group policies. A total of EC$24,720,000 (US$9.1 million) in premiums, while a total of EC$17,467,481 (US$6.5 million) was paid out in claims. • Coverage is not offered in some instances (based on preexisting conditions, age, or claims above a

EC$23.3 in capital expenditure (EC$16.8 million of this went to construct, furnish and equip the New National Hospital that year). In comparison, a total of EC$24.7 million was collected in premiums for private insurance, equivalent to 20 percent of total MOHW budget or 25 percent of the recurrent expenditure.

[4] Hospital fee payment is governed by Hospital Fees Regulations, SI No. 68 of 1992. Medical coverage is provided for those who a) receive an income of less than US$2,222.00 per annum; b) are registered paupers; c) is a child of a person described in a) or b); d); has attained sixty (60) years of age and is in receipt of an income of less than six thousand dollars per annum; e) is a member of the Nursing Service of the state; f) is a member of the Police Force, Fire Service, or Prison Service of the State; or g) is a contributor to the National Insurance.

	service payments with deductibles and coinsurance. • Overseas referrals done through managed care with beneficiaries paying a higher price if they go out of network.	certain amount for eligible conditions (e.g. EC$30,000 or US$11,111). • A major limitation is the resettable lifetime limit. When reached, an individual has to self-pay or rely on public/charity care until the 3-year period has passed and limit is reset.

10. **Healthcare services are delivered by the public and private sectors as well as several NGOs.** Within the public sector, health care in Saint Lucia is delivered through 34 health centers, two polyclinics, two district hospitals and one general hospital (Victoria Hospital); the general hospital is expected to be decommissioned and converted to a polyclinic. There is also a parastatal polyclinic and a parastatal hospital (The Owen King European Union Hospital is expected to be statutorized[5] shortly). The public sector is estimated to provide a third of primary care services and about 93 percent of hospital services. Incentive structures are also limited in the public sector as public sector facilities do not keep the revenues collected from private insurance companies, and thus have little incentive to pursue collection or report performance. In contrast, St. Jude Hospital, which has been statutorized, receives a government subsidy but has financial autonomy. Within the private sector, the exact number of providers for primary care is presently unknown (it was 77 in 2011), but there are five polyclinics and one general hospital (Tapion Hospital). The private sector focuses on primary care services, diagnostic tests and pharmaceuticals, with limited involvement in hospital services, though the specific quantum of services delivered is difficult to estimate. Meanwhile, NGOs provide health services that tend to be focused on certain conditions or target groups, though these services cover relatively few patients. For example, the World Pediatric Project delivers almost all services for children free of charge (costs are covered by the NGO).

11. **Despite the many actors providing health services, it is estimated that there is an unmet need of at least 30 percent in primary care services and 23 percent in secondary and tertiary care services**. Further, while Saint Lucia exceeds the minimum targets for human resources in health (HRH) density, there is a lack of specialists and an aging nursing workforce. In addition, health facilities are inadequately equipped to cope with the growing burden of disease due to NCDs. Challenges are also seen in primary care services, which serve as the first point of contact with the health system, which are often not equipped to deal with NCDs as seen in Table 3, forcing patients to rely on higher (and costlier) levels of care, such as hospitals. This is inefficient, and reduces access to services. Moreover, low productivity presents a further challenge to increase service delivery at the primary care level as health facilities are paid on a historical basis which can lead to providers seeing fewer patients.

[5] Statutorization refers to a government agency, in this case the hospital, being allowed to be managed independently on a commercial basis and with its own Board.

Table 3. Availability of diabetic medicines, basic technologies and procedures in the public health sector[6]

Medicines in primary care facilities	
Insulin	●
Metformin	●
Sulphonylurea	●
Procedures	
Retinal photocoagulation	○
Renal replacement therapy by dialysis	○
Renal replacement therapy by transplantation	○

Basic technologies in primary care facilities	
Blood glucose measurement	●
Oral glucose tolerance test	○
HbA1c test	○
Dilated fundus examination	○
Foot vibration perception by tuning fork	●
Foot vascular status by Doppler	○
Urine strips for glucose and ketone measurement	●

12. **Against a sectoral backdrop of limited fiscal space, a double burden of disease, emerging new diseases, and a service delivery system unable to meet population needs, there has been a new push for health sector reform in the country.** As part of this push, the government is looking to roll out an essential package of health services through a new unit (National Health Insurance Unit within the MOHW) formed for this purpose. This unit will also seek to develop and implement a national health financing mechanism to fund the delivery of these services, while improving the efficiency and sustainability of current financing and identifying new sources of revenue for the sector. The reform effort prioritizes the strengthening of the primary level of care by introducing financial incentives to enhance service delivery at the primary health care level, improve health infrastructure to ensure the primary health care level is properly outfitted to provide the necessary care services stemming from the complexities of a double burden of disease, and improving preparedness and response for public health emergencies through improvements in care integration at the primary level**.**

13. **Efforts to reform the health sector to address these challenges are not new, going back as far as 2000 and outlined in the National Strategic Plan for Health 2006-2011, which continues to remain valid.** Universal Health Care (UHC) was seen as a way to ensure access to services regardless of ability to pay, and to ensure the quality of services.[7] In addition, UHC was explored as a route to ensuring adequate financing of the sector given the willingness of users to pay for services through premiums instead of through out-of-pocket payments. The establishment of UHC through a national scheme would allow prepayment, sharing of risks, and pooling of funds. However, the economic downturn that occurred shortly thereafter hindered UHC efforts at the time.

