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

Appraisal Stage | Date Prepared/Updated: 07-Jan-2020 | Report No: PIDISDSA27776

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Lao People's Democratic Republic	P166165	Health and Nutrition Services Access Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	17-Jan-2020	12-Mar-2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Lao People's Democratic Republic	Ministry of Health	

Proposed Development Objective(s)

To improve access to quality health and nutrition services in targeted areas of Lao PDR.

Components

Component 1: Integrating Service Delivery Performance with National Health Insurance Payments
Component 2: Service Delivery and Nutrition Convergence
Component 3: Adaptive Learning and Project Management
Component 4: : Contingency Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	28.00
Total Financing	28.00
of which IBRD/IDA	15.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	15.00
IDA Credit	15.00

Non-World Bank Group Financing	
Trust Funds	3.00
Freestanding Tfs - Health, Nutrition & Population GP	3.00
Other Sources	10.00
The Global Fund to Fight AIDS, Tuberculosis & Malaria	10.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

The Lao People's Democratic Republic (Lao PDR) has experienced rapid economic growth over the past decade, though this has not translated into proportional gains in poverty reduction. The country's gross domestic product (GDP) grew over 7 percent per year over the past decade while the growth has moderated at around 6.5 percent in the recent years. Economic growth has been heavily concentrated in urban areas[1] while in rural areas, high levels of poverty and inequality prevail. Poverty incidence is estimated at 23.2 percent nationally, but it is 40 percent in rural areas without roads compared to 10 percent in urban areas. Poverty and human development indicators are also worse for ethnic minorities, many of whom live in remote areas.

Recent increases in public spending have improved availability of public funding in the health sector. However, fiscal pressures and larger issues around the effectiveness of public sector management have been affecting the availability and quality of health service delivery. The recent public financial management (PFM) assessment in health service delivery conducted by MOH and WBG confirmed that service availability and readiness of the health providers were the major service delivery bottlenecks at all levels, but more acute for the health centers.

A substantial quantum of funds from government budgetary sources and user fees are managed at the health facility level, but there is no systematic financial management system to document how funds are utilized and accounted for. Further, health facilities don't always systematically document the collection of user fee and its use by the facility. With the expansion of the NHI, increasingly more and more funds are and will be channeled through the NHI funds, thus increasing the need for strengthening the PFM capacity at all

[1] World Bank. 2014. "Poverty Profile in Lao PDR: Poverty Report from the Lao Consumption and Expenditure Survey 2012-3."

levels to ensure that minimum standards will be in place for sufficient accountability and transparency of funding and utilization of funds to improve quality of spending and efficiency of health service delivery.

The PFM assessment also underscored weaknesses in planning and budgeting systems in the health sector that reflect the broader macro level planning and budgeting systems weaknesses but are also derived from structural health-specific disease programing constraints, weak coordination of decentralized provincial planning and non-existent facility planning and budgeting. Addressing inefficiencies in the allocation of resources at both central and decentralized levels of the health system against increasing healthcare demands of Lao PDR is urgent, since the sector will have to do more with less resources given current macro fiscal conditions.

B. Sectoral and Institutional Context

Over the past decades, Lao PDR has made substantial progress regarding key public health outcomes. Life expectancy at birth increased from 49 years in 1980 to 66 years in 2014, while infant mortality decreased from 135 per 1,000 live births in 1980 to 40 in 2017. Under-five mortality dropped from 200 per 1,000 live births to 46 in the same period. Similarly, maternal mortality ratio and total fertility rate have significantly declined from 546 in 2000 to 206 per 100,000 live births in 2015, and 4.3 from 2000 to 2.7 in 2017 respectively.