14. **Recent expenditure pressures associated with the opening of the Owen King-European Union (OKEU) Hospital have reignited the push for reform.** The hospital was completed in 2017, and is meant to replace Victoria Hospital, which will be turned into the urban Castries polyclinic. The OKEU has 200 beds compared to the approximately 160 beds at Victoria Hospital. A study conducted in 2011 estimates that adequately staffing and operating the OKEU Hospital will require at least $20 million more than the 2010 Victoria Hospital budget; more recent estimates are not available.[8] The same study notes that a budget of EC$5.5 million (equivalent to US$2 million) will be needed to run Victoria Hospital once it is converted to a polyclinic. Meanwhile, St. Jude Hospital was damaged in a fire in 2009 and has been operating out of a stadium. It is expected to continue to operate out of the stadium for the next year and a half (at least). While some savings may be possible due to aversion of offshore referrals for services that will be provided at OKEU, these are likely to be limited. Further, it remains unclear whether the OKEU Hospital will be successful at addressing some of the limitations currently

[6] World Health Organization. Diabetes Country Profile – St. Lucia. 2016. Darkened circles represent availability; empty circles indicate unavailability.
[7] USAID. Saint Lucia Health Systems and Private Sector Assessment 2011. 2012.
[8] USAID. Saint Lucia Health Systems and Private Sector Assessment 2011. 2012.

seen at Victoria Hospital and Saint Jude Hospital – namely low occupancy rates in inpatient services in general, but very high occupancy rates in certain wards. However, the OKEU Hospital is expected to be statutorized, which would allow it to manage its own financing and thus be responsible for revenue collection, thereby declining the need for tax funds to run the hospital.[9] The OKEU Hospital is expected to be fully open by December 2018, with the fee schedule determined by the Board (and approved by the Minister of Finance) as outlined in the Millennium Heights Medical Complex Act 2015.

15. **As part of the recent push for reform, an essential benefits package has been developed by the MOHW, with delivery of the full package estimated at approximately EC$69 million (US$25.5 million), 62 percent more than the current MOHW budget (EC$110 million, US$40 million),[10] further highlighting the need to identify less costly ways of delivering healthcare and to explore additional financing options for delivery of necessary services.** The proposed essential benefits package has been determined based on the cost of services provided at the Victoria Hospital, which may differ from the fee schedule set by the OKEU Hospital going forward. This will need to be taken into consideration in the rollout of the essential benefits package, to ensure that public hospitals are able to deliver the secondary/tertiary care services as guaranteed through the essential benefits package. At this time, the predominant model under consideration for financing of the essential benefits package is one whereby revenue generation is shifted to the employed, with the Government responsible for premiums for the unemployed and the poor, and where health funds are privately managed in order to improve efficiency. Other options actively being reviewed, which will be further assessed for financing the essential benefits package include sin taxes, increasing the NIC contributions for health, and increasing the Value Added Tax.

16. **As part of the Health Strategy, the government also seeks to improve the efficiency and fiscal sustainability of service delivery, a major part of which involves improving the integration of primary care services and scaling-up NCD prevention efforts.** In support of these efforts, the National NCD Commission was reestablished in 2017 with the agenda of accelerated NCD action to achieve the 2025 global NCD targets and the health-related targets within the 2030 Sustainable Development Goals Agenda. Eighty percent of cancers, diabetes and heart diseases are preventable, with prevention efforts found to be very cost-effective. NCDs currently represent the major cause of morbidity and premature mortality in Saint Lucia, with a grim outlook for the future given the high prevalence of risk factors for NCDs. For example, while the prevalence of diabetes is currently 14.6 percent, close to 60 percent of the population are overweight, more than 40 percent are inactive and almost 30 percent are obese. Real-time data is problematic to obtain, making it difficult to identify those at risk and to make evidence-based recommendations, as well to inform strategic purchasing and health technology assessments. The lack of data also makes it challenging to respond to public health emergencies when they occur. Nonetheless, extensive efforts are underway to improve Saint Lucia's Health Information Systems, as described in Box 1.

[9] A board was recently appointed for the OKEU Hospital, and includes representatives from the MOHW.
[10] Of the current MOHW budget of EC$110 million, only EC$10 million of costs are recovered.

Box 1. Health Information Management Systems in Saint Lucia

The Saint Lucia Health Information System (SLUHIS) currently has several efforts going on in parallel. At the primary care level, the SLUHIS has been rolled out to 32 out of 34 primary health care centers as well as the Medical Supplies Unit/Central Procurement and the Ministry of Health. In addition to collecting information on patient demographics, vitals such as blood pressure, reason for visit, clinical diagnosis and other related areas, electronic prescriptions can also be generated and printed from SLUHIS, and the system is linked to patient appointments and referrals.

At the hospital level, SLUHIS is being rolled out in several modules, beginning with patient registration and scheduling. In addition, an extensive data cleaning exercise is currently underway to facilitate a "one patient, one record" system across primary and secondary care services. A separate platform is currently under development for the Environmental Health Department of the MOHW, which will be interfaced with SLUHIS for vector-, food- and water-borne conditions. Plans are also in place to integrate the Laboratory Information System with SLUHIS to facilitate immediate access to lab results. The SLUHIS will eventually be comprehensive, allowing for active surveillance, improved monitoring and evaluation efforts and informing budgetary allocations and performance, as well as tracking of medical supplies.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The development objective is to improve the accessibility, efficiency, and responsiveness of key health services.

Key Results

17. The following key results will be monitored throughout the Project.

(i) Number of people registered under the National Health Scheme (Accessibility)
(ii) Percent of diabetic/hypertensive patients > 18 years at primary care facilities managed according to national protocols (disaggregated by gender) (Efficiency)
(iii) Improved score on the achievement of 13 core capacities of the 2005 International Health Regulations (IHR) (Responsiveness)

D. Project Description

18. **The Government has requested World Bank financing for a Project to support its strategy for achieving UHC.** The Proposed Project in the amount of US$20 million will strengthen Saint Lucia's health system, focusing on the establishment of an essential benefits package, strengthening institutional readiness and performance particularly at the primary care level, and improving public health emergency preparedness and response. An essential benefits package has been drafted, and will be refined and rolled out using a phased approach. Following the deployment of similar programs in other countries in the region, it would begin with a minimum, essential benefits package which fits within the government's fiscal space, with benefits added over time as efficiency gains are made and administrative systems (and revenue collection) improve.

19. **To support the services delivered through the essential benefits package, the Project will strengthen service delivery, with a focus at the primary care level.** This will be done through three specific areas. First, through the Project, the Government will introduce Performance-based Financing (PBF) to enhance service delivery at the primary care level. Second, the Project will strengthen health infrastructure by properly equipping health facilities the primary health care level. Finally, the Project looks to improve preparedness and response for public health emergencies by integrating care provided at the primary care level. Activities conducted under the Project will take place alongside ongoing developments, such as the expected transition of Victoria Hospital to a polyclinic. The rollout of the essential benefits package, which is expected to be conducted in phases, will take upcoming transitions and expenditure pressures into consideration.

20. **The proposed Project has three Components as described below.** Component 1 would focus on the demand-side of health services by supporting the Government to develop and implement a coverage scheme that would allow its population to receive access to services outlined in the essential benefits package. The delivery of an essential benefits package will require improvements in institutional readiness, ensuring that facilities are adequately equipped to deliver the proposed package of services. In addition, a focus on results instead of inputs will be necessary to ensure efficiency gains, thereby enabling an expansion of the essential benefits package over time. As such, the supply-side of services will need to be strengthened. This will be done through Component 2 of the Project, which will focus on the supply-side of service delivery. Through PBF, incentives will be provided to ensure a focus on results. In addition, primary care and ancillary facilities (such as laboratory services) would be assessed and equipped to ensure they are able to deliver the services promised through the essential benefits package. This component would support the Government in strengthening the integration of primary care systems to enhance the role of primary care facilities and encourage their use as the first point of contact for health services, particularly NCDs and public health emergencies, by equipping them through the needed works, equipment, and supplies; and as importantly, with the needed operational protocols to establish a coordinated pathway of care and referral. Component 3 of the project would provide support to overall project management and monitoring and evaluation to gauge project progress.

Component 1. Design and Implementation of an Essential Benefits Package (US$5.5 million)

21. This Component would include the review and implementation of the benefits package, including administration, purchasing and contracting arrangements, regulations surrounding the scheme, and potential sources of additional revenue for expanding health service coverage. The project will finance the analytics to support the Government in its design of the package and the roll-out of information technology and systems platforms in support of the implementation of the package. Public funds will finance the provision of the package and the project will complement this funding by financing a bonus incentive, through Subcomponent 2.1, to be provided to the health facilities for their achievement of targets related to providing diabetes and hypertension pre-screening and care. Activities described under Component 1 will be undertaken in parallel.

22. A summary of the proposed benefits package is provided below; areas in bolded text are those proposed as part of the first phase of rollout of benefits.

Area		Primary Care			Secondary/Tertiary Care	
		Screening	Management	Other	Inpatient/ Outpatient/ Emergency/ Laboratory Services	Other
i. ii.	**Diabetes Hypertension**	✔	✔	**Pharmaceuticals**	✔	**Operating Room Services (Diabetes only), Radiology/Diagnostic Services, Physiotherapy Sessions, Dialysis (Diabetes only)**
iii.	Injuries/Trauma	✔	✔	×	✔	Operating Room, Radiology/Diagnostic Services, Physiotherapy Sessions
iv.	Respiratory Conditions	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services, Physiotherapy Sessions
v.	Sexual and Reproductive Health (Including Family Planning)	✔	✔	Pharmaceuticals	×	X
vi.	**Maternal and Child Health**	×	×	**Antenatal and postnatal care; Child Health/Immunization; Adolescent Health**	✔	**Operating Room Services, Delivery Room, Radiology/Diagnostic Services**
vii.	Selected Communicable Diseases[11]	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services
viii.	Selected Cancers[12]	✔	×	×	✔	Operating Room Services, Radiology/Diagnostic Services, Day Surgery, Chemotherapy, Physiotherapy, Radiotherapy
ix.	General Cancer Services	×	×	×	✔	Radiology/Diagnostic Services, Day Surgery, Chemotherapy, Physiotherapy
x.	Dental	×	×	Cleanings, Fillings, Root Canals	×	×
xi.	Hearing Health	✔	✔	×	×	×