However, substantial challenges remain; maternal and child mortality rates and chronic malnutrition (stunting) levels remain among the highest in the region. For maternal and child health outcomes, the country remains amongst the poorest performers globally, as well as in the East Asia and Pacific region. While under-five and infant mortality rates have shown measurable improvement, maternal mortality ratio is still significantly higher than for example in neighboring Cambodia which had started from a higher level in 1990. Adolescent fertility is also a major concern with 83 births per 1,000 women aged 15-19 years old in 2017, only a slight decline from 2012 at 97 births per 1,000. In addition, undernutrition remains a significant challenge. Corresponding to the poor maternal and child health outcomes are low quality of health care and low levels of coverage and utilization of key interventions, including antenatal care, skilled birth attendance, and immunization.

Challenges in improving health and nutrition outcomes adversely affect the accumulation of human capital in Lao PDR. According to the Human Capital Index, children born in Lao PDR today could expect to be only 45 percent as productive as they could have been if they had optimal education, good health and a well-nourished childhood. While Lao PDR is above the average for low-income countries, it is below the average for lower middle-income countries.

About 33 percent of children under five years are stunted, 21 percent are underweight, and 9 percent are wasted. Stunting affects several groups disproportionately—the poor, ethnic minorities, rural children, and upland areas of the country—and stunting and underweight rates among children in the poorest wealth quintile (which is predominantly rural) are over three times the rates for children in the richest quintile. This persistence of high levels of childhood undernutrition presents a staggering, yet avoidable loss of human and economic potential for Lao PDR. Moreover, the national aggregates mask wide inequalities with far worse outcomes in some provinces than in others. For example, stunting rates are higher in provinces like Huaphanh (40.7 percent), Phongsaly (54 percent), Xiengkhuang (48.3 percent) and Sekong (49.9 percent). There is also significant variation across income levels.

Poor access to and quality of health and nutrition services are persistent problems, and disproportionately affect women and the poor, leaving a large gap in essential services needed by mothers and children. Service availability and readiness of the health providers are one of the major service delivery bottlenecks: according to the findings from the 2014 Service Availability and Readiness Assessment (SARA), the overall general service readiness index for Lao PDR was 59 percent in 2014–meaning that, on average, 59 percent of facilities had the required tracer items and amenities to provide basic health services to the population.

Financing for health sector in Lao PDR has long been challenged by the low level of government investment in health and correspondingly high reliance on out of pocket (OOP) health expenditure and external assistance for health. However, there has been significant increase in the government budgetary spending on health from US$11 per capita in 2011 to US$ 53 per capita in 2017. While overall government spending on health has increased, further evidence is needed to understand if the increase has translated into improved availability and delivery of health services.

As Lao PDR prepares to graduate from Least Developed Country (LDC) status by 2024 to become an upper-middle-income country by 2030, it also expects to face declining funding from external sources and the need to increase domestic financing for health. This could potentially have a destabilizing impact on key health services, such as immunization, malaria, HIV and tuberculosis (TB) programs as the country substantial dependence on external finance–in particular, in these priority health programs. Already some of the key development partners have initiated a process of transition and are reducing or even withdrawing their support to procuring commodities including family planning and vaccines and to financing the operating costs for the provision of these services. The reduced availability and unpredictability of the funding for priority health programs may potentially cause a challenge in sustaining and expanding coverage of critical services.

Lao PDR is grappling with some of the world's largest equity differentials with regard to coverage and outcomes of maternal and child health (MCH) services between the rich and poor population (World Bank 2017). As a result, there are high socioeconomic and geographic disparities in reproductive, maternal, neonatal, child and adolescent health (RMNCAH) outcomes in Lao PDR, and especially inequalities related to wealth and ethnicity are pronounced. Low coverage and income disparities in the use of high impact RMNCAH interventions such as family planning and post-natal care for newborns have a negative impact on RMNCAH outcomes.

GOL has been implementing its Health Sector Reform Strategy (HSRS) with a focus to build a people-centered health system that provides equitable access to quality services. The Strategy defines priorities for achieving Universal Health Coverage (UHC) by 2025, with five priority areas of reform in three phases: (i) Human Resources for Health; (ii) Service Delivery; (iii) Health Financing; (iv) Governance, Organization and Management; and (v) Health Information System. Under the second phase of the HSRS implementation, the government has made a major policy decision to establish the National Health Insurance (NHI) scheme and to progressively expand social health projection to the whole population through a unified scheme by integrating the free health services for the poor (HEF), policy for free services for mothers and children under 5 years of age (FMNCH) and community-based voluntary health insurance (CBHI) - thereby reducing fragmentation in the system. Currently, the NHI scheme covers about 5 million people or about 74 percent of the total population, which takes the social health protection coverage in Lao PDR (including insurance schemes for civil servants and private employees) to 94 percent of the population.

The challenge Lao PDR faces on quality of health and nutrition services is now increasingly at the centerstage of policy attention. As a key part of the health sector reform, the MOH has adopted the policy on health care service quality assurance of "Five Good, One Satisfaction" at all levels of the health system since 2016. It calls for the attainment of indicators in the domains of Warm Welcome, Cleanliness. Convenience, Accurate Diagnosis, Good and Quick Treatment as the five 'goods' and on patient satisfaction. This changing configuration of the health system in Lao PDR is occurring amidst multiple transitions in the way healthcare is financed in the country and necessitates alignment of financial and technical support from development partners and close coordination among different stakeholders in the health sector.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To improve access to quality health and nutrition services in targeted areas of Lao PDR.

Key Results

- Number of deliveries attended by a skilled birth attendant (this has been chosen as an access indicator from the list of indicators monitored by the National Assembly; it can be tracked from DHIS2; it is also an important measure of access and equity for pregnant women)
- Number of children under 2 years of age whose growth is adequately monitored as per national guidelines in the four nutrition convergence provinces (this is a nutrition convergence indicator; can be tracked from DHIS2)
- Number of health centers scoring above 60% on a standard quality assessment system with third-party verification (it is a measure of quality and will be based on administrative data from QPS; can be tracked from DHIS2)
- Share of new outpatient cases delivered at the primary healthcare facilities (%) (indicator of efficiency, indicator of primary care performance)

D. Project Description

Component 1: Integrating Service Delivery Performance with National Health Insurance Payments:

This component aims to add a performance layer to NHIB capitation payments to health centers, based on regular assessments using a comprehensive Quality and Performance Scorecard, or QPS. . The scorecard will cover multiple dimensions to assess the performance of service delivery and quality, including infection prevention and control, staff knowledge and skills, availability of key supplies and commodities, delivery of integrated outreach services to zone 2 and zone 3 villages, and performance on priority public health programs with a high weightage for indicators on MCH, Nutrition and TB. The salient features of the QPS are summarized below:

Table 1: Key features of the Quality and Performance Scorecard

- *Quality and Performance linked payments to health centers, using the existing channel that provides fixed capitation payments from the national health insurance system.*
- *Systematic assessment of the health center performance across key dimensions of quality of service delivery, verified by an independent institution*
- *Creates performance linkages to the capitation payments; (currently, National Health Insurance (NHI) payment system is a fixed amount of capitation which is also limited to facility-based services and though in theory linked to a specified benefit package, in practice it is not influenced - positively or negatively - by facility performance or quality). The project will focus on prioritized tracer indicators for priority health and nutrition services that will enhance measurement, accountability and motivation to deliver these services.*
- *Will require efforts to improve autonomy to use these resources, and strengthened Public Financial Management (PFM) and accountability systems*
- *Systematic platform for measurement and incentivization that will be objective and predictable based on facility performance*
- *With focus on performance on key public health and nutrition programs being part of the scorecard, this component will also help in the integration of these programs*
- *Rollout will be undertaken in a phased manner to allow the system to evolve and to ensure adequate supervision and capacity building effort, especially in the early, adaptive learning stages of the system.*