[11] Communicable diseases covered are Dengue, Schistomiasis, Hansen's, Tuberculosis, and Leptospirosis.
[12] Cancers covered are Prostate, Cervical, Breast, Colon, and Stomach.

xii.	Mental Health	✔	✔	Pharmaceuticals	No Outpatient Services	Radiology/Diagnostic Services
xiii.	Substance Abuse	✔	×	Counseling	✔	X
xiv.	Cardiovascular Disease	✔	✔	Pharmaceuticals	✔	Radiology/Diagnostic Services; Surgery (Pacemaker/Defillibrator implantation/ Pericardiocentesis/Pericardial Tap/Pleural Tap – Overseas Care)
xv.	Eye Health	✔	✔	×	✔	Day Surgery
xvi.	Sickle Cell Anemia	×	×	×	✔	Radiology/Diagnostic Services, Surgery, Physiotherapy Services
xvii. xviii. xix.	Surgery Gynecology Medicine	×	×	×	✔	Operating Room Services, Radiology/Diagnostic Services, Physiotherapy Services

23. **Subcomponent 1.1. Review of the Essential Benefits Package (US$1 million).** This subcomponent would support the review of the essential benefits package. Proposed activities under this subcomponent, which will be undertaken in parallel, include: (i) a review of public sector expenditure in health, including recommendations for efficiency gains and improvements in equity, and recommendations for the development of National Health Accounts; (ii) analytical review of current insurance payment systems and coverage, including reviews of existing structural mechanisms with a potential role in the financing of the benefits package (e.g. NIC), and of the proposed essential benefits package and costing, including actuarial assessments, and periodic update mechanisms (including health technology evaluation mechanisms); (iii) evaluation of coverage options for those in the informal (e.g. farmers and taxi drivers) and nonwork sectors; (iv) review and simulations of the essential benefits package to identify possible phases for rollout and associated cost and coverage implications; (v) the development of Standard Operating Procedures (SOPs)/clinical procedures for case management (e.g. diabetes); (vi) an in-depth assessment of the national health information system (HIS), including interoperability and integration; and (vii) review and development of legislation governing the proposed benefits package.

24. **Subcomponent 1.2. Implementation of the Essential Benefits Package (US$4.5 million).** Findings from the previous subcomponent will support direct actions to roll out the implementation of the benefits package. Proposed activities under this component would include: (i) an assessment of and investments in IT systems and infrastructure for administration of the benefits package, including HIS, SOPs for data entry/management, computer equipment, and a benefits package management system (which will also track referrals); (ii) development/review of purchaser provider agreements; (iii) review of and improvements to existing and proposed financial control mechanisms and technical audits (such as financial audits and strategic purchasing arrangements); and (iv) a communications campaign surrounding the benefits package. In addition, this subcomponent would also support necessary capacity building and training efforts for MOHW staff, as well as the rollout of the benefits package among the population, including a helpline for the startup phase. Dependent on the outcome of the evaluation of coverage (Subcomponent 1.1 above), the selection criteria and targeting mechanisms of the potential beneficiaries will be determined to ensure inclusion of the vulnerable population.

Component 2. Strengthening Service Delivery in Support of the Essential Benefits Package (US$13 million)

25. **Subcomponent 2.1. Improving Service Delivery through Performance-Based Financing (US$4 million).** This subcomponent proposes to include PBF focused on diabetes and hypertension to improve the efficiency of health expenditure by providing bonuses based on performance. PBF for health has been implemented in several countries to achieve health outcomes by linking incentives with results. Commonly referred to as pay for performance or performance-based incentives, programs reward healthcare providers or facilities upon achieving certain performance targets such as immunizing a percentage of the population or increasing the number of preventative screenings in an area. In the case of Saint Lucia, the proposed PBF scheme will focus on strengthening NCD management at the primary care level. In particular, it would aim to strengthen the quality of care for diabetes and hypertension based on standard care protocols, and would provide financial rewards for health facilities according to the achievement of results. The health facilities will have flexibility in use of the funds received provided they are considered eligible expenditures (see Annex 1); for example, they may choose to distribute them as bonuses for the health providers or to use the funds as resources for improvements of the facilities. A draft Operations Manual for the PBF scheme was developed independently of the National Health Scheme, and will be revised to reflect the revised reimbursement structure to ensure it is appropriately linked to the National Health Scheme.

26. Activities to be financed under this subcomponent include (i) the revised design of the proposed PBF scheme, including M&E plan and utilization of indicators from the HIS; (ii) health facility outreach; and (iii) PBF bonus payments based on performance. Project funds in the amount of US$3.3 million for PBF bonus payments will be included in a separate disbursement category. Under the PBF mechanism, the MOHW will enter into agreements (such as Memorandums of Understanding or Service Level Agreements) with participating health facilities to deliver the services outlined in the basic benefits package. The MOHW and health facilities will agree on the targets to be achieved in two areas, number of patients $\geq$ 18 years screened for diabetes/hypertension based on national protocols; and percent of patients $\geq$ 18 years with diabetes/hypertension diagnosed and managed according to national protocols. Under the PBF scheme, the health facilities will be paid a bonus based on their achievement of the agreed targets. This bonus will be a small percentage of the cost of providing the essential benefits package to an individual (the per capita amount). The potential maximum payment a health facility can receive will be calculated by taking the per capita amount multiplied by the number of enrolled, eligible beneficiaries at that health facility. Third, the bonus payment a health facility can receive will be 5-10 percent of their total cost of providing the services outlined in the essential benefits package (the per capita cost multiplied by enrolled population at the health facility). While the frequency of payments has not been determined, a payment frequency of every 4 months has been proposed. Verification will be conducted by an external agency, who will be contracted to determine progress on achievement of the tracer conditions and recommend disbursement amounts to the MOHW.

Box 2. A Two-Stage Payment Structure: The Link Between the Essential Benefits Package and Performance-Based Financing

It is estimated that approximately 33 percent of primary health services and approximately 90 percent of secondary/tertiary services are delivered through the public sector, with the balance delivered through the private and nonprofit sectors. At a national level, it is estimated that there is an unmet need of 30 percent in primary care and 23 percent in secondary and tertiary care services, though the recent completion of the OKEU Hospital is expected to help address this unmet need.

Primary care services within the public sector are not adequately equipped to deliver services efficiently. While the Project will address some of these deficiencies through investments in civil works, goods and services (Subcomponent 2.2), additional incentives are necessary to (i) enhance effective coverage; and (ii) increase the capacity of primary care facilities to implement mechanisms for an integrated delivery care system. In line with this, a two-stage fund transfer structure is proposed. In the first stage, primary care facilities (and hospitals) would receive public funds as outlined in the essential benefits package. This transfer will be based on the per capita cost of the health facility in providing the services outlined in the benefits package multiplied by its enrolled population. While the payment is envisioned as a capitation-based approach, other options will be explored as part of the assessment to also consider fee-for-service, bundled payments or a combination thereof. Project funds will not be used for this first transfer, as it would be funded through payments from the MOHW.

Transfer 1: MOHW funds		**Transfer 2: Project funds**
100 percent of cost of delivering services defined by the essential benefits package Payment transferred based on size of enrolled population	+	5-10 percent of cost of delivering services defined by the essential benefits package Payment transferred based on results of tracer indicators among enrolled population

The second transfer, made simultaneously, would be financed through the Project and would consist of bonus payments based on the performance of primary care facilities on selected tracer conditions, namely: (i) number of patients $\geq$ 18 years screened for diabetes / hypertension based on national protocols; and (ii) percent of patients $\geq$ 18 years with diabetes / hypertension diagnosed and managed according to national protocols. The maximum bonus payment will be calculated as 5-10 percent (precise figure to be determined) of the cost of providing services described in the essential benefits package for that facility. While a precise figure is not yet available, preliminary estimates for the package of services suggest that it will be around EC$465 (US$172) per person per year, meaning that the maximum bonus payment would be along the lines of EC$46.50 (US$17.20) per person per year if all tracer conditions are achieved. This will be further assessed and described in the PBF manual. Bonus payments will be used for eligible expenditures as described in Annex 1. Health facilities will be required to sign agreements (for example, a Memorandum of Understanding or a Service Level Agreement) with the MOHW to be eligible to receive bonus payments. Performance of the health facilities will be verified by an independent third party, and the project will support related investments, such as improvements to the Health Information Systems and the development of clinical protocols, to contribute to efforts to improve service delivery.

Given the limited capacity of the public sector and the substantial role of the private sector, analytical work will also explore options for inclusion of private sector providers in the National Health Scheme, but they will not be eligible to participate in the PBF scheme. With the recent passing of the National Healthcare Quality Policy (NHQP) by Cabinet (2018), private sector providers who meet the criteria of cost (acceptance of reimbursement criteria under the NHS) and quality (licensed according the NHQP) may be included as part of the National Health Scheme. This option, along with others, will be explored under Subcomponent 1.1.

27. **Subcomponent 2.2. Strengthening the Supply of Health Care Services (US$4.5 million).** This subcomponent would involve strengthening the integration of primary care systems to enhance the role of primary care facilities and encourage their use as the first point of contact for health services, particularly NCDs. This component would finance goods, minor refurbishments, consultancy services, trainings/workshops, and operational costs in support of key investments/activities. Activities conducted under this subcomponent include (i) a comprehensive survey of health facilities to ensure institutional readiness to deliver NCD services under the essential benefits package; (ii) improvement of health facilities including refurbishment, provision of equipment and medical supplies; and (iii) development of a health facility network to improve tracking of patients across the care pathway. A survey of primary health facilities including equipment inventory, procedures provided, and infrastructure would be conducted to ensure that facilities can deliver the necessary services as described in the benefits package and as required by the NHQP 2016-2026 which aims to provide national commitment, direction and guidance for improving quality in healthcare. Where possible, this survey would utilize available information (such as the Smart Health Facilities Assessment) and available tools such as the World Health Organizations' Service Availability and Readiness Assessment (2005). Subsequently, improvements (such as refurbishment or provision of equipment) to health facilities will be made based on survey outcomes. The type of refurbishments envisioned could include minimal infrastructure adjustments such as establishing partitions in existing structures, improving lighting, and painting. The magnitude of such refurbishments is minor as potential adverse environmental impacts due to these interventions potentially involve dry-wall installation, installation of new lighting fixtures, and properly disposing of unused paint. It is also possible that additions, expansions, or annexes will be rehabilitated or raised, though these are expected to be limited and will not require new land acquisitions, for example, a small area dedicated for storage of medical waste. Where feasible, energy efficient improvements such as improvements in lighting, appliances and equipment will be made. Under the project, the national health care waste management plan will be updated for activities that include the minor refurbishments and the proper disposal of medical equipment. This may involve improvements to wastewater disposal systems and/or medical waste storage facilities. In addition, the care pathway across the health system will be reviewed to potentiate the use of the less costly primary health care services as the entry point into the system of care. Other possible activities under this component include the roll-out of mobile clinics, Geographic Information Systems, and radio systems for communication with health facilities.