The initial roll out of this performance-based payment to health centers will take place in the four northern priority provinces: Oudomxay, Phongsaly, Huaphan and Xiengkhuang. After then, the mechanism will be rolled out in 2 to 4 additional provinces in each six-monthly cycle, to allow time for assessor training and PFM capacity building in a phased, sustained manner. Performance assessment of health centers will take place every six months by certified assessors from the district health offices using a structured assessment mechanism. To ensure continued reliability and rigor of the system, a random sample of health centers will be re-assessed by an external verification agency that will be competitively recruited by NHIB for this purpose. During the same period of May-June 2021, DHR and DHPE will undertake training for the next set of district assessors, for rolling out the system in two to four additional provinces. This cycle will then continue in every six-monthly period, increasing the number of health centers assessed in each round, until national rollout is achieved.

Component 2: Service Delivery and Nutrition Convergence

This component will use a combination of disbursement linked indicators (DLIs) prioritized toward the four multisectoral nutrition convergence provinces in northern Lao PDR, and other DLIs with a nationwide footprint. It will continue the legacy of results-based instruments focused on service delivery improvements from the predecessor Health Governance and Nutrition Development Project, adapted to the nutrition convergence approach and to the changing health system configuration in the Lao PDR. DLIs will also be instrumental in the delivery of HANSA, to organize and implement the quality assessment

system, for public financial management improvements directed at the health facility level, and to strengthen the integration and sustainability of vertical programs, particularly for TB and HIV programs.

The proposed DLIs will focus on: a) Improved quality of health services at health center level; b) addressing malnutrition; and c) strengthening priority public health programs, including immunization, TB case finding and treatment, as well as coverage of HIV testing for key populations; and c) Strengthening priority public health programs. There will also be a focus on health security and preparedness, especially at ports of entry.

***Component 3: Adaptive Learning and Project Management*:**

This component will finance project coordination and management costs as well as some critical activities that will support the implementation of the project. These will include investments in health information systems, mainstreaming of focus on gender and equity dimensions, external verification of results for both components 1 and 2. The project will also continue to support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management, environmental and social safeguards, M&E and financial audit. A technical staff for supporting the QPS will be supported as well. The component will also support provision of capacity building and supervision of MOH staff at all levels – central, provincial and district – for health program planning and implementation, and carrying out of studies and surveys necessary to inform the implementation of activities and of social and environmental safeguards.

***Component 4: Contingency Emergency Response Component*:**

The objective of the contingency emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the International Development Association (IDA) Immediate Response Mechanism in order to provide an immediate response to an eligible crisis or emergency, as needed. The Component would support a rapid response to a request for urgent assistance in respect of an event that has caused, or is likely to imminently cause, a major adverse economic and/or social impact in health sector associated with natural or man-made crises or disasters. government as a disbursement condition for this component.

Geographical focus

HANSA has a particular focus on the four northern provinces in Lao PDR (Oudomxay, Phongsaly, Xienghuang, Huaphan), which have been chosen for multiple, simultaneous and mutually reinforcing investments by the Government of Lao PDR and the World Bank, as these provinces represent the most ethnically diverse, remote and disadvantaged geographical locations in Lao PDR, with several service access challenges for women and children in particular. Several nutrition-specific interventions under HANSA supported through DLIs, such as SBCC, integrated outreach and for growth monitoring and promotion, are concentrated in these four provinces. Other interventions, which will eventually roll out nationwide over the lifetime of HANSA, such as the Quality and Performance Scorecard (QPS), PFM capacity building at health center levels , and the direct data entry under DHIS2, also commence in these four provinces first, and therefore will see the longest duration of investment effort in these provinces.

E. Implementation

Institutional and Implementation Arrangements

The project will be an Investment Projects Financing (IPF) using a mix of input and results-based financing, including the DLI mechanism but reinforcing this aspect by adding a performance-based payment mechanism at the health center level. In consideration of the current IDA cycle, the project will be frontloaded with the available resources in IDA18, including retroactive financing, and an additional financing will need to be undertaken when IDA 19 resources become available.