28. **Subcomponent 2.3. Public Health Emergency Preparedness and Response (US$4.5 million).** As part of efforts to strengthen the health system and address the growing threat posed by climate change, this Project also aims to address weaknesses in public health emergency preparedness and response. Activities conducted under this subcomponent involve strengthening of surveillance and information systems, laboratory capacity, and preparedness for public health emergencies. Activities under this subcomponent include: (i) the development of protocols and the provision of equipment to primary health care centers to enable them to serve as the first point of detection for selected infectious diseases; (ii) investments in laboratory facilities (such

as equipment), data management, transportation and storage to enable rapid testing for pathogens of interest, including those associated with vector-borne diseases; and (iii) the development of health emergency preparedness and response plans, establishment of emergency operation centers and rapid response teams for public health emergencies, and outbreak communications. Where relevant, investments will also be made in IT systems, e.g. strengthening communication between HIS and MOHW for notification of selected diseases. For example, this subcomponent will support the development of a maternal and child registry following the impact of Zika on microcephaly. Under the project, the National Health Care Waste Management Plan will be updated to include measures for how to manage equipment distribution and installation in the case of a disease outbreak.

Component 3: Institutional Capacity Building, Project Management and Coordination (US$1.5 million)

29. This Component supports project implementation efforts, including project management, fiduciary tasks and monitoring and evaluation (M&E). This component would involve monitoring and evaluation and project management costs associated with supervision of the Project. This Project will be managed by a stand-alone PIU housed within the MOHW, whose duties will include oversight of refurbishing projects as well as compliance with safeguards and local permit requirements during refurbishment/rehabilitation, and implementation of the Health Care Waste Management System (HWMS) during operation. The Project also plans to seek a Project Preparation Advance, which will take place prior to the setup of the PIU within the MOHW. Thus, activities to be financed by the PPA will be implemented with oversight from the existing national-level PIU (N-PIU). Activities to be covered under the PPA will consist solely of consultancies and hiring of staff for the PIU within MOHW. As such, support is envisioned for financial management and procurement functions, in addition to the development of a HWMS in accordance with the Terms of Reference in the ESMF.

E. Implementation

Institutional and Implementation Arrangements

30. The implementation arrangements for the project will be established as a two-phase approach with the eventual goal of providing the Saint Lucia MOHW with the overall responsibility for project implementation. The first phase will engage the existing National Project Implementation Unit (N-PIU) to manage the project implementation during an interim period to align with the implementation of the Project Preparation Advance (PPA) activities which will run from July 1, 2018 to February 28, 2019. The second phase will transition the project management function from the N-PIU to the MOHW Project Implementation Unit (MOHW PIU) for the remaining life of the project.

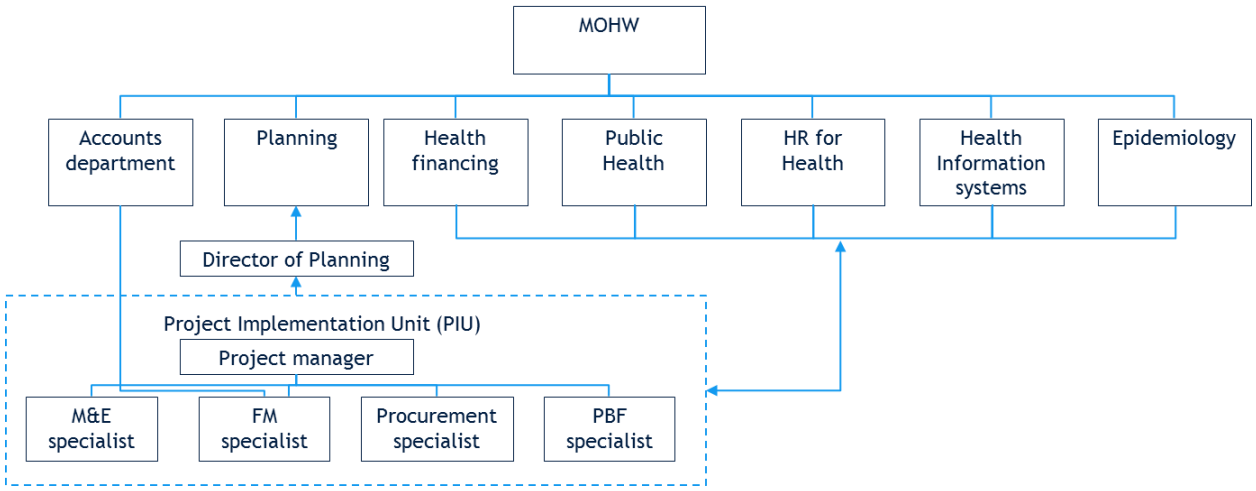
31. Under the PPA, a Project Manager, Financial Management Specialist, and Procurement Specialist will be contracted for the project and will be incorporated into the MOHW team as the (MOHW PIU). The advertising and contracting of these three positions will be prioritized under the PPA to ensure they are contracted during the PPA period. This would allow the N-PIU to provide oversight and guidance to the MOHW PIU and “on-the-job” training across the PPA implementation, which in addition to the training to be provided by the Bank fiduciary teams, will ensure the MOHW PIU team has the capacity to take on the project management functions. This would also allow the MOHW PIU to acquire and put in place the project accounting system, document fiduciary procedures in the Operations Manual and prepare terms of reference for the annual external audit. Once these three positions are staffed and trained, which has been established as February 28, 2019 at latest, the project management function will transition to the MOHW PIU.