The institutional arrangement of the project will follow a similar mechanism as that of the ongoing HGNDP. At the national level, the existing NPCO in the DPC will continue to be responsible for overall project management and administration, implementation of project activities and achievement of DLIs in close coordination with MOH technical departments and those PHOs and DHOs participating in the project implementation and monitoring and evaluation (M&E).

The National Health Insurance Bureau and Department of Healthcare and Rehabilitation will play a central role in the design and implementation of the QPS, in close coordination with other key technical departments, as centers under these departments who will likewise play a critical role in the implementation of activities in their respective key areas. Department of Finance will also play an increasingly larger role both taking on more fiduciary management responsibilities, but also coordinating and taking on the oversight role for building FM capacity at subnational levels, including at health center level.

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

Part of the activities under HANSA will be implemented nationwide; while certain activities related to nutrition will be priorities in the four priority provinces in the northern part of the country: Oudomxay, Phongsaly, Xiengkhouang and Houaphan. It is anticipated that participating provinces will likely have a relatively high concentration of ethnic minority groups. The main focus of the project at this stage is health centers at the commune/ primary care level, which are typically located in populated areas (e.g. close to the center of a village or a town). The HANSA builds on the progress of ongoing Health Governance and Nutrition Development Project (HGNDP), and its nutrition Social and Behavior Change Communication (SBCC) component will cover the same four provinces which are considered the poorest. These areas have diverse ethnic groups – up to 28 ethnic groups, including four ethno-linguistic groups of Hmong-Mien, Mon-Khmer, Lao-Tai, and Chino-Tibetan. The national scope of the project and the initial focus on the four northern priority provinces will result in project activities taking place where Indigenous Peoples are present and as such World Bank Policy 4.10 on Indigenous Peoples is triggered. Under the HGNDP, a Social Assessment was undertaken with free, prior and informed consultations with key stakeholders, and an Ethnic Group Development Plan (EGDP) was developed to ensure that vulnerable groups, including but not limited to ethnic groups, can freely participate in and benefit from the project. Learning from the HGNDP experience, the MOH undertook a Social Assessment for HANSA to assess the proposed project's potential positive and adverse effects with regard to National Health Insurance (NHI) and Maternal, Newborn and Child Health (MNCH) on local communities, barriers and how to address them prior to the project appraisal.

Some of the key health sector issues identified by the social assessment include accessibility, affordability, language and culture, limited health staff and weak information dissemination.

G. Environmental and Social Safeguards Specialists on the Team

Pamornrat Tansanguanwong, Social Specialist
Sang Minh Le, Environmental Specialist
Alkadevi Morarji Patel, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	OP 4.01 is triggered as the project may increase health care waste and create minor environmental impacts associated with small scale renovation activities in selected health care facilities. The Environmental Management Framework is developed by MOH to address these potential impacts.
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	The project will not cause any degradation of natural habitats as defined under the safeguard policy.
Forests OP/BP 4.36	No	The project will not degrade critical forest areas as defined under the safeguard policy.
Pest Management OP 4.09	No	The project will not involve any procurement of pesticides nor cause any increased use of pesticide.
Physical Cultural Resources OP/BP 4.11	No	The project will not adversely affect sites with archaeological, paleontological, historical, religious, or unique natural values.
Indigenous Peoples OP/BP 4.10	Yes	The implementation of the project will start with four geographies converging for nutrition results in the northern provinces of Lao PDR, namely Oudomxay, Phongsaly, Xiengkhuang and Houaphan where the majority ethnic groups reside. The project would then be rolled out to cover all provinces. It is expected that the project will expand to 2-4 provinces in each cycle. Final areas and timing

for the expansion will be decided by the government committee in charge of the project later on.

The ethno-linguistic classification of ethnic groups in Lao PDR identifies 49 categories of ethnic groups with over 160 sub-groups. The project is expected to help strengthen inclusion and accessibility to health services of the poor and vulnerable groups as well as ethnic groups especially those in remote rural areas. While adverse impacts on Indigenous Peoples or vulnerable groups are not expected, the project will benefit these groups and as such the World Bank Operational Policy 4.10 on Indigenous Peoples is triggered.

A social assessment was conducted during preparation focusing on the accessibility and performance of the NHI and MNCH services and barriers and how to address them. An Ethnic Group Development Framework (EGDF) has been prepared based on the social assessment and consultations to address policy requirements and to ensure that the project would provide culturally appropriate benefits to ethnic populations. The EGDF includes the elements of an Indigenous Peoples Planning Framework as required under OP 4.10.

Free, prior and informed consultations were conducted with key stakeholders such as representatives from ethnic minority groups and other vulnerable groups, such as the poor and women-headed households. The project received broad community support including from the community health practitioners.

Beyond the procedures and guidelines provided under the EGDF, the project has also integrated social inclusion aspects in the Quality Performance Scorecards at the health centers for component I as well as in the DLI for component 2. This is to ensure that aspects of social safeguards are imbedded in the project process and will be implemented and monitored throughout the project implementation. The EGDF is be disclosed on the MoH website on ……. and on World Bank's website on…….

Involuntary Resettlement OP/BP 4.12	No	Potential impacts under 4.12 will be assessed and determined during project preparation.
Safety of Dams OP/BP 4.37	No	The project does not involve any dams.
Projects on International Waterways OP/BP 7.50	No	The project does not involve international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project will not be located in any known disputed areas as defined in the policy.

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:

Environmental safeguard issues:

Project triggers the Environmental Assessment OP/BP 4.01 safeguard policy. The project will not finance any new construction but health facilities may be able to use their own resources for minor repair. The renovation and refurbishing activities are minor and would be done in the same existing buildings, within the same footprint and without the extension of the respective buildings. These activities are considered minor civil works which may generate limited adverse environmental impacts such as dust, noise, vibration, waste, solid waste and safety issues. Also, there could be isolated health risks associated with exposure to asbestos containing materials in the case of old facilities that are using asbestos roofs. Additionally, in the case of building renovation activities including changes of internal layout (e.g., walls), there is a potential risk on the structure and safety of the existing buildings. It is anticipated that the potential impacts of construction/renovation will be minor, site specific and manageable by mitigation measures.

The project will improve healthcare service delivery at the facility level, therefore, increase generation of healthcare waste and relevant wastewater. Only 10-25% of solid healthcare waste at primary healthcare settings is regarded as “hazardous waste” including sharps, infectious wastes, anatomical waste (placenta) and small amount of pharmaceutical waste. If segregated correctly, generation of hazardous healthcare waste is 0.1 kg/bed/day at health center and 0.12 kg/bed/day at district hospital . Wastewater from health center has insignificant weight approximately 1m3 per day and has the same basic component as the domestic wastewater. Given to small amount of healthcare waste and wastewater from health facilities, potential impacts on the environment are deemed to be minor, site specific, and for which mitigation measures can be readily designed.

Social safeguard issues:

The project will be implemented nationwide, with the first phase concentrating in the four northern priority provinces where ethnic groups reside. No adverse social impacts are anticipated, however the project has the potential for benefits that should reach Indigenous Peoples and vulnerable groups. The social assessment and free, prior and informed consultations findings include: i) limited access to information of the National Health Insurance (NHI) policy; ii) limited understanding by the beneficiaries of the certified documents needed for the service; iii) lists of the poor to receive exemption from payment are not up-to-date and not distributed to the health facilities; iv) some patients

reported paying extra fees on top of co-payment or user fees; v) limited knowledge and capacity of health facility staff regarding NHI implementation; vi) limited capacity of the health care staff to provide basic Maternal, Newborn and Child Health (MNCH)care; vii) limited trained female Skilled Birth Attendant (SBA) staff to enable access for ethnic women; iii) health facilities do not have staff who can speak ethnic languages; viii) the physical environment for birthing rooms is inappropriate, it needs to be more culturally acceptable and incorporate non-harmful women's cultural practices; ix) limited awareness of the importance of facility-based delivery and other MNCH services; common beliefs in remote rural communities that pregnancy and childbirth are 'natural' occurrences and do not require medical treatment; and x) limited understanding among men in general on the importance of MNCH services. Free, Prior and Informed Consultations indicated that the project has broad community support and communities will benefit from better access to NHI, MNCH and nutrition services.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
There is no indirect or long-term impacts due to anticipated future activities in the project area.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
Not applicable