32. During the first phase, the transition phase, the N-PIU will manage the project implementation. The N-PIU has the existing structure (physical and human) in place and the experience and capacity based on its long-standing role in managing the implementation of Bank-financed projects. The N-PIU has been and currently continues to manage the implementation of Bank-financed projects in Saint Lucia. The N-PIU has an overall manager who will provide oversight and guidance to the project management duties. In addition, the N-PIU will make available the time of a Financial Management Specialist and Procurement Specialist to support the implementation of activities under the PPA. The N-PIU will also manage the PPA activities which includes the process for hiring the MOHW PIU's Project Manager, Financial Management Specialist, and Procurement Specialist. Once these three positions are staffed and trained, the project management function will transition to the MOHW PIU. During the interim period, the MOHW has appointed two staff from the MOHW to engage on the overall project management activities with one focusing more on the procurement requirements and another on the financial management requirements. These two staff will also be trained by the N-PIU, in particular the staff focused on financial management as he would remain engaged, providing 20 percent of his time to supervise the FMS in the project after transfer of the PIU to the MOHW. In addition, the MOHW team has appointed their staff Engineer, who has received safeguards training, to support the initial development of the project and ensure all safeguards requirements are completed and complied with.

33. During the second phase, the MOHW PIU will be physically located within the MOHW. A Project Manager will lead the day-to-day implementation of the project and will report to the MOHW Director of Planning on project interventions in MOHW priority and strategic areas, on the coordination of efforts with other partners, and for technical coordination of activities financed under the project. The MOHW PIU team will include the following roles: a Monitoring and Evaluation Specialist, a project Financial Management Specialist, a Procurement Specialist, and a PBF Project Coordinator, who all report to the Project Manager, who in turn reports to the MOHW-Director of Planning. Furthermore, the MOHW PIU team will be supported by technical staff of the MOHW for specific areas of the project, such as health financing, public health, human resources for health, health information systems, epidemiology and accounts department among others. Figure 6 below provides a visual overview of the MOHW structure that will support and implement the project.

34. The institutional arrangements for this specific project differ from the institutional arrangements followed by other World Bank-financed projects in Saint Lucia. This is due to this project's highly technical nature which requires a closely coordinated process across technical areas in the MOHW and fiduciary requirements. In addition, the current N-PIU is already stretched thin from the demanding project management and fiduciary needs of the disaster risk project together with the other existing projects in the portfolio. While the N-PIU can provide temporary project management support during an interim period, this is not a long-term option and will not build capacity in the MOHW. Thus, the project has put in place a two-phase approach.

Figure 6. Implementation and Fiduciary Arrangements - Saint Lucia Health Insurance Project



.

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

The project aims to support the strengthening of the health system on a national level. The expected beneficiaries of the project include the national population who will benefit from an improved health system providing a basic package of health services responding to the population needs. As part of the evaluation of the affordability and sustainability of the basic package of health services, the project will focus on ensuring that health coverage is available for the most vulnerable, such as the elderly, children, and poorest segments of the population. Furthermore, due to the important gender dimensions of the project, specific activities in support of addressing gender dimensions include directly monitoring the increase in primary health care service utilization rates (disaggregated by gender), the development of a maternal and child registry following the impact of Zika on microcephaly, and including women, particularly pregnant women, as part of citizen engagement efforts. Component 2 of the Project would include improvements and refurbishments of up to 34 selected primary health facilities including equipment inventory, procedures provided, and infrastructure, based on a survey to be conducted during implementation. Refurbishment works may take at existing facilities anywhere on the island of Saint Lucia. In addition, national health care waste management plans will be updated for activities that include minor refurbishments and the proper disposal of medical equipment. The type of refurbishments envisioned could include minimal infrastructure adjustments such as establishing partitions in existing structures, improving lighting, and painting. The magnitude of such refurbishments is minor as potential adverse environmental impacts due to these interventions potentially involving dry-wall installation, installation of new lighting fixtures, and properly disposing of unused paint. It is also possible that additions, expansions, or annexes might also be rehabilitated or constructed. Under the project, the national health care waste management plans will be updated for activities that include the minor refurbishments and the proper disposal of medical equipment. This may involve improvements to wastewater disposal systems and/or medical waste storage facilities.