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.
The MOH has developed experience implementing World Bank-financed project over time including requirements regarding Safeguard Policies. Under the ongoing HGNDP, the MOH has been implementing an Environmental Management Plan including (i) application of specific Environmental Code of Practices (ECOPs) to address potential adverse environmental impacts linked to refurbishment works, and (ii) deployment of sharp waste management plan to address infectious and non-infectious sharp waste that will be generated by the HCFs. Throughout the implementation of HGNDP, the MOH developed the sharp waste management guidelines. The current rating of environmental safeguard compliance is moderately satisfactory.

As part of HANSA project preparation, MOH developed an Environmental Management Framework (EMF). Scope of EMF includes: (a) ECOPs to address environmental risks related to refurbishment works; (b) sharp waste management guidance to manage sharps and infectious waste generated from HCFs. In addition, the EMF lays out the procedures for safeguard implementation, monitoring and reporting as well as institutional arrangement, training and cost for safeguard implementation. The EMF is in compliance with the national regulations on environmental management and The World Bank's safeguard policies.

HANSA is built on the experience of HGNDP. MOH has set up a safeguards committee to implement safeguards according to the Ethnic Group Development Framework. Under HANSA, the MoH has expanded the committee members to include all key agencies working on all components of HANSA. One safeguards consultant will be hired to support the committee and to ensure that safeguards is implemented effectively. Safeguards will be integrated in the overall training for health staff at all levels. The Ethnic Group Development Framework (EGDF) was developed taken into account the findings and recommendations from social assessment and free, prior, informed consultations. The EGDF includes the elements of an Indigenous Peoples Planning Framework as required under World Bank Policy, OP 4.10, on Indigenous Peoples. It includes procedures help enhance participation of ethnic groups, consultations and assessment, monitoring, capacity building and feedback resolution mechanism. Budget for safeguards implementation will be allocated under Component III. Measures to enhance inclusion of ethnic groups were also integrated in the Quality Performance Scorecards of the health centers.

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

Key stakeholders include: (i) MOH and National Project Coordination Office; (ii) Provincial Health Office (PHO) and Provincial Project Coordination Team; (iii) healthcare facilities and professionals; (iv) District Health Office (DHO) and District Project Coordination Team; (v) Health Center; and (vi) local communities at commune and village levels, including vulnerable and under-served population groups such as ethnic minorities.

During the project preparation, social assessment, EGDF and EMF were conducted. Free, prior and informed consultations were organized during March 10-23, 2019 in 23 villages and 6 health centers of the four convergence provinces. Meaningful consultations on the draft EMF and EGDF were conducted again at the provincial consultative workshop on May 28, 2019 and October 31, 2019. Participants include representatives from MOH, PHOs, DHOs and healthcare staff including ethnic staff. The EMF including the ECOPs and the sharp waste management guidelines, EGDF and Social Assessment have been disclosed in country on .../.../2019.

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-Dec-2019	20-Dec-2019	

"In country" Disclosure

Lao People's Democratic Republic
26-Dec-2019

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
05-Dec-2019	20-Dec-2019

"In country" Disclosure

Lao People's Democratic Republic
26-Dec-2019

Comments

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?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

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
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes
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?
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

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APPROVAL

Task Team Leader(s):	Somil Nagpal	

Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Enis Baris	20-Dec-2019
Country Director:	Viengsamay Srithirath	07-Jan-2020