G. Environmental and Social Safeguards Specialists on the Team

Gibwa A. Kajubi, Social Safeguards Specialist
Michael J. Darr, Environmental Safeguards Specialist
Ximena Rosio Herbas Ramirez, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	An Environmental and Social Management Framework (ESMF) was prepared given that location of works is unknown at this time. The ESMF references the WBG EHS Guidelines and the sector guidance WBG Environmental Health and Safety Guidelines for Health Care Facilities.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	Natural Habitats will not be triggered. All project interventions are to be carried out in existing facilities and the Project will not affect critical or sensitive natural habitats.
Forests OP/BP 4.36	No	Forests will not be triggered. The project will not support activities in forest areas.
Pest Management OP 4.09	No	Pest management will not be triggered. Support for emergency response or outbreaks will not include pesticide use for vector control, but rather technical, logistic, and planning activities. Any minor quantities of pesticides would be addressed by specific measures and procedures in the ESMF for storage, handling and application of pesticides.
Physical Cultural Resources OP/BP 4.11	No	Physical Cultural Resources will not be triggered. The project physical works will be mainly rehabilitation of existing health care facilities.
Indigenous Peoples OP/BP 4.10	No	Indigenous Peoples will not be triggered. There are no groups that meet the criteria of OP 4.10 in Saint Lucia.

Involuntary Resettlement OP/BP 4.12	No	Involuntary Resettlement will not be triggered as the project will not require physical or economic displacement, or restriction of access to natural resources. No land acquisition/resettlement is expected under the project.
Safety of Dams OP/BP 4.37	No	Safety of Dams will not be triggered as the project will not have activities related to dams.
Projects on International Waterways OP/BP 7.50	No	Project on International Waterways will not be triggered as the project will not have activities related to international waterways.
Projects in Disputed Areas OP/BP 7.60	No	Projects in Disputed Areas will not be triggered. The project will not operate in disputed areas.

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 considered as environmental risk Category B, given that the proposed Project is not likely to result in significant negative, irreversible and/or large-scale impacts on human populations and/or the environment. The Environment and Social risk rating is considered Moderate.

The potential negative impacts can be grouped into two categories: those associated with typical small civil works during refurbishment, and those associated with medical waste management during operation. The former are minor and short-term, and are addressed within the Environmental and Social Management Framework (ESMF) by the provision of a generic Environmental and Social Management Plan (ESMP) with Best Management Practices (BMPs) and standard contract clauses for small civil works, and a pre-design screening to identify any special conditions requiring additional mitigation measures. The latter are addressed by provision of Terms of Reference (TOR) to develop a Health Care Waste Management System (HWMS) during the early stages of implementation.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Improved access and quality to health care will result in long-term benefits to the population. Improved waste management may result in long-term benefits to the environment, to health care workers, and to the surrounding communities.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
Alternatives will be considered as part of the design of each potential improvement or action. The ESMF includes screening formats and criteria to ensure that refurbishments, rehabilitations, or improvements do not inadvertently result in impacts to physical cultural resources, natural habitats, acquire lands or affect assets or access. The Ministry of Health and Wellness (MOHW) has on staff an Engineer who reviews plans, inspects work locations, and ensures the proper and orderly development of projects related to public health.

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 program-level ESMF has been prepared by the MOHW. The MOHW has on staff an Engineer who reviews plans, inspects work locations, and ensures the proper and orderly development of projects related to public health. In addition, there is a Quality Assurance Manager within the Corporate Planning Unit of the MOHW who provides input on issues related to quality of health facilities.

This Project will be managed by a stand-alone PIU housed within the MOHW, whose duties will include oversight of refurbishing projects as well as compliance with safeguards and local permit requirements during refurbishment/rehabilitation, and implementation of the Health Care Waste Management System (HWMS) during operation. The Project also plans to seek a Project Preparation Advance (PPA), which will take place prior to the setup of the PIU within the MOHW. The development of the HWMS will include capacity-building through occupational health and safety training, including exposure to diseases, medical waste and the use of certain equipment with radiation, in accordance with the Terms of Reference in the ESMF.

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

The draft ESMF has been disclosed on the MOHW website along with an invitation to provide input and feedback via the email address or telephone numbers provided. In addition, emails and links to the draft document were provided to key stakeholders to solicit input. The ESMF will be updated to include the comments from the public consultation, and the final version will be posted on the websites of the MOHW and WBG.

The ESMF includes a grievance redress/feedback mechanism to be established to ensure citizens have a forum to raise concerns/complaints and/or provide feedback on services delivered or from which they may have been excluded.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
05-Jun-2018	07-Jun-2018	

"In country" Disclosure

St. Lucia
07-Jun-2018

Comments

The ESMF has been disclosed on the Saint Lucia MOHW website. http://www.govt.lc/publications/environmental-social-management-framework-document

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

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
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

All Safeguard Policies

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

CONTACT POINT

World Bank

Carmen Carpio
Senior Operations Officer

Neesha Harnam
Health Specialist

Borrower/Client/Recipient

Ministry of Finance, Economic Growth, Job Creation, External Affairs and Public Service
Cointha Thomas
Director of Finance
cointha.thomas@govt.lc

Implementing Agencies

Ministry of Health and Wellness, Saint Lucia
Felix St. Hill
Permanent Secretary
fsthill@gosl.gov.lc

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Carmen Carpio Neesha Harnam

Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Daniel Dulitzky	25-Jun-2018
Country Director:	Sabine Hader	16-Jul-2